Aneurin Bevan University Health Board - Public Board

Wed 22 November 2023, 09:30 - 17:30

Conference Centre, Headquaters, St Cadocs

Agenda

1.
Preliminary Matters

1.1.
Welcome and Introductions

Verbal *Chair*

1.2.
Apologies for Absence for Noting

Verbal *Chair*

1.3.
Declarations of Interest for Noting

Verbal *Chair*

1.4.
Draft Minutes of the Health Board Meeting, held on 27th September 2023, for Approval

Attachment *Chair*

1.4 Draft Board Minutes 27.09.23 Chair approved.pdf (12 pages)

1.5.
Summary of Board Business, held In-Committee, on 27th September 2023, 11th October 2023, and 25th October 2023

Attachment *Chair*

1.5 Summary of Board Business held In Committee.pdf (5 pages)

1.6.
Board Action Log for Review

Attachment *Chair*

1.6 Board Action Log for Review.pdf (3 pages)

1.7.
Report on Sealed Documents and Chair's Actions

Attachment *Chair*

1.7 Report on Sealed Documents and Chairs Actions1.pdf (4 pages)

1.8.
Report from the Chair

Verbal *Chair*

1.9.
Report from the Chief Executive

Verbal *Chief Executive*

2.
Patient Experience and Public Engagement

2.1.
Report from Llais, Gwent Region

Attachment *Regional Director, Llais*

2.1 Llais Gwent Region - Report for Aneurin Bevan University Health Board - Public Board Meeting - Nov 2023.pdf (10 pages)

2.2.
Patient Story: Tyleri Ward Community Resource Team (CRT)

Presentation *Director of Nursing*

3.
Items for Approval/Ratification/Decision

3.1.
Health & Safety Annual Report

Attachment *Director of Therapy and Health Science*

3.1 Health and Safety Annual Report (Ver. 4 - 13 Nov 2023).pdf (10 pages)
3.1a Appendix 1 ABUHB Health Safety and Fire Annual Report 2022-23 (Draft - Version 14 - 13 Nov 2023).pdf (43 pages)

3.2.
Nursing and Midwifery Strategy

Attachment *Director of Nursing*

3.2 Nursing and Midwifery Strategy 2023-2026.pdf (4 pages)
3.2 a Nursing Midwifery Strategy - 2023-2026 - APPROVED AT EXEC 091123.pdf (25 pages)

3.3.
Quality and Safety Systems Framework for Speaking Up

Attachment *Director of Nursing & Director of Workforce and OD*

3.3 Quality and Safety Systems Framework for Speaking Up - FINAL.pdf (5 pages)
3.3 a 48156 speaking up safely E Document.pdf (30 pages)
3.3 b 2023-08-25 JP to CEs Quality and Safety Systems.pdf (3 pages)
3.3 c 26 10 23 Letter to HA - Re Speaking up Safely Framework - Response.pdf (2 pages)
3.3 d 19 10 23 Speaking up Safely Self Assessment final.pdf (9 pages)

3.4.
Winter Plan 2023/24

Attachment *Director of Strategy, Planning and Partnerships*

3.4 Winter Plan 2023-24.pdf (5 pages)
3.4 a Winter Plan 2023 Final.pdf (38 pages)

3.5.
Strategic Equality Plan 2024-2028

Attachment *Director of Workforce and OD*

- 3.5 Strategic Equality Plan 2024-2028 FINAL .pdf (11 pages)
- 3.5 a Copy of Project Plan SEP Consultation Appendix 1.pdf (1 pages)

3.6.
Patient Safety Incident Reporting and Management Policy

Attachment *Director of Nursing*

- 3.6 Patient Safety Incident Reporting and Management Policy (002).pdf (6 pages)
- 3.6aFINAL VERSION Patient Safety Incident Reporting Management Policy 2023.pdf (36 pages)

3.7.
Long-Term Strategy: Approach and Principles

Attachment *Director of Strategy, Planning and Partnership*

- 3.7 Long Term Strategy- Approach and Principles FINAL.pdf (6 pages)

4.
Items for Discussion

4.1.
Stroke Reconfiguration Update

Attachment *Director of Strategy, Planning and Partnerships*

- 4.1 Stroke Reconfiguration Update.pdf (9 pages)

4.2.
Nurse Staffing Levels Wales Act (NSLWA) Annual Report

Attachment *Director of Nursing*

- 4.2 Nurse Staffing Levels Wales Act (NSWLA) Annual Report.pdf (4 pages)
- 4.2a Appendix 1 NSLWA Template Nov23.pdf (8 pages)
- 4.2b Appendix 2 - Summary of Nurse Staffing Levels (Adult Acute Medical inpatient wards).pdf (2 pages)
- 4.2c Appendix 2 - Summary of Nurse Staffing Levels (Adult Acute Surgical Wards).pdf (1 pages)
- 4.2d Appendix 2 - Summary of Nurse Staffing Levels (Paediatric Wards).pdf (1 pages)

4.3.
Quality Performance Report

Attachment *Director of Nursing*

- 4.3 Quality Performance Report Nov 23.pdf (4 pages)
- 4.3 a Quality Report - April to September 2023.pdf (36 pages)

4.4.
Integrated Performance Report, Quarter 2

Attachment *Director of Strategy, Planning and Partnership*

- 4.4 Integrated Performance Report, Quarter 2.pdf (6 pages)
- 4.4a 202326 Quarter 2 Outcome and Performance Report BOARD.pdf (30 pages)
- 4.4b Outcomes Framework Q2 2324.pdf (6 pages)

4.5.

Financial Performance

4.5.1.
Month 7 Performance Report

Attachment *Director of Finance and Procurement*

- 4.5.1 Month 7 Performance Report V2.pdf (36 pages)
- 4.5.1 a Appendix 1 Aneurin Bevan University Health Board.pdf (27 pages)

4.5.2.
Financial Recovery Governance Framework

Attachment *Director of Finance and Procurement*

- 4.5.2 Financial Recovery Governance Framework (final).pdf (4 pages)
- 4.5.2a Financial Delivery Governance framework_Board_23.11.22.final.pdf (12 pages)

4.6.
Strategic Risk Report

Attachment *Chief Executive*

- 4.6 Strategic Risk Report v4.pdf (7 pages)
- 4.6a Appendix A_Master Strategic Risk Register.pdf (2 pages)
- 4.6b Appendix A_Strategic Risk Assessments.pdf (35 pages)
- 4.6c Appendix B SRR 011 Service Delivery_Director of Public Health Strategies.pdf (1 pages)

4.7.
Executive Committee Chair's Report

Attachment *Chief Executive*

- 4.7 Executive Committee Chairs Report -November 2023 V4.pdf (7 pages)

4.8.
Public Service Board Update

Attachment *Director of Public Health*

- 4.8 Public Service Board Update.pdf (4 pages)

4.9.
Regional Partnership Board Update

Attachment *Director of Strategic, Planning & Partnership*

- 4.9 Regional Partnership Board Update November 2023.pdf (5 pages)

4.10.
An Overview of Joint Committee Activity

4.10.1.
WHSSC Update Report

Attachment *Chief Executive*

- 4.10.1 WHSSC Update Report.pdf (4 pages)
- 4.10.1a Appendix 1 JC Briefing (Public) 19 September 2023 vFinal.pdf (6 pages)

4.10.2.
EASC Update Report

Attachment *Chief Executive*

- 4.10.2 EASC Update Report.pdf (12 pages)

4.11.
Key Matters from Committees of the Board

Attachment *Committee Chairs*

4.11 Key Matters from Committees of the Board.pdf (13 pages)
4.11a Appendix 1 SSPC Assurance Report 21 September 2023.pdf (8 pages)

5.
Other Matters

5.1.
Date of the next meeting is Wednesday 24th of January 2024

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN

MINUTES OF ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING

DATE OF MEETING	Wednesday 27th September 2023
VENUE	Conference Centre, St Cadoc's Hospital and via Microsoft Teams

PPRESENT	Ann Lloyd	Chair
	Nicola Prygodzicz	Chief Executive
	James Calvert	Medical Director
	Peter Carr	Director of Therapies and Health Science
	Sarah Simmonds	Director of Workforce and OD
	Jennifer Winslade	Director of Nursing
	Hannah Evans	Director of Strategy, Planning and Partnerships
	Robert Holcombe	Director of Finance & Procurement
	Paul Deneen	Independent Member (Community)
	Louise Wright	Independent Member (Trades Union)
	Dafydd Vaughan	Independent Member (Digital)
	Philip Robson	Special Advisor to the Board
	Iwan Jones	Independent Member (Finance)
	Leanne Watkins	Chief Operating Officer
	Prof Helen Sweetland	Independent Member (University)
	Shelley Bosson	Independent Member (Community)
	Paul Solloway	Director of Digital
IN ATTENDANCE	Rani Dash	Director of Corporate Governance
	Bryony Codd	Head of Corporate Governance
	Karen Newman	Assistant Director Communication and Engagement
	Tanya Strange	Head of Nursing, Patient Centred Care
Apologies	Pippa Britton	Vice Chair
	Tracy Daszkiewicz	Director of Public Health
	Cllr Richard Clark	Independent Member (Local Authority)
	Martin Blakebrough	Independent Member (Third Sector)
	Jemma Morgan	Regional Director, Llais
	Linda Joseph	Deputy Regional Director, Llais

ABUHB 2709/01	**Welcome and Introductions** The Chair welcomed members to the meeting, in particular members of the public who were able to join the meeting to observe in person and on line. It was noted that the meeting would be recorded and published on the Health Board's website following the meeting.
ABUHB 2709/02	**Declarations of Interest** There were no Declarations of Interest raised relating to items on the agenda.

ABUHB 2709/03	**Minutes of the previous meeting** The minutes of the meeting held on 19th July 2023 were agreed as a true and accurate record.
ABUHB 2709/04	**Summary of Board Business, held In-Committee, on 19th July, 9th August and 31st August 2023** The Board NOTED an overview of the formal discussions held by the Board at its private meetings held on 19th July, 9th August and 31st August 2023
ABUHB 2709/05	**Action Log and Matters Arising** It was noted that all actions within the Board's action log had been completed or were in progress. Shelley Bosson (SB) queried whether or not there would be any impact on service users due to the delay in the development of a commissioning approach for continuing healthcare. Leanne Watkins (LW), Chief Operating Officer, confirmed that there was no service user/provider impact. An independent review was being undertaken in continuing healthcare and an update would be presented to the next meeting. **Action: Chief Operating Officer**
ABUHB 2709/06	**Report on Sealed Documents and Chair's Actions** Rani Dash (RD), Director of Corporate Governance, provided an overview of the use of the Health Board's Seal and Chair's Actions that had been undertaken during the period 4th July and 6th September 2023. The Board NOTED and RATIFIED the use of the common seal and Chair's Actions in line with Standing Orders, as set out within the paper.
ABUHB 2709/07	**Chair's Report** The Chair provided her verbal report, with an overview of the activities she had undertaken, outside of her routine meetings and visits, as follows: • Attended three Ministerial meetings; ○ one relating to the financial pressures being experienced by the health service in Wales at which the Minister requested plans to achieve further savings in addition to those already planned. These had been submitted by the Health Boards and the Chair thanked the teams involved in preparing these within short timescales. ○ A meeting regarding winter planning, attended by local authorities, Regional Partnership Boards and Health Boards. The Minister was aware of the pressures currently faced across the system and the increased pressure that winter would bring and was keen for local authorities and health boards to work together on solutions, together with RPBs. • Undertaken a number of visits, including to NHH to talk to staff about the issue of RAAC, noting an update was included on today's agenda. • Attended RPB leadership forum, looking at performance, resources and governance. She had previously requested that a governance review of the Gwent RPB be undertaken to ensure it was fit for purpose in its extended role. This report had been received and a small working group established to take forward the recommendations. • RPB had requested guidance as to whether or not the tapering arrangements will be implemented next year as this would have a significant impact on planning in all the statutory bodies. • RPBs had met with Ministers, with discussions focussing on children's services and the eliminate agenda.

	• Meetings with Chairs of Health Boards, with discussions focussed on finance, quality of care and the 10 year plan. The Chair highlighted her gratitude to staff for coping with the demands placed on their services and the care that they provide. Also, to the Executive for their hard work and the sensible advice that they provide. The Chair confirmed that as a Board we would strive to do our utmost to deliver good quality, timely care for the people of Gwent. The Board NOTED the Chair's Report.
ABUHB 1907/08	**Chief Executive's Report** Nicola Prygodzicz (NP), Chief Executive, reinforced the significant focus that has been required on the challenging financial context at both a national and local level; and noted the significant effort and structures put in place across the Health Board to ensure that options are considered through a quality and safety lens to fully understand the impact of decisions. NP explained that an enhanced control environment was in place as costs were still running above the plan. NP highlighted the positive response from staff with over 300 suggestions received about how the Health Board could make savings, which were being considered and taken forward. The Health Board has received confirmation from Welsh Government that it will be put into enhanced monitoring for planning and finance, which is consistent with all Health Boards as part of the NHS Wales Escalation Framework due to the financial position across NHS Wales. NP confirmed that there was a continuing focus on working to meet the increasing demand on services, recover waiting times and meet planned care targets. A quantitative report was being prepared to demonstrate how demand on the Health Board's services has changed over recent years, bringing additional pressure on the system. NP acknowledged the increase in COVID prevalence, and the national work being undertaken to monitor the variant to ensure the vaccination programme responded appropriately. NP stated that she had visited a number of services in recent weeks, including the neonatal unit, mental health services at Acer House, Health Visiting at Blaenau Gwent, Ysbyty Aneurin Bevan, Tredegar Health and Wellbeing Centre and had attended the mental health wellbeing day event. NP commented on how she continued to be impressed by the positivity and energy of teams who were always looking at opportunities for new ways of working. NP congratulated those staff nominated, and were winners, in the South Wales Argus awards. The Board NOTED the CEO's Report.

ABUHB 2709/09	**Report from Llais** The Board noted apologies from Jemma Morgan, Regional Director, Llais. The Board received the report from Llais which provided an overview of the current issues of concern and positive observations, being addressed by Llais Gwent Region in relation to the planning and delivery of health services. It was agreed that the following queries would be feedback to Llais: • The report references "*Some people told us if they could make changes to the information they receive, to make it easier for them to understand, they would make the information "very concise and easy to understand," "no jargon" and "more understandable*." – It was suggested that, if possible, patients could share information on those services from which information is confusing so that the organisation could support targeted improvement. There was also a request for a discussion on the work that Llais' is undertaking with Children and Young People. The Board NOTED the report.
ABUHB 2709/10	**Patient Story – Dementia Care** Tanya Strange (TS), Head of Nursing, Patient Centred Care, presented a short story to demonstrate how the Health Board was listening to feedback and making positive changes as a result. The Board had heard 'John's Story' previously, in which John's wife, Paula, shared her experience of the hospital care received by her husband, John, who had dementia during the pandemic. TS explained that a learning event had been held with the clinical teams involved in John's care and the focus of the dementia care action plan had changed as a result. The Health Board had relaunched 'John's Campaign' – a framework for making sure that carers of people living with dementia were welcome on hospital wards. A Dementia Specialist Practitioner had been appointed and dementia training was now mandatory on the electronic staff record. TS highlighted that key learning was for anyone going on to a ward to recognise people with dementia and the dementia daisy was now in place. Additional training had also been provided to staff on oral care, meaningful activity and anticipatory loss. The Chair thanked Paula again for sharing her story. Shelley Bosson (SB), Independent Member, asked what the compliance levels were with the dementia training, and if the same standards had been put in place across all of the Health Board's hospitals. TS confirmed that the standards and training were in place across all areas for all staff and agreed to confirm current compliance levels outside the meeting. **Action: Director of Nursing/Head of Nursing, Patient Centred Care**

	Jennifer Winslade (JW), Director of Nursing, confirmed that a Patient Advice and Liaison Services (PALS) service would commence in October and this would change the nature of interactions between the Health Board and families. JW also acknowledged the work undertaken by Tanya and the team in relation to dementia care. The Board NOTED the patient story and actions to improve services as a result.
ABUHB 2709/11	**Performance and Accountability Management Framework** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, presented l the Performance and Accountability Framework for approval and provided clarity on how the Health Board would approach accountability and performance management, and support the standards and ambitions that had been set. The Framework set out the principles and approach from both a behavioural and structural point of view. The document put into context the Welsh Government Accountability Framework, from Board level to individual PADRs, with a focus on divisional and corporate accountability. It was confirmed that progress against the framework would be monitored via the Finance and Performance Committee, with a future audit on its application being undertaken by the Audit, Risk and Assurance Committee. Members agreed the importance of Accountability letters so that all staff knew how this framework would operate and how it would affect them. The Board APPROVED the Performance and Accountability Framework and agreed that a review on implementation would be provided to the Finance and Performance Committee in 6 months. **Action: Director of Strategy, Planning and Partnerships**
ABUHB 2709/12	**Updated Standing Orders and Standing Financial Instructions** Rani Dash (RD), Director of Corporate Governance, presented for approval the revised Standing Orders and Standing Financial Instructions, which had been issued by Welsh Government for approval. RD highlighted that the revised versions contained two local amendments, previously agreed by the Board in relation to the timing of the issuing of Board papers and the timing of the AGM for 2022/23. The Board ADOPTED the revised Standing Orders and Standing Financial Instructions.
ABUHB 2709/13	**Clinical Advisory Forum Terms of Reference and the Quality Impact Assessment Process** Jennifer Winslade (JW), Director of Nursing, presented the Clinical Advisory Forum (CAF)Terms of Reference for approval. It was noted that an interim CAF had been established following financial recovery discussions. JW explained that the CAF would provide a mechanism to seek an essential contribution from clinicians across the Health Board in the development of the Health Board's clinical, patient experience and quality strategies. The role of the CAF would be to advise and recommend, not to take decisions.

	Rani Dash (RD), Director of Corporate Governance, confirmed that this was a required advisory forum for the Board and therefore Ministerial approval would be required to appoint the Chair as an Associate Member of the Board. Helen Sweetland (HS), Independent Member, noted the representation of all professions and queried how best to ensure representation of all activities across the Health Board. JW confirmed that, for this reason, there was scope in the ToR to extend the membership beyond those listed, to ensure full representation. Phil Robson (PR), Special Advisor, asked whether or not representation could be included in order to introduce challenge. RD confirmed that the ToR enabled this to happen for specific areas of work but the membership required internal representation. The Board APPROVED the Clinical Advisory Forum Terms of Reference and Operating Arrangements.
ABUHB 2709/14	**Configuration of Midwifery-led Units: Outcome of Public Engagement** Jennifer Winslade (JW), Director of Nursing, presented for approval the preferred option for implementation for future service configuration, following a period of public engagement. JW confirmed that the Board had previously discussed the ongoing pressures in maternity services and agreed interim arrangements as a result, followed by public engagement. This had now been undertaken with no significant objections received to the arrangements. It was noted that the financial assessment had been previously circulated and there was no financial impact on the changes.) Within the paper presented to the Board in September 2022 regarding the extension of temporary service change to MLUs, it was noted that the change secured the release of 4.4 WTE midwives and 1 WTE health care support worker to support midwifery activity across the service. It was agreed that the costs associated with the service would be recirculated to Board Members. **Action: Director of Nursing** JW confirmed that the outcomes of maternity services were monitored by the Patient Quality, Safety and Outcomes Committee. JW explained that this change was part of broader work required into maternity services to understand what a future proof model would look like. The Board NOTED the outcome of the implementation and APPROVED the implementation of the preferred option – to make permanent the changes instigated in May 2022. A report would be provided to the Patient Quality, Safety & Outcomes Committee in 6 months to evaluate effectiveness. **Action: Director of Nursing**
ABUHB 2709/15	**Welsh Language Annual Report** Sarah Simmonds (SS), Director of Workforce and OD, presented for approval the Welsh Language Annual Report 2022/23. SS highlighted some key successes, including:

	• Appointment of internal translator to increase translation capacity and the lower costs of translation. • 10% increase in compliance in recording Welsh Language competencies • Roll out the new mandatory More Than Just Words training for all staff, with compliance currently at 63% • Proactive work with services to promote the active offer. Further work was to be undertaken included compliance with the 121 Welsh Language Standards and funding, has been provided to appoint a Welsh language tutor later in the year. Iwan Jones (IJ), Independent Member, asked what the costs of this work. SS confirmed that there was a funded Welsh language unit as part of the Workforce and OD division and a small budget for translation. However, there were ongoing costs to services in terms of bilingual letters etc and work was ongoing in relation to patient choice regarding the language in which they wanted to receive correspondence. Paul Solloway (PS), Director of Digital, explained that a patient communication platform would be launched next year which would store patient choice. There was also a new tool on Microsoft which included much improved Welsh translation. The Board APPROVED the Welsh Language Annual Report.
ABUHB 2709/16	**Communication and Engagement Strategy** Karen Newman (KN), Assistant Director of Communications and Engagement presented the Communication and Engagement Strategy for approval, noting that formal consultation and engagement remained the responsibility of the the planning team. KN confirmed that the Strategy had been reviewed by the Equality Impact Assessment group. The Strategy contained 7 aims, framed around the IMTP priorities and recognised the changing landscape of communication. KN confirmed that there were no financial implications for the Strategy. Shelley Bosson (SB), Independent Member, asked whether or not it would be possible to include case studies to show how change had occurred due to engagement to provide more context and demonstrate where this work is helping to change services. This was noted. The Board welcomed the document and APPROVED the Communication and Engagement Strategy.
ABUHB 2709/17	**Update on Reinforced Autoclaved Aerated Concrete (RAAC)** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided an update on the outcome of recent surveys in to RAAC prevalence at Nevill Hall Hospital (NHH) and the proposed next steps for development of a service and site plan. HE outlined that, following the desktop review requested by Welsh Government, RAAC had been identified at NHH. A detailed survey of 53,500m^2 had found RAAC

	in approximately 14,000m^2. This equated to 7,500 planks of RAAC. The two blocks accommodating wards did not have RAAC. All planks of RAAC had been surveyed and categorised. Just under 5% were categorised as high critical and immediate actions undertaken in terms of propping and planking. HE emphasised the safety of patients, visitors and staff were of paramount importance in stabilizing the buildings. HE outlined the approach being undertaken in relation to the assessment and mitigation of immediate risk and the detailed work to move out of areas with RAAC has commenced. It was noted that 'making good' was not an appropriate approach due to the costs. Plans were therefore being developed to move out of RAAC affected areas and to redesign the services provided at NHH. HE confirmed that the Health Board had incurred costs of £250k to date. High level indicative costs were available for remedial works but the Board would need a plan that would provide for the longer term. The costs for this were not yet known. HE re-stated the commitment to the NHH site and its future but noted that it was important to look, initially at how the future services would be configured. The Chair acknowledged that this was a complex issue and noted the significant effort to ensure the safety of staff, visitors and patients, which would continue. The Chair thanked all those who continued to work in these challenging areas. The Board NOTED the report.
ABUHB 1709/18	**Annual Plan 2024/25: Approach and Key Milestones** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided an overview of the approach taken in the development of next years Annual Plan, noting the challenging year ahead and the requirement to focus on quality and safety through a value lens. The final plan would be presented to the Board in March 2024 and would identify: • Actions that lead towards sustainability • Clear parameters around which services could plan • The strengthening of the integrated nature of the plan And which would be ambitious but realistic in terms of ministerial targets and resources. Phil Robson (PR), Special Advisor, welcomed the plan but was concerned that it was focussed on the Health Board as a single organisation and might not reflect the ethos of modern public services. Nicola Prygodzicz (NP), Chief Executive, agreed and commented on a helpful discussion recently with local authorities, police and other partners about the key areas of work to undertake together, using the marmot region ethos and launch. The Annual Plan could then link with this and its principles. The Chair confirmed that she had raised the need for clear joint priorities with the PSB and local leaders.

	Shelley Bosson (SB), Independent Member, raised concern at the annual plan approach and have it related to the 3,5,10 year plan and requested clarity on this in future reports. Iwan Jones (IJ), Independent Member, raised the need to demonstrate how the Annual Plan would bring the Health Board towards financial balance in 3 years, as per the Integrated Medium-Term Plan. The Board NOTED the report.
ABUHB 2709/19	**Integrated Performance Report** Hannah Evans (HE), Director of Strategy, Planning and Partnerships, provided an overview of progress against the main reportable targets and standards at the end of August 2023. HE highlighted: • Good progress in reducing long waits in paediatric surgery • Eliminating long waits in outpatients, with the exception of a few due to patient choice • Reduction in outpatient DNAs • Single cancer pathway performance at 60.2% in July, with early indications of improved performance in August; recognising the further work required Key challenges included: • Off profile for 104 weeks waits in planned care due to specific issues in ENT, spinal surgery and neurology • Urgent and emergency care systems remained challenging • Challenges in performance in relation to mental health, Leanne Watkins (LW), Chief Operating Officer explained that issues with WCCIS had meant that the Health Board had been unable to report performance. These issues had now been resolved and had shown that performance was not at the required levels for mental health services. Fortnightly performance meetings have been established with the division to drive forward performance. A detailed recovery plan was required, acknowledging the significant increase in demand post covid. There was a need for a forensic assessment and multiagency approach to address the issues. It was agreed that future reports needed to capture demand in a more cohesive way to aid understanding of the context within which we are working. The Chair welcomed the improvements in waiting times for paediatric surgery and queried progress with the performance of the specialist service provided by Cardiff and Vale UHB. Nicola Prygodzicz (NP), Chief Executive, confirmed that this had been discussed at WHSSC and capacity had been outsourced to England to help to reduce long waits. The Board NOTED the report.
ABUHB 2709/20	**Financial Performance** Rob Holcombe (RH), Director of Finance and Procurement, presented the paper outlining the financial performance at the end of August 2023.

	The year-to-date revenue position was a deficit of £71m with a best case forecast year end position of £112m deficit. The report outlined the risks and significant mitigations required to achieve this. The risk range was £112m to £160m. The Health Board continued to forecast a breakeven position for capital expenditure. RH highlighted the following assumptions: • Full receipt of anticipated funding sources – actively discussing changes to policy with Welsh Government • Funding for pay awards The IMTP included £51m savings with a forecast delivery of £30m with £21m assessed as 'red'. The Chair acknowledged that this was a very worrying and serious position. She understood the effort throughout the organisation to restrict spending and not impact patient care; however, the organisation may still be expected to make further savings. RH commented that the target was still to achieve the forecast of £112m deficit. However, the Health Board was off profile to achieve this. There was a need to revisit all plans to ensure accelerated delivery and to maximise in year savings. It was important for the Board to be aware that there may be a need to revisit previous decisions. The Chair confirmed that it was essential to support the executive team to deliver efficient and effective services. Shelley Bosson (SB), Independent Member, asked if the Discharge Board was aware of the 29% of delayed patients waiting due to family placements/choice. Jennifer Winslade (JW), Director of Nursing, explained that there was a need to change the culture of clinical decision making and risk tolerance. A number of changes and positive processes had been enacted in relation to discharge. The patient safety days, held collaboratively across teams, would provide additional support for this. The Board NOTED the report.
ABUHB 2709/21	**Strategic Risk Report** Nicola Prygodzicz (NP), Chief Executive, presented the report which provided an assessment of strategic risks associated with achieving the Board's strategic priorities for assurance. Paul Deneen (PD), Independent Member asked how NHS Wales wide risks were captured. Rani Dash (RD), Director of Corporate Governance, explained that the strategic risk register assessed the risks in achieving the Health Board's priorities and would address the integrated nature of plans. The Board NOTED the report
ABUHB 2709/22	**Board Self-Assessment**

	Rani Dash (RD), Director of Corporate Governance, presented the Board's self-assessment of effectiveness for 2022/23, noting that the areas for development were outlined within the report. RD confirmed that committees of the Board were now starting to undertake mid-year self-assessments to inform end of year reporting and assessment. The Board NOTED the report.
ABUHB 2709/23	**Executive Committee Activity** Nicola Prygodzicz (NP), Chief Executive, presented an overview of a range of issues discussed by the Executive Committee at meetings held between 8th July and 7th September 2023. NP highlighted: • Launched CIVICA - a citizen experience platform which provided a powerful tool for staff to receive balanced feedback. • Challenges in relation to Mental Health with a weekly improvement plan in place. • Core Learning Committee established. The Board NOTED the report.
ABUHB 2709/24	**Regional Partnership Board Update** Hannah Evans (HE), Director of Strategy, Planning and Partnerships provided an update on RPB activities. HE confirmed that the RPB had met since the report had been prepared and had formally received the governance review. There was a recognition that further work was required regarding joint priorities and in strengthening relationships. The RPB had also received the draft Strategic Capital Plan and Strategy, recognising the further work required to ensure it reflected supporting of partnership priorities.
ABUHB 2709/25	**An overview of Joint Committee Activity** Nicola Prygodzicz (NP), Chief Executive, provided an update on the issues discussed and agreed at recent meetings of Welsh Health Specialised Services Committee (WHSSC) and Emergency Ambulance Services Committee (EASC), as joint committees of the Board. The Board NOTED the report.
ABUHB 2709/26	**Key Matters from Committees of the Board** The Board RECEIVED Assurance Reports from the following Committees: • Partnerships, Population Health and Planning Committee – 12th July • Audit, Risk and Assurance Committee – 18th July • Patient Quality, Safety and Outcomes Committee – 26th July • Mental Health Act Monitoring Committee – 5th September • Finance and Performance Committee – 7th September • Shared Services Partnership Committee – 20th July 2023

ABUHB 2709/27	**Date of the Next Meeting:** Wednesday 22nd November 2023

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Governance Matters: Summary of Board Business held In-Committee**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rani Dash, Director of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Gwybodaeth/For Information

The purpose of this report is to share a summary of the formal discussion of the Board at its private meetings during September and October 2023, and to report any key decisions taken, in-line with good governance principles and requirements set out in the Health Board's Standing Orders.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In accordance with its Standing Orders, Aneurin Bevan University Health Board conducts as much of its formal business in public as is possible (Section 7.5). There may, however, be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary [Director of Corporate Governance]) will schedule these issues accordingly and require that any observers withdraw from the meeting. This is sometimes known as a 'Private/Confidential Board meeting' or an 'In-Committee Board meeting.' The legal basis by which observers would be asked to withdraw from such meetings, is as set out within the *Public Bodies (Admission to Meetings) Act 1960, section 1 (2)*.

In circumstances where the Board meets in a private formal session, it shall formally report any decisions taken to the next meeting of the Board in public session.

Aneurin Bevan University Health Board is committed to carrying out its business openly and transparently, in a manner that encourages the active engagement of its citizens, community partners and other stakeholders.

The purpose of this report is to share a summary of formal discussion held by the Board at its private meetings held during September and October 2023 and to report any key decisions taken.

Cefndir / Background

Summary of Discussions

Financial Position and Delivery of Financial Plans

The Board received an overview of the financial challenges that the organisation faced and the work of the Executive Team in addressing this issue. The year-to-date position at month 6 was £82M deficit which was at this time a slowing trend. However, the Board noted that this was £22m away from the expected position.

The Board was provided with an update of the savings identified within the IMTP of £51M. £39M was expected to be achieved through a combination of cost mitigations, new funding, slippage, and revised operating arrangements. This represented a positive improvement of £9M from Month 5.

At Month 6 the Board was informed as follows:

- Initial Month 6 forecast position identified £154M adverse position prior to identifying savings;
- Additional amber savings of £3M were being progressed with a possible further £5M proposals that require further work to ensure viability;
- New opportunities had been identified and risk assessed in terms of yielding the financial savings to provide a range; at "best" this would reduce the deficit to £140M and at "worst" £150M.
- A 'likely' revised forecast of £145M was suggested as the revised position, noting that this was based on an executive assessment of delivery for several other "Amber" schemes and "new" mitigations recently identified.

The Board agreed to submit to Welsh Government a revised financial forecast position of £145M deficit, with a commitment to try to reduce this further. The Board also agreed to the Health Board requesting strategic cash support as required.

Emergency Department Extension Business Justification Case (BJC)

Since its opening in November 2020, the Grange University Hospital (GUH) Emergency Department (ED) has experienced between 140 and 280 attendances per day, with an average of 263 daily attendances. The demand for self-presenting patients is higher than 100 to 170 attendances modelled in the original Clinical Futures service model.

As a result, the current ED main wait area is unable to accommodate adequately the daily demand and has been the subject of a number of patient complaints. Furthermore, the need for an improved environment for patients has been recognised by Health Inspectorate Wales (HIW) and the Community Health Council (CHC), now Llais.

The Health Board has reviewed and implemented alternative services, including Same Day Emergency Care (SDEC) services in order to reduce the demand on the ED and Assessment Units. These changes to service delivery have ameliorated some of the issues facing ED; however, the Health Board continues to experience significant pressures across the system.

The Board received a Business Justification Case (BJC) which set out proposals for a £14.69m extension to extend the main waiting area of ED, with the existing waiting area being reconfigured to a 'Rapid Assessment Area', negating the requirement for patients to wait in corridors and circulation space within the Majors Department. The BJC set out a pragmatic proposal to addressing some of the issues which are impeded by the estate restrictions, including patient experience, enhanced patient visibility and improved infection control measures.

The Board was provided with an overview of the work to date in respect of this project. The Board received an overview of the current accommodation and the proposed project that, if agreed, would be delivered in two phases, and would include:

- Phase 1 that would see the construction of the extension that was scheduled for completion by December 2024 and,
- Phase 2 establishment of the Rapid Assessment Area, which was scheduled for completion by March 2025.

The Board noted that the capital costs were not to exceed £14.69M whilst recurrent revenue costs were estimated at £438,375 and £174, 674 in 2024/25 related to Estates and Facilities costs. The costs will be further reviewed to reduce the revenue associated with this development. The revenue model for the BJC did not make any provision for any increase in clinical staffing costs as the Board noted that any changes would be driven by changes in the clinical model and not as a result of the build and would be the subject of further scrutiny and prioritisation.

The Board agreed to:

- APPROVE and agree the submission of the BJC costed at £14.69M to Welsh Government
- Provide support for the revenue implications of the project as detailed within the BJC, and
- Provide approval for the enabling works to proceed.

Asesiad / Assessment

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

Argymhelliad / Recommendation

The Board is requested to note this report.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Enabler
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable to this report

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

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

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item. Not applicable to this report

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD
ACTION LOG

Outstanding	In Progress	Not Due	Completed	Transferred to another Committee

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
24th May 2023	**ABUHB 2405/07**	**Chair's Report:** Tyleri Ward Community Resource Team (CRT) to be invited to share their experience with the Board	Director of Corporate Governance	November 2023	Included on the agenda for November Board at item 2.2 (Patient story)
24th May 2023	**ABUHB 2405/17**	**Annual Complex Care/Mental Health and Learning Disabilities Independent Provider Fee Uplift for 2023/24:** An update on the development of a commissioning approach based on the place based care model would be presented to the Board in 3 months time.	Chief Operating Officer	November 2023	An independent review of CHC Commissioning has commenced. It is anticipated that the outcome of this will be presented to the Board in January 2023.
19th July 2023	**ABUHB 1907/13**	**Stroke Reconfiguration:** a more detailed operational plan to describe fully the stroke rehabilitation service and COTE model which will be affected as a result of the change to be provided	Chief Operating Officer	November 2023	Included on the agenda for November Board at item 4.1

Committee Meeting	Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
19th July 2023	**ABUHB 1907/20**	**WCCIS Update:** staff story on the issues that WCCIS has caused for staff be prepared	Director of Digital		An update from the Director of Digitial was shared with Board Members on 15th November 2023.
27th September 2023	**ABUHB 2709/10**	**Patient Story – Dementia Care:** Compliance levels with dementia training to be confirmed	**Director of Nursing/Head of Nursing, Patient Centred Care**	November 2023	The Health Board compliance on 040 Mandatory Dementia Awareness was **81.68%** - for April to September 2023.
27th September 2023	**ABUHB 2709/11**	**Performance and Accountability Management Framework:** review on implementation to be provided to the Finance and Performance Committee in 6 months	**Director of Strategy, Planning and Partnerships**	March 2023	Included on Forward Work Programme for the Finance and Performance Committee
27th September 2023	**ABUHB 2709/14**	**Configuration of Midwifery-led Units: Outcome of Public Engagement:** Financial assessment to be re-circulated to members	Director of Nursing	November 2023	An update was shared with Board members in November 2023.
		A report to be provided to the Patient Quality, Safety & Outcomes Committee in 6 months to evaluate effectiveness		March 2023	Included in Forward Work Programme for the Patient Quality, Safety and Outcomes Committee

All actions in this log are currently active and are either part of the Board's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Board meeting will be ready.
Once the Board is assured that an action is complete, it will be removed. This will be agreed at each Board meeting.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Governance Matters: Report on Sealed Documents and Chair's Actions**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Jones, Head of Board Business

Pwrpas yr Adroddiad
Purpose of the Report

Ar Gyfer Penderfyniad/For Decision

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper presents for the Board a report on the use of Chair's Action and the Common Seal of the Health Board between the 7th September 2023 and 31st October 2023.

The Board is asked to note that there have been five (5) documents that required the use of the Health Board's seal during the above period.

Chair's Action in Standing Orders requires approval by the Chair, Chief Executive and two Independent Members, with advice from the Board Secretary (the Director of Corporate Governance). All Chair's Actions require ratification by the Board at its next meeting.

During the period between the 7th September 2023 and 31st October 2023, one (1) Chair's Action has been agreed.

Cefndir / Background

1. Sealed Documents

The common seal of the Health Board is primarily used to seal legal documents such as transfers of land, lease agreements and other contracts. The seal may only be affixed to a document if the Board or Committee of the Board has

determined it should be sealed, or if the transaction has been approved by the Board, a Committee of the Board or under delegated authority.

2. Chair's Action

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

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

3. Key Issues

3.1 Sealed Documents

Under the provisions of Standing Orders, the Chair or Vice Chair and the Chief Executive or Deputy Chief Executive must seal documents on behalf of the Health Board. Two documents were sealed between the 7th September 2023 and 31st October 2023, as outlined below.

Date	Title
18.09.23	Aneurin Bevan University Health Board and Kier Construction Ltd and Studwelders Composite Floor Decks Ltd joining deed relating to Newport East Health and Wellbeing Centre, Ringland, Newport.
18.09.23	Land Registry TR1:CYM8735914 3 High Street, Six bells, Abertillery.
18.09.23	Aneurin Bevan University Health Board and Kier Construction Ltd and Shufflebottom Ltd joining deed relating to Newport East Health and Wellbeing Centre, Ringland, Newport.
21.09.23	Aneurin Bevan University Health Board lease extension of second floor, Brecon House, Mamhilad Park Estate, Pontypool, Torfaen, NP4 0HZ between Johnsey Estates UK ltd and Aneurin Bevan University Health Board.
9.10.23	Renewal lease by preference to existing lease relating to Suite 7, Red Dragon Court, Bridgend industrial Estate, Bridgend between Nordoor International Ltd and Aneurin Bevan University Health Board.

3.2 Chair's Action

The Chair's Actions approved between 7th September 2023 and 31st October 2023 is provided below:

Date	Title
3.10.23	To award a Bed Services & Maintenance Contract via the SBS Framework to Drive Devillbiss for a period of 5years with option to extend for 5 years.

Asesiad / Assessment

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

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Enabler
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item. Not applicable to this report

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	None

Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None

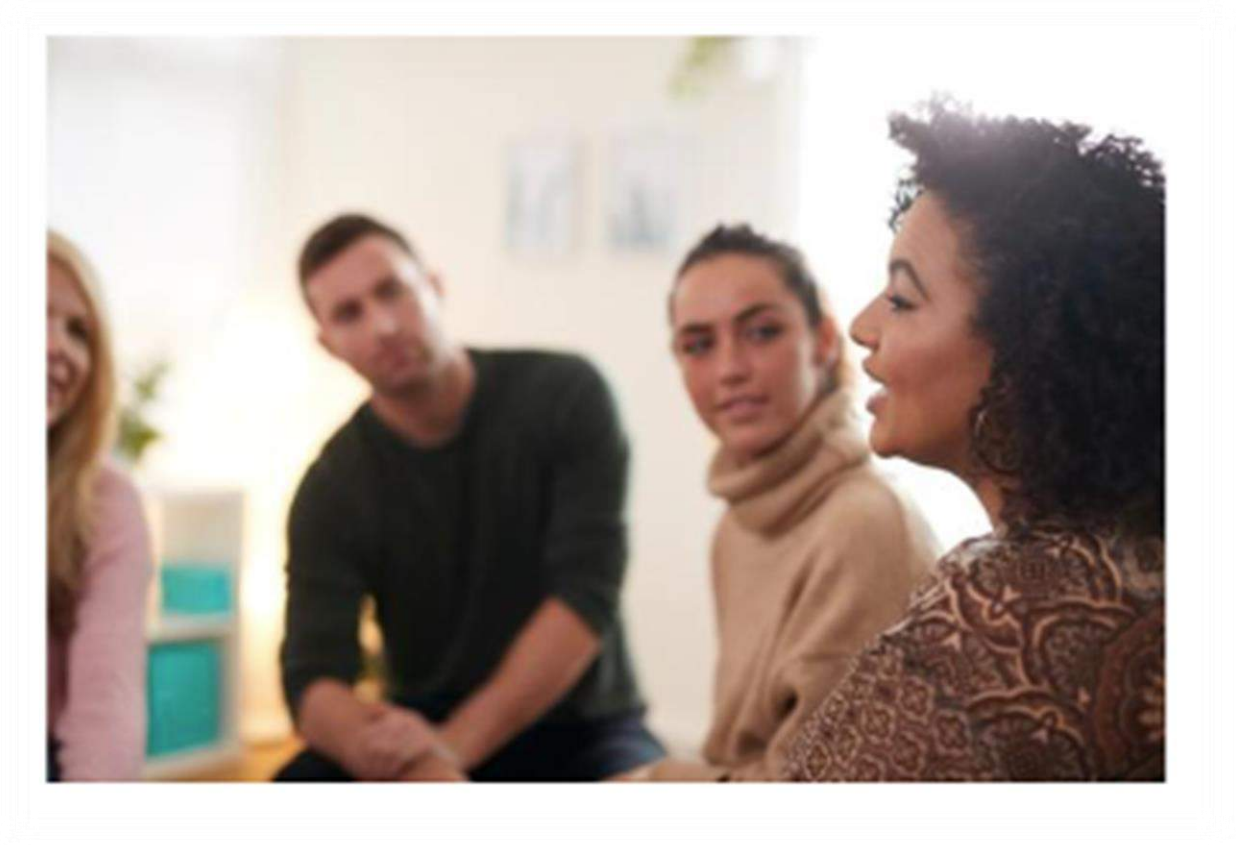
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan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

Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

Llais Gwent Region

Report for Aneurin Bevan University Health Board – Public Board Meeting

November 2023



Accessible formats

This publication is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us. You can ask for a copy by contacting our office:

01633 838516

gwentenquiries@llaiscymru.org

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Contents

About Llais

Llais is a statutory body, set up by the Welsh Government to give the people of Wales much more say in the planning and delivery of their health and social care services – locally, regionally, and nationally.

We are here to understand people's views and experiences of health and social care, and to make sure feedback is used by decision-makers to shape services.

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

There are 7 Llais Regions in Wales. We all work together to represent people's voices in relation to their health and social care needs.

Introduction

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

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

Llais 100-day plan – transition period

When Llais was launched on the 1st of April 2023, we published our 100-day plan, which set out our national intentions, plans and objectives for the first 100 days of the new organisation. Full details of our plan can be found on our website here: Our 100-day plan | Llais (llaiswales.org)

In brief, our plan in the first 100 days included:

- Having a regional presence.
- Producing and publishing regional plans.
- Developing our Diversity, Equality & Inclusion Policy.
- Developing new digital ways of working.
- Launching a national volunteering campaign.
- Launching our marketing campaign.
- Developing how we work with others.
- Submitting CHC's UK Covid-19 inquiry work.
- Appointing to new Llais roles.
- Publishing our response to draft Code of Practice (entry to premises).
- Partnership working with other UK citizen representative bodies.
- Engaging with the population.
- Sharing what we hear with decision makers.
- Supporting people to raise concerns.

Our regional annual plan includes legacy work handed over from Aneurin Bevan CHC, for continuity, as well as new activities and items of work informed by the public and stakeholder engagement exercise that was undertaken in January 2023. The following items in this report reflect some of the new work we are undertaking, and the CHC's legacy work. We will build on that legacy work as the new organisation develops. We are committed to continuing to represent our communities and in particular our clients who use health and social care services so that they have a voice in the design and delivery of the services they need.

Llais Gwent Region update

Current activities and feedback:

1. Public feedback from our Advocacy service

From the 1st of September to the 31st of October 2023, our Advocacy service has received 73 new contacts from members of the public with enquiries or formal concerns about health or social care.

- 57 of those contacts were about the NHS and 1 of those contacts was in relation to Social Care.

- 15 of the contacts were general enquiries about the NHS. Enquiries have been mixed in terms of their subject ranging from waiting times for test results, waiting times for operations, waiting times for ENT appointments along with concerns relating to hospital transport and discharge/transfer from hospital.

- 37 authorisation forms were returned during this period to pursue a formal complaint. Services and the subjects of concerns have also been mixed but include Care of the Elderly, Primary Care, Adult Mental Health Services and waiting times for surgery/appointments.

2. Representations that we have made or been involved in

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

Since 1st April 2023, we have been involved in or made representations about:

- Crickhowell Group Practice's application to close its branch surgery in Gilwern (Powys Teach Health Board cross boundary matter) – formal correspondence.

- Maternity Services proposals for Midwifery-led services
- Primary Care panels for Deri Branch surgery, Churchwood Medical Centre vacant practice, Lawn Medical Centre vacant practice and the Mount Surgery vacant practice, New Inn, and Goytre Branch Surgeries
- A&E handovers from Ambulance crew and people's experiences when waiting in the Emergency Department.
- Stroke rehabilitation service developments
- eLGH department/unit reconfiguration developments
- and we attended:
- Tredegar Health and Wellbeing Centre project board
- Patient Safety and Quality Outcomes Committee
- Outpatients Steering Group
- Outpatient Transformation Programme
- Enhanced Services Operational Group
- Sustainability Board
- Gwent Local Medical Committee
- NCN Development

3. Engagement in Gwent

Since April 1st we have attended engagement events across Gwent, and in total we have spoken to over 540 people.

Events we have attended so far include, Newport & Barnardo's Carers event, Cwmbran's Big Event, Caerphilly Pride, Pontypool Party in the Park, Viva Fest, Brynmawr Volunteering event, Monmouthshire Raft Race, Torfaen Voluntary Alliance Opening Doors Networking Forums and The Usk Show.

We have decided to increase our community engagement as it's vital that people in Gwent know of our organisation should they need to contact us. We have organised to attend day centres, community hubs, and supermarkets etc. within Gwent.

Since organising this, our community engagement volunteers have engaged with people in Torfaen and Monmouthshire. Plans have been put in place to attend community spaces in Newport, and staff will attend Libraries across Gwent.

NHS feedback has included:

- “More staff” needed for all services, particularly at the Emergency Department at the Grange University Hospital.
- Access to Mental Health Services.
- Planned care waiting lists being “too long.”
- Obtaining GP appointments is difficult due to the phone lines being busy in the morning.

4. GP Exit Survey Polls: Malpas Brook Health Centre

On the 12th and 13th of October, our visiting volunteers attended Malpas Brook Health Centre. The purpose of this was for our volunteers to stand outside of the practices and engage with people as they left, to ask them if they would like to give us feedback of what it is like for them to access their practice.

To carry this out, we contacted the practice manager to inform them that our visiting volunteers would be attending, and what days we planned to visit. We also sent a poster and survey packs to the practice ahead of our visits, so people had the opportunity to fill in the surveys prior to us attending. The practice manager was very welcoming of our volunteers attending their practice to carryout surveys outside.

In total, we received 17 responses to our survey.

A briefing report will be drafted and submitted to UHB.

N.B. *All surveys are launched bilingually on our social media channels and are available in alternative formats and languages upon request. We also share surveys with our external stakeholders, this is to ensure we are reaching as many people as possible.*

Upcoming activities:

1. Survey: Trauma & Orthopaedic – Hip and Knee

As mentioned in our previous report, we are going to launch a survey to find out people's experiences of waiting for their hip or knee surgery in the Gwent area.

We are in the process of organising surveys to be sent to the relevant sites in ABUHB.

2. Survey: Transition from Child to Adult health and social care services.

As mentioned in our previous report, we will be working collaboratively with Gwent Regional Partnership Board's and ABUHB to find out young people's experiences of changing from child to adult services in both health and social care.

We are in the final process of launching this project.

3. Winter Patient Experience Project

In December we will start to plan for our yearly Winter Patient Experience Project. The purpose of this project is to find out people's experiences of accessing NHS services in a Minor Injuries Unit or the Emergency Department. We will take into consideration, the current pressures the UHB and people are experiencing, including the winter months that bring added pressures and how this can affect patient experience.

Llais visiting volunteers will visit these departments to gain feedback from people face-to-face.

Weekly briefings will be sent to colleagues in the UHB to provide them with a summary of the feedback we have received from the previous week.

We will plan to launch this project at the beginning of January 2024, and it will run for 6 weeks.

Correspondence will be shortly sent to colleagues in UHB to advise them of our intent to launch this project, with the hopes of their continued support as per previous years.

Thanks

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

We hope the feedback people have taken the time to share influences health and social care services to recognise and value what they do well – and act where they need to as quickly as they can.

Feedback

We would 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.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Health, Safety & Fire Annual Report 2022/23
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Peter Carr, Executive Director of Therapies & Health Science
SWYDDOG ADRODD: **REPORTING OFFICER:**	

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to present to the Board the Health, Safety & Fire Annual Report for 2022/23.

The report identifies both the opportunities and challenges for the Health Board in ensuring and sustaining compliance with Health and Safety legislation.

The Board is asked to approve the annual report and note the actions being taken to ensure compliance.

Cefndir / Background

The Health and Safety Executive (HSE) is the national independent regulator for health and safety in the workplace. This includes private or publicly owned health and social care settings in Great Britain. They work in partnership with co-regulators in local authorities to inspect, investigate and where necessary take enforcement action.

The Health, Safety & Fire Annual Report 2022/23 (Appendix 1) provides an overview of the Health Boards performance for the last financial year.

In addition to the progress and improvements made within the reported period, the Health and Safety Committee has recommended a series of risk areas on which to focus in 2023/24.

- Manual handling training compliance
- Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
- Lack of proactive health and safety monitoring plan
- The quality and standard of health and safety risk assessments
- Compliance with the review of fire risk assessments
- Adequacy of fire alarm systems
- Compliance with the management of fire barriers (compartmentation)

Following internal audits relating to health and safety, the Corporate Health & Safety (CH&S) Department is leading on addressing the audit recommendations that are monitored via the Audit, Risk & Assurance Committee. These recommendations relate to risk assessments, workplace inspections and monitoring HSE engagement/actions.

Regulation 7 of ***The Management of Health and Safety at Work Regulations 1999*** states that every employer shall appoint one or more Competent Persons to assist in undertaking the measures needed to take to comply with the requirements and prohibitions imposed upon the organisation by or under the relevant statutory provisions.

The legislation states that a person shall be regarded as 'competent' if they have sufficient training, experience, or knowledge.

The (CH&S) Department employs specialist safety professionals to advise and support the Health Board to deliver and maintain health and safety standards. The CH&S Department is structured within specific functions i.e., health & safety, fire safety, manual handling, and violence & aggression.

The CH&S Department is dynamic in its response to organisational priorities, demands and risks. The CH&S Department supports the Health Board to comply with health and safety legislation by carrying out the following operational functions:

Health & Safety
- Conduct audits and inspections to assess compliance within health and safety.
- Support the risk management process by delivering risk assessment training and assisting managers in the completion of risk assessments.
- Delivery of health and safety training to Health Board staff.
- Review and investigation of health and safety related incidents, to ensure appropriate learning is captured and shared.

Fire Safety
- Support the risk management process by conducting fire risk assessments for all areas across the Health Board.
- Delivery of fire safety training to Health Board staff aligned to the training needs analysis. This also includes fire drills and exercises.
- Review and investigate all fire safety incidents, including fires and unwanted fire signals, to ensure appropriate learning is captured and improvements made where necessary.

Manual Handling

- Co-ordinating and supporting the delivery of manual handling training to Health Board staff, aligned to the All-Wales Passport.
- Review and investigation of manual handling incidents, to ensure appropriate learning is captured and shared.
- Conduct audits and inspections to assess compliance within manual handling, including assessment of equipment.
- Support local managers with the mobility of patients with complex needs.

Violence & Aggression

- Support victims of workplace violence.
- Engage with local managers to support with the development of safety plans to address risks of violence and aggression from patients/members of the public.
- Act as a point of contact with Gwent Police to ensure cases are managed appropriately.
- Review and investigation of workplace violence incidents, to ensure appropriate learning is captured and shared.
- Delivery of violence and aggression training to Health Board staff, aligned to the All-Wales Passport.

The CH&S Department provide a point of contact and coordinates all liaison, reporting, and responses to the enforcing authorities i.e., Health and Safety Executive (HSE), South Wales Fire & Rescue Service (SWFRS) etc.

There are significant challenges in addressing the risk areas of focus reported within the annual report due to the current capacity within the Corporate Health and Safety (CH&S) Department.

Within the next five months (by end of March 2024) a review of the capacity will be undertaken, and an option appraisal developed and presented to the Executive Committee for consideration.

Governance and Assurance Arrangements

The Chief Executive Officer (CEO) is accountable for Health and Safety with responsibility for executive leadership delegated to the Executive Director of Therapies & Health Science.

The Health and Safety Committee has been established to plan, manage, and monitor Health Board compliance with statutory health and safety requirements and specific NHS duties.

The Executive Director of Therapies & Health Science is the Chair of the Health and Safety Committee, being the Director with delegated responsibility for health and safety within the Health Board. The Health and Safety Committee is accountable to the Board.

A number of health and safety subgroups report to the Health and Safety Committee, these include the Fire Safety Committee, Manual Handling Group, Sharps Safety Group and Violence & Aggression Group.

The requirement to maintain the other subgroups will be considered as part of the planned review of the health and safety governance and assurance framework.

An objective planned for 2023/24 is to review the Health Board's health & safety governance and assurance framework. A proposal will be to raise the profile of the Health and Safety Committee by strengthening the representation from the Executive Committee.

The intention is for the Committee to be supported by an operational group, with representation from the Divisions/Services to demonstrate implementation of the health and safety requirements. This will be linked to the implementation of the Health Boards Quality Strategy.

Health, Safety and Security is one of the pillars of the Health Board's Quality Strategy
(See image right).

The Quality Strategy states:

"We are committed to ensuring that the fundamental standards of health, safety and security are continuously improved. We have a committed workforce of operational leaders who we will educate to ensure they have the advanced skills to deliver safe services. We will support the development of local policies and practices through our Health, Safety and Security Practitioners. We will conduct reviews of all sites and an annual snapshot of health and safety. Our focus for the duration of this strategy will be to reduce staff harm from lifting and handling, violence and aggression and slips, trips, and falls."

Asesiad / Assessment

The following risk areas have been highlighted as the focus for requiring improvement in order to ensure ongoing compliance with health and safety legislation. Detailed below is information on the actions planned to ensure compliance and mitigate the risk.

Manual Handling Training

The Health Board manual handling training compliance as of 31 March 2023 was 52%. At the end of September 2023, the performance had lifted slightly to 55%. This is significantly less than the organisational target of 85%.

The following health and safety legislation highlight the legal requirements to provide manual handling training.

Section 2(2)(c) of ***The Health and Safety at Work etc. Act 1974*** places a duty on employers to provide information, instruction, training, and supervision as is necessary to ensure, so far as is reasonably practicable, the health and safety at work of his employees.

Regulation 13 (Capabilities and training) of ***The Management of Health and Safety at Work Regulations 1999*** states that every employer shall ensure that his employees are provided with adequate health and safety training.

Regulation 4 of ***The Manual Handling Operations Regulations 1992*** places a duty on employers to take appropriate steps to reduce the risk of injury to those

employees arising out of their undertaking any such manual handling operations to the lowest level reasonably practicable.

Key factors that have contributed to the poor level of compliance include:

- The resource within Corporate Health & Safety to deliver the manual handling foundation training to new starters does not equate with the current demands.
- The local cascade trainers (Transfer Specialists for patient handling and Safer Handling Coaches for inanimate load handling) are not delivering the refresher/update training at the required frequencies.
- The current training facilities have been subject to maintenance issues, and these have impacted on delivery plans.

A three-year training plan has been developed and will offer weekly foundation training to reduce the backlog. The plan sets out a risk-based approach and prioritises patient handling training for the high-risk areas. Support will be offered to Practice Educators within the Divisions and the local cascade trainers to ensure staff are updated at the set frequencies.

The current vacancies within Corporate Health and Safety are funding the provision of manual handling training by an external provider. This has been agreed until 31 March 2024.

A revised training strategy for staff inanimate load handlers is being developed and will be in place by March 2024. The strategy will be risk based and practical training will only be delivered to staff who require it following a risk assessment. It is anticipated that a large majority of staff will only need on-line training, therefore reducing the requirement to attend practical sessions.

RIDDOR Reporting
During 2022/23 49% (39 incidents) were reported outside of the legal timeframes outlined in The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. The Health Board RIDDOR compliance had increased to 65% in September 2023.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013, requires the responsible person to report to the relevant enforcing authority within either 10 or 15 days of the incident, depending on the type of incident i.e., injuries, fatalities, dangerous occurrences and over 7-day injury.

Delays with reporting and investigation are the main causes for incidents not being reported within the legal timeframes.

A range of different actions are being taken forward with the Divisions to ensure timely reporting and investigation of incidents, which in turn will enable the Health Board to improve compliance with the RIDDOR legislation. Actions include:

- A '*Health and Safety Information Sheet*' previously developed will be re-issued again across the Health Board, raising awareness of the RIDDOR legislation.

- A RIDDOR dashboard has been developed within the Datix System to enable active monitoring of potential reportable incidents. The dashboard is actively reviewed by Safety Professionals within Corporate Health and Safety.
- Improved communication between the Putting Things Right (PTR) Team, Quality & Patient Safety (QPS) Team and Corporate Health and Safety (CH&S) on patient falls resulting in significant harm, to ensure incidents that meet the threshold to report are triaged and escalated for reporting.
- Review of standard operating procedures for managers completing incident reports and action plan, to make explicit their responsibilities for timely RIDDOR reporting.

The Health Board RIDDOR compliance had increased to 65% in September 2023.

Health and Safety Monitoring
The health and safety audit and inspection programme focused on Respiratory Protective Equipment (RPE) in 2022/23 and whilst this demonstrates proactive monitoring, there is a requirement to conduct further audits against other areas of health and safety to identify compliance and obtain assurance.

Regulation 5 (Health and safety arrangements) of ***The Management of Health and Safety at Work Regulations 1999*** states every employer shall make and give effect to such arrangements as are appropriate for the effective planning, organisation, control, monitoring, and review of the preventive and protective measures.

To enable the Health Board to measure compliance against health and safety legislation a programme of audits and inspections will be determined and prioritised by the H&S Committee based on the compliance monitoring undertaken by the CH&S Department. This revised programme of audits and inspections will be signed off by the Health and Safety Committee by March 2024.

The findings of the audit programme will provide the Health Board with intelligence about the compliance against specific statutory instruments, with routine reporting to the Health Board Health and Safety Committee.

Health and Safety Risk Assessments
There is currently limited intelligence within the Health Board relating to the quality and standard of health and safety risk assessments.

Regulation 3 (Risk assessment) of ***The Management of Health and Safety at Work Regulations 1999*** states every employer shall make a suitable and sufficient assessment of the risks to the health and safety of his employees to which they are exposed whilst they are at work, and the risks to the health and safety of persons not in his employment arising out of or in connection with the conduct by him of his undertaking.

In order to provide assurance that suitable and sufficient health and safety risk assessments are completed, a Divisional level self-assessment will be carried out across the Health Board. The information captured will inform a targeted improvement plan, and the actions within the plan will be implemented by April 2024.

Fire Safety Risk Assessments
During 2022/23 the Health Board conducted 66% of the fire risk assessments due for review during the financial year. The areas and sites that had a fire risk assessment completed in 2022/23 were prioritised based on risk.

The review frequency of the fire risk assessments is not determined in the regulation but is a standard that has been agreed within the Health Board, with the review period determined by risk i.e., patient facing areas are assessed more frequently.

Whilst the Health Board did not meet the target of 100% reviewed during the financial year, all areas across the Health Board have been assessed from a fire safety perspective.

Article 9 (Risk assessment) of ***The Regulatory Reform (Fire Safety) Order 2005*** states that the responsible person must make a suitable and sufficient assessment of the risks to which relevant persons are exposed for the purpose of identifying the general fire precautions he needs to take to comply with the requirements and prohibitions imposed on him by or under this Order.

The main contributory factor for the deficit in the review of the fire risk assessments is associated with the capacity of the Fire Safety Team to meet the demands.

Options are being considered to address the backlog and to ensure the number of overdue fire risk assessments do not increase further. This includes reviewing the current frequency of low hazard fire risk assessments i.e., non-patient facing areas. This will provide the Health Board with a more intelligent and risk-based standard for consideration and agreement by the Health and Safety Committee.

Fire Alarm Systems
The fire alarm system required at a building depends on a number of factors including the size and complexity of the building, the use of the building and the profile of the building users.

Fire alarm and detection systems degrade over time and require constant maintenance and repair. Components, such as detectors, have a limited working life and need to be replaced regularly Manufacturers periodically replace older technology with new versions of systems that can render whole systems obsolete.

The Health Board has identified risks associated with the fire alarm and detection systems at the Royal Gwent Hospital and St Cadocs Hospital. The systems in these hospitals, whilst currently fully functional. are obsolete and require replacement.

Article 13 (Fire-fighting and fire detection) of ***The Regulatory Reform (Fire Safety) Order 2005*** states that, where necessary in order to safeguard the safety of relevant persons, the responsible person must ensure that the premises are, to the extent that it is appropriate, equipped with appropriate fire-fighting equipment and with fire detectors and alarms; and any non-automatic fire-fighting equipment so provided is easily accessible, simple to use and indicated by signs.

Improvements schemes, funded by the Welsh Government (Capital, Estates & Facilities) Funding Programme for Targeted Improvements (2023-2025), are planned to commence at both sites in 2023 however the current capital allocation is insufficient to allow full rectification of the problems at The Royal Gwent Hospital in a timely manner. The completion of the system at The Royal Gwent Hospital will require future capital allocation beyond this current Welsh Government allocation.

Fire Compartmentation
Management of fire barriers (compartmentation) fitted across hospital sites is problematic. Historically the safeguarding of fire barriers against contractor damage has been human resource intensive. Modern software solutions that are more economical are unavailable due to a lack of up-to-date plans.

The option of physically checking partitions following all construction work on sites is heavily reliant on human resources that are not currently available.

Article 8 (Duty to take general fire precautions) of ***The Regulatory Reform (Fire Safety) Order 2005*** states that the responsible person must take such general fire precautions as will ensure, so far as is reasonably practicable, the safety of any of his employees; and in relation to relevant persons who are not his employees, take such general fire precautions as may reasonably be required in the circumstances of the case to ensure that the premises are safe.

Improvement schemes are being prepared to repair fire partitions in Nevill Hall Hospital and the Casnewydd Unit at St Woolos Hospital.

A compartmentation survey is required at The Royal Gwent Hospital to identify the current condition of passive fire protection.

A system of managing the fire compartmentation within the Health Board buildings is being developed and will be presented to the Executive Committee for consideration.

The Health Board will develop a Corporate Health and Safety Risk Register that will quantify the risks and identify the mitigation. The risk register will be regularly review and monitored via the Health and Safety Committee.

Argymhelliad / Recommendation

The Board is asked to receive the annual report and the actions being taken to ensure compliance.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	NA

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2.1 Managing Risk and Promoting Health and Safety Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Draft Health, Safety & Fire Annual Report 2022/23
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Health Board Health and Safety Committee Health Board Executive Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Choose an item.
• **Service Activity & Performance**	Choose an item.
• **Financial**	Choose an item.
Asesiad Effaith Cydraddoldeb	Choose an item.

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

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Health, Safety and Fire Annual Report 2022/23

Our Values and Behaviours

People First

Personal Responsibility

Passion for Improvement

Pride in What We Do

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1 EXECUTIVE SUMMARY

The purpose of the report is to provide the Health Board with a summary of principal activity and outcomes relating to the management of health and safety within Aneurin Bevan University Health Board during 2022/23. The report also highlights key priorities for the Health and Safety Committee and its subgroups for the financial year 2023/24.

The report summarises the prevailing legislative framework within which health and safety concerns are managed and addressed and outlines the local governance arrangements that underpin health and safety arrangements within the Health Board. Additionally, the report provides information relating to key activities undertaken by the Health and Safety Committee and reporting subgroups with respect to:

- Fire Safety
- Health and Safety Training Provision
- Manual Handling
- Risk Management
- Security Management
- Violence and Aggression

The Executive Chair of the Health and Safety Committee, and director with the delegated responsibility for Health and Safety within the Health Board, continues with the Executive Director of Therapies & Health Science.

In addition to the progress made within the reported period, the Health and Safety Committee has recommended a series of risk areas for focus in 2023/24.

The Health Board will develop a Corporate Health and Safety Risk Register that will quantify the risks and identify the mitigation. The risk register will be regularly review and monitored via the Health and Safety Committee.

1.1 Risk Areas for Focus in 2023/24

Manual handling training compliance

The Health Board will implement a sustainable programme of manual handling training, particularly for high-risk areas.

A revised training strategy for inanimate load handlers is being developed and will be in place by March 2024. The strategy will be risk based and practical training will only be delivered to staff who require it following a risk assessment. It is anticipated that a large majority of staff will only need on-line training, therefore reducing the requirement to attend practical sessions.

Compliance with the legal timeframes of reporting outlined within the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013
The Health Board will implement a range of different actions with the Divisions to ensure timely reporting and investigation of incidents, which in turn will enable the Health Board to improve compliance with the RIDDOR legislation.

Lack of proactive health and safety monitoring plan
To enable the Health Board to measure compliance against health and safety legislation a programme of audits and inspections will be determined and prioritised by the Health and Safety Committee based on the compliance monitoring undertaken by the CH&S Department. This revised programme of audits and inspections will be signed off by the Health and Safety Committee by March 2024.

The quality and standard of health and safety risk assessments
In order to provide assurance that suitable and sufficient health and safety risk assessments are completed a Divisional level self-assessment will be carried out across the Health Board. The information captured will inform a targeted improvement plan, and the actions within the plan will be implemented by April 2024.

Compliance with the review of fire risk assessments
Options are being considered to address the backlog, to ensure the number of overdue fire risk assessments do not increase further. This includes reviewing the current frequency of low hazard fire risk assessments i.e. non-patient facing areas.

Adequacy of fire alarm systems
The Health Board has identified risks associated with the fire alarm and detection systems at the Royal Gwent Hospital and St Cadocs Hospital. The systems in these hospitals are obsolete and require replacement.

Improvements schemes, funded by the Welsh Government (Capital, Estates & Facilities) Funding Programme for Targeted Improvements (2023-2025), are planned to commence at both sites in 2023.

Compliance with the management of fire barriers (compartmentation)
A system of managing the fire compartmentation within the Health Board buildings is being developed and will be presented to the Executive Committee for consideration.

Improvement schemes are being prepared to repair fire partitions in Nevill Hall Hospital and the Casnewydd Unit at St Woolos Hospital. A compartmentation survey is required at The Royal Gwent Hospital to identify the current condition of passive fire protection.

2 INTRODUCTION

This report provides analysis of the level of health and safety performance throughout the Health Board for 2022/23.

The Health and Safety at Work (etc.) Act 1974 provides a legislative framework to promote, stimulate and encourage high standards of health and safety at work.

In particular, the Act requires an organisation to provide and maintain:

- A Health and Safety Policy;
- A system to manage and control risks in connection with the use, handling, storage and transport of articles and substances;
- A safe and secure working environment, including provision and maintenance of access to and egress from premises;
- Safe and suitable plant, work equipment and systems of work that are without risks;
- Information, instruction, training and supervision as necessary;
- Adequate welfare facilities;

The report is underpinned by Health and Care Standard 2.1 Safe Care: **Managing Risk and Promoting Health and Safety**. People's health, safety and welfare are actively promoted and protected. Risks are identified, monitored and where possible, reduced or prevented.

The Health Board operates a Health and Safety Management System, utilising the Health and Safety Executive (HSE) '*Managing for health and safety*' (HSG65) model.

Diagram 1: PDCA Health and Safety Management Model

The model is structured into the Plan, Do, Check, Act approach (see diagram 1).

Plan, Do, Check, Act helps achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

3 HEALTH, SAFETY AND FIRE GOVERNANCE STRUCTURE

3.1 Accountability

The Chief Executive Officer (CEO) is accountable for Health and Safety with responsibility for executive leadership delegated to the Executive Director of Therapies & Health Science.

3.2 Health and Safety Leadership

Effective health and safety performance is led by the senior responsible officers of the Health Board. Members of the Board have both collective and individual responsibility for health and safety. Directors and boards need to examine their own behaviours, both individually and collectively, against the guidance given and, where they see that they fall short of the standards it sets them, to change what they do to become more effective leaders in health and safety.

Why directors and board members need to act:

- Protecting the health and safety of employees or members of the public who may be affected by your activities is an essential part of risk management and must be led by the board.

- Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership.

- Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety.

Business leaders have responsibility for determining and implementing effective health and safety management and monitoring its success, so it's essential that they understand how to implement a risk management strategy.

To support Board Members to deploy their responsibilities health and safety training for Executives and Directors will be arranged in 2023/24.

Regulation 7 of The Management of Health and Safety at Work Regulations 1999 states that *"Every employer shall, subject to paragraphs (6) and (7), appoint one or more Competent Persons to assist him in undertaking the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions"*.

The legislation states that a person shall be regarded as 'competent' if they have sufficient training, experience, or knowledge and 'other qualities'.

The Corporate Health and Safety Department employs specialist safety professionals to advise and support the Health Board to deliver and maintain health and safety standards. The current department structure is illustrated in diagram 2.

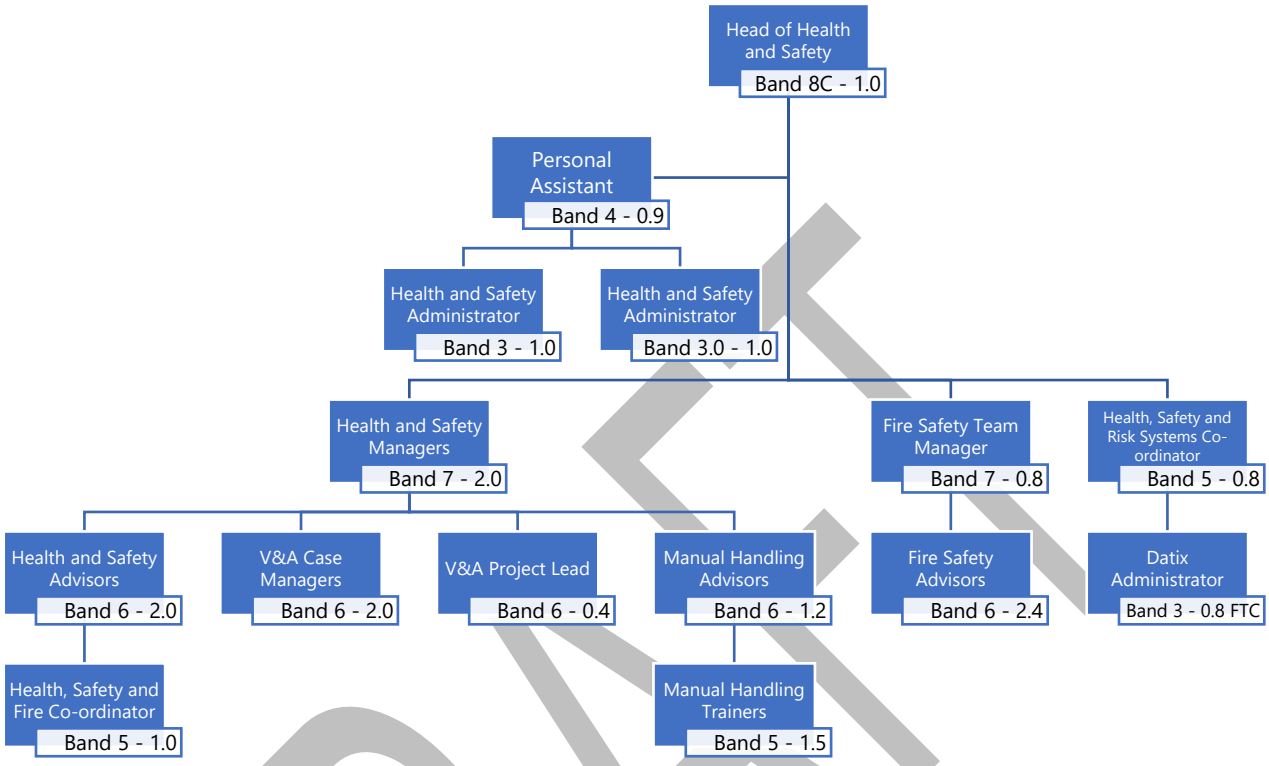


Diagram 2: Corporate Health and Safety Department Structure

The Corporate Health and Safety Department is structured within specific functions i.e. health & safety, fire safety, manual handling and violence & aggression.

The individuals within the functions are allocated areas of responsibility across the Health Board to support the development of effective relationships with key stakeholders. (See diagram 3)

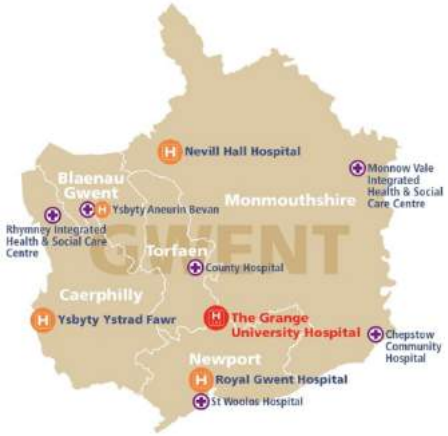


Diagram 3: Map of Gwent Hospitals

During 2022/23 the Corporate Health and Safety Department has effectively integrated into the Health Board leadership structures and regularly engage via specific Health Board meetings, including Quality and Patient Safety, Hospital Management Groups etc.

A review of the Corporate Health and Safety Department is planned in 2023/24. The review will evaluate the resource capacity against the legislative requirements placed on the Health Board.

3.3 Health and Safety Reporting Arrangements

The Health and Safety Committee has been established to plan, manage and monitor Health Board compliance with statutory health and safety requirements and specific NHS duties.

The Executive Director of Therapies & Health Science is the Chair of the Health and Safety Committee, being the Director with delegated responsibility for health and safety within Aneurin Bevan University Health Board. The Health and Safety Committee is accountable to the Quality and Patient Safety Operational Group, which is in turn, responsible to the Patient Quality and Safety Outcomes Committee.

The Health and Safety Committee receives reports from the subgroups and ratifies policies. The reporting arrangements are illustrated in diagram 4.

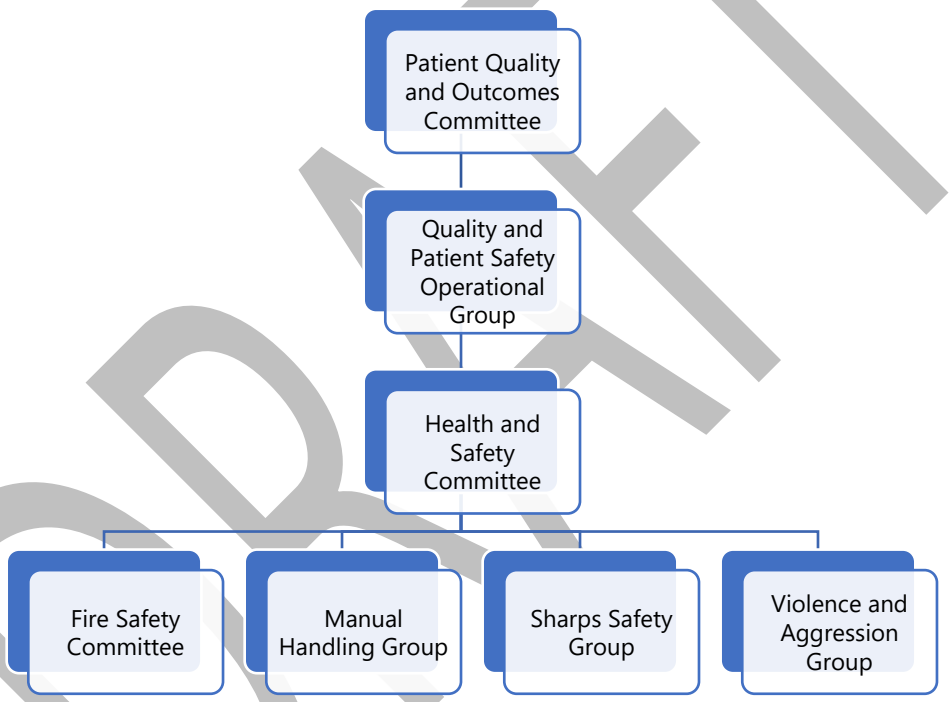


Diagram 4: Health and safety reporting arrangements

3.4 Health and Safety Committee Subgroups

A number of health and safety subgroups report to the Health and Safety Committee, these subgroups are documented below.

Group	Chair	Frequency of Meetings
Fire Safety Committee	Executive Director of Therapies & Health Science	Quarterly
Manual Handling Group	Head of Health, Safety & Fire	Quarterly
Sharps Safety Group	Head of Health, Safety & Fire	Quarterly
Violence & Aggression Group	Executive Director of Therapies & Health Science	Quarterly

Each subgroup is responsible for the production and updating of their own policies and terms of reference. These documents are submitted to the Health and Safety Committee for ratification.

During 2022/23 only the Fire Safety Committee has routinely met. The requirement to maintain the other subgroups will be considered as part of the review of the health and safety governance and assurance framework.

A task & finish group in relation to Health at Work has been developed in 2022/23 to review various topics relating to Health aspects including Occupational Stress, Hard Arm Vibration Syndrome, Noise at Work etc.

As part of the task & finish groups activity a stress risk assessment, based on the Health and Safety Executive's (HSE) Management Standards, has been developed for use by staff and their line managers. There is also an accompanying guide on the hazards and control measures. These documents have been developed to support the identification of issues at source and consider workable and practical ways to manage them.

Based on the work undertaken through the group there is wider scope to aid improvement through the development of a Health at Work Subgroup, to support the management of the health at work agenda.

In addition to the corporate reporting arrangements, health and safety is a regular agenda item at the Divisional Quality and Patient Safety forums providing an opportunity to monitor health and safety performance.

3.5 Health and Safety Policies & Procedures

Numerous health and safety policies have been developed to outline the Health Boards plans to achieve compliance with the relevant health and safety legislation and/or standards.

The table below illustrates the current health and safety policies within the Health Board. An objective for 2023/24 is to ensure all policies are reviewed and updated as appropriate.

Policy Title	Issue Date	Review Date
Handling Violence and/or Aggression (Internal Sanctions) Policy and Procedure	October 2014	October 2017
Use of Restrictive Physical Intervention Policy	September 2016	June 2019
Lone Working Policy	April 2017	April 2020
Control of Substances Hazardous to Health (COSHH) Policy	October 2017	October 2020
Policy for the Control of Legionella and the Management of Water Systems	October 2018	October 2021
Safer Manual Handling Policy	January 2019	January 2022
Health and Safety Obligations at Work for Pregnant Employees and those Returning from Maternity Leave	March 2019	March 2022
Occupational Health & Safety Policy	March 2019	March 2022
Incident Reporting Policy	December 2019	December 2022
Procurement and Use of Portable Items of Non-Clinical Electrical Equipment Policy	January 2020	January 2023
Fire Safety Policy	January 2020	January 2023
Management of Violence and Aggression by members of the Public Policy	July 2021	July 2024
The Use of Bedrails and Bedrail Covers Policy	February 2022	February 2025
Policy for Workstation Display Screen Equipment (DSE)	March 2022	March 2025
First Aid at Work Policy	November 2022	November 2025

Enforcement action taken by the South Wales Fire & Rescue Service relating to the control and management of ignition sources in healthcare has highlighted the requirement to develop a 'Search Policy'. This development is currently being led by the Corporate Health and Safety Department with engagement from key individuals across the Health Board.

The Health Boards policy for First Aid at Work has been reviewed and updated to ensure that the Health Board is able to meet its legislative requirements under the Health and Safety (First Aid) Regulations 1981, in addition to the general requirements under the statutory provision, the updated First Aid at Work Policy has been updated to include the provision of Mental Health First Aid and will support managers in undertaking an assessment to identify if Mental Health First Aiders are required within their service or department in addition to physical First Aiders.

3.6 Audit and Assurance

There has been one Internal Audit conducted during 2022/23 which relates to health and safety. The purpose of the audit was to review the arrangements in place within the Health Board for the logging, tracking and implementation of actions arising from external inspectorates, specifically the Health and Safety Executive (HSE). The outcome of the audit was reasonable assurance.

The matters requiring management attention include:

- A standard operating procedure should be developed to set out how HSE actions are monitored, tracked, escalated and overall assurance provided.
- An inconsistent approach and a lack of evidence to the tracking of HSE actions by the respective committees

Recommendations from previous Internal Audits conducted in 2019/20, which elicited a 'limited assurance' response, are still being monitored. The recommendations relate to health and safety workplace inspections and quality of risk assessments.

The plan to revitalise the health and safety monitoring process was severely impacted by the demands placed on the Corporate Health and Safety Department by the Covid-19 Pandemic. Regular and robust monitoring will be introduced in 2023/24. This has been supported by the recruitment of a Health and Safety Advisor who has designated responsibility for monitoring compliance with health and safety standards, complimenting managerial controls.

There has been engagement with the Divisions to actively review and update risks recorded on the risk module on the DatixWeb system. This will support the programme to improve the quality and management of risk assessments. The Corporate Health and Safety Department are leading the education programme for risk assessment within the Health Board.

The Health and Safety Legislative Assurance Framework identifies the compliance with health and safety statutory instruments. The document is subject to an assessment by the Corporate Health and Safety Department and Business Leads in 2023/24.

4 HEALTH, SAFETY AND FIRE ENFORCEMENT ACTIVITY

During 2022/23, no prosecutions or enforcement actions have been issued by the Health and Safety Executive (HSE) or South Wales Fire & Rescue Service (SWFRS).

However, during this period, there have been HSE intervention costs of approximately £13,000. These intervention costs relate specifically to HSE investigations into patient falls incidents. (The Health and Safety (Fees) Regulations 2012 places a duty on HSE to recover its costs for carrying out its regulatory functions, from those found to be in material breach of health and safety law.)

The HSE currently have one ongoing investigation.

In November 2022, an inspection of the Department of Microbiology at Royal Gwent Hospital was conducted by the HSE Specialist Inspector.

The primary purpose of the visit was to conduct a sampling-based assessment of the adequacy of the Health Board's facilities, procedural controls, and supporting systems in meeting the legal requirements applying to its diagnostic work with biological agents. In this regard, the inspections had a particular emphasis on those activities undertaken at Containment Level 3 (CL3) and included exploration of the health and safety management arrangements as well as sample front-line inspection of the laboratories.

The inspection identified several areas that required remedial actions to maintain compliance with the legislation (The Management of Health and Safety at Work Regulations 1999 and The Control of Substances Hazardous to Health (CoSHH) Regulations 2002) and minimise the risk of exposure to infectious agents arising out of the activity. In May 2023, the HSE Specialist Inspector confirmed that the response from the Health Board provided sufficient assurance that appropriate actions had been implemented.

Further to an inspection programme carried out by the HSE between 2018 and 2022, a summary of findings on the management of risks from workplace violence and aggression (V&A) and musculoskeletal disorders (MSDs) was issued to the Health Board in March 2023.

The common feature where contraventions were identified were management failings. These are failings of the management systems and relate to 1) risk assessment; 2) training; 3) roles and responsibilities; 4) monitoring and review.

To obtain assurance the HSE will be undertaking further interventions with the NHS over the next 12 months. These interventions will follow a two-step approach as follows:

Step One: Several high-level interventions by appointment between NHS Trust Chief Executives and HSE Field Operations Division (FOD) Operational Managers, to discuss what is being done at senior management level to address the risks from V&A and MSDs.

Step Two: Inspectors will carry out several site inspections to seek assurance that what was described to us, in the high-level interventions, is being delivered on the ground.
SWFRS have conducted nine fire safety inspections across the Health Board during the financial year. The majority of these were at County Hospital, however, other inspections were carried out at Chepstow Community Hospital and Nevill Hall Hospital.

All the recommendations arising from the SWFRS inspections are recorded on the Health Board fire risk register and consideration is given to address these based on the risk presented.

5 RISK MANAGEMENT AND RISK REPORTING

The completion of risks assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the risk assessment programme, the Corporate Health and Safety Department deliver risk assessment training, promoting best practice in the completion of a risk assessment and the principals of effective Risk Management within departments and in the wider organisation.

The Health and Safety Professionals within the Corporate Health and Safety Department continue to provide advice and guidance on the implementation of statutory risk assessments through the various subgroups. Specialist risk assessments being completed by the Health and Safety Professional upon request.

In November 2022 a new simplified health and safety risk assessment form was introduced. The new assessment form has been developed to support and aid those who are required to complete risk assessments through the 5 Steps to risk assessment process, this will help improve safety standards and support in the completion of suitable and sufficient risk assessments.

Most of the health and safety risks are reported via the risk module on the DatixWeb system. The Health Board also subscribe to CoSHH management software for the risk assessments relating to substances hazardous to health. All fire safety risk assessments are recorded via the NWSSP fire auditing and reporting system.

The Health and Safety Committee receives reports on health and safety risks from the Divisions for consideration, action and assurance.

As part of the monitoring arrangements, the Corporate Health and Safety Department have engaged with Risk Leads to review the risks recorded as Extreme High and High with the view to provide further advice and support and ensure that appropriate mitigation is applied as a means to manage the risks at a level that is so far is reasonably practicable.

6 HEALTH, SAFETY AND FIRE TRAINING

Suitable and sufficient training is a requirement of The Health and Safety at Work Act 1974 and The Management of Health and Safety at Work Regulations 1999.

The Management of Health and Safety at Work Regulations state "every employer shall ensure that his employees are provided with adequate health and safety training".

The health and safety statutory and mandatory training compliance as of 31 March 2023 was as follows:

Training Course	Compliance %
Health and Safety Awareness	82%
Fire Safety	79%
Manual Handling	52%
Violence & Aggression	81%

Except for manual handling training, the delivery of the health and safety statutory and mandatory training programme in 2022/23 continues to be delivered by eLearning with access via the electronic staff record (ESR) self-service portal for ease to individuals. Line managers can view their team's compliance and are also notified when staff are nearing non-compliance.

There is an aspiration to introduce face to face training in 2023/24. However, this will require a review of Health Board resources to deliver effectively.

Compliance levels for manual handling training are well below the required standard. The manual handling training strategy is to be reviewed in 2023/24 to ensure the Health Board has a sustainable programme of manual handling education, particularly for high-risk areas.

Manual Handling training within NHS Wales is delivered to the scope of the All-Wales Manual Handling Passport. This ensures a consistent and standard approach to training.

Violence and aggression training is aligned to the All-Wales NHS Violence & Aggression Passport Scheme. The passport scheme is broken down into three areas:

Module A - Induction and Awareness Raising
Module B – Theory of Personal Safety and De-escalation
Module C – Breakaway

All Health Board staff are mandated to complete modules A & B, whist module C is based on risk assessment. Members of the Corporate Health and Safety Department have attended accredited training to enable them to teach module C.

6.1 Health and Safety Training for Managers

The Health and Safety Training for Managers Training package is currently under review and once complete will provide Ward / Department Managers with an awareness of their role in health and safety management and implementation. The course will cover vital information such as the legal requirements, safety management systems, safety culture, risk assessment & hazard control and incident investigation.

6.2 Ward Talk Safety Talks

Ward Talk Safety Talks have been implemented as a method to provide further information, instruction & training to Health Board employees in relation to health and safety matters.

The Ward Talk Safety Talks are short training presentations that are conducted within the working environment and provide safety reminders, brief refreshers and quick lessons on safety topics. The Ward Talk Safety Talks are developed by the Corporate Health and Safety Department and can either be delivered by a member of the Corporate Health and Safety Department or local Ward / Department Manager.

The use of Ward Talk Safety Talks has provided greater opportunity to discuss recent incidents, near misses and everyday tasks, such as "Use of Respiratory Protective Equipment (RPE)", "Management of Slips Trips and Falls", "Use of Manual Handling Equipment". The sessions promote best practice and help reinforce desired behaviours.

6.3 Manual Handling Cascade Trainers Training

To support the delivery of the manual handling training strategy, cascade trainers are nominated in areas across the Health Board. The cascade trainers i.e. Transfer Specialists, Safer Handling Coaches etc. attend foundation training and are required to attend update to maintain their competency.

The COVID-19 pandemic contributed to a backlog of trainers becoming out of date with their two-yearly refresher. The register of cascade manual handling trainers has been cleansed and a programme of updates will be executed in 2023/24.

6.4 Risk Assessment Training

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. To support the Health Board to maintain its legislative requirement and ensuring the provision of competent risk assessors, the Risk Assessor Training course has been revitalised for 2023.

The aim of the course is to ensure all participants have an understanding on the concept of risk assessment, when a risk assessment is required within the workplace and how to conduct a suitable and sufficient risk assessment. A training programme has been developed and communicated through the Health Boards structure, further to the delivery of Risk Assessment Training in 2023. There has been positive feedback in relation to the updated course and participants who have attended the training have scored their confidence and ability to conduct a risk assessment highly. This feedback has been captured as part of the post course evaluation form.

6.5 Risk Management Training

To support with the management and escalation of risks the Corporate Health and Safety Department have developed a new training course, the course provides a brief introduction to Risk Management principals, and the use of Datix Risk Module as means to record and review risks. The course has been offered to all Divisions and where delivered, has provided participants with greater confidence in utilising the Datix Risk Module as a method of recording, monitoring and managing risks which is in accordance with the Health Boards risk management strategy.

6.6 Fire Safety Training

As part of a major review of fire safety training in 2022/23, a training needs analysis was undertaken to identify suitable levels of training for groups within the Health Board. A more targeted training needs analysis document was produced with one of the major outcomes being the implementation of a programme of fire advisor led, face to face training, for all staff working in areas with inpatient facilities. This approach is aligned with the fire safety guidance contained in Welsh Health Technical Memorandum (WHTM) 05:01.

6.7 Fire Warden Training

Fire wardens at Health Board premises perform a vital function in maintaining safe environments. Their role during fire emergencies is as a *critical friend* to department and ward managers who are responsible for initiating and managing evacuations.

Key functions of fire wardens include the continual monitoring and completion of monthly safety checks of their areas to identify fire safety problems. The position is secured on a voluntary basis and they provide the valuable service of liaison with the Fire Safety Advisors to provide early warning and resolution of potential safety issues.

The Fire Safety Team continue to promote the identification and training of fire wardens for all areas across the Health Board. This is monitored via the fire risk assessment process and where a fire warden is not identified for an area, this is recorded as an action within the assessment.

An additional 80 fire wardens were identified and attended training in 2022/23.

6.8 Fire Response Team Training

Following liaison with the operations directorate and site management teams, training has been provided (in line with the training needs analysis) for fire response teams at Nevill Hall Hospital, The Royal Gwent Hospital and Grange University Hospital.

The training included awareness of how the buildings are constructed to limit fire spread, site specific evacuation procedures and facilities on site to allow movement of patients between floors i.e. escape stairs and evacuation lifts.

6.9 Fire Drills & Exercises

The Fire Safety Team conduct an annual programme of fire drills and exercises across the Health Board. The purpose of these is to confirm the fire evacuation strategies for the areas are robust. An evacuation exercise is planned at Ysbyty Ystrad Fawr in 2023/24 which has engagement from South Wales Fire & Rescue Service.

7 RIDDOR REPORTING

Under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013), certain workplace accidents, incidents, ill health and certain near miss events must be recorded. Depending on the severity and nature of the injury, and indeed the party affected, the Health Board has a legal duty to report this data to the Health and Safety Executive (HSE).

The reporting process to the HSE is undertaken by the Corporate Health and Safety Department.

The total number of RIDDOR reportable incidents reported to the HSE in 2022/23 was the same figure as reported in 2021/22. (*See figure 1*)

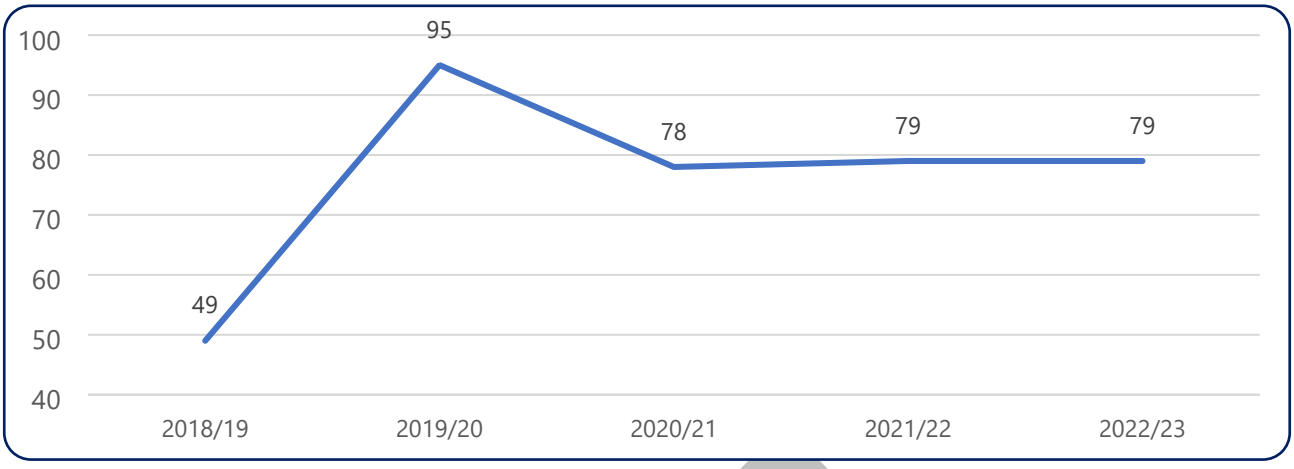


Figure 1: Total number of RIDDOR reportable incidents reported to the HSE for the past five financial years

In 2022/23 there has been one fatal incident reported, a patient fall. The is the same number of fatal incidents reported in 2021/22. Over-seven-day incapacitation of a worker are the highest reported classification in 2022/23, however, this is a reduction from the previous financial year where 60 incidents were reported. The number of specified injuries has risen from 13 incidents reported in 2021/22 to 18 in 2022/23. *(See figure 2)*

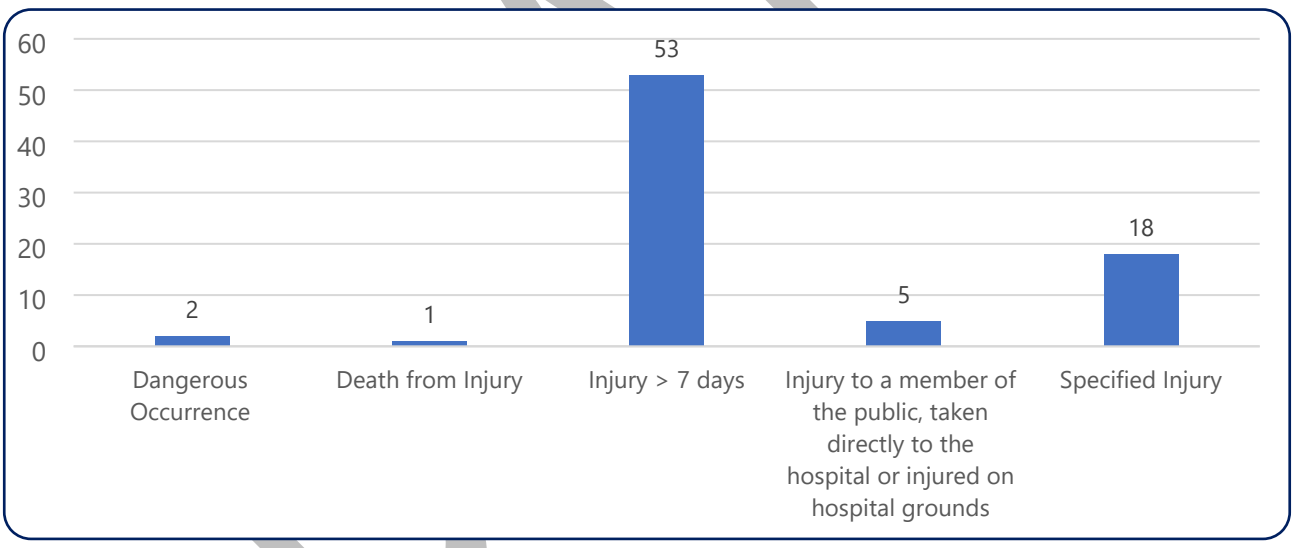


Figure 2: RIDDOR reportable incidents by classification reported to the HSE for 2022/23

Slips, trips and falls to staff continue to be the highest type of RIDDOR reportable incident reported to the HSE. However, the 28 reported in 2022/23 was a 20% reduction from the 35 reported in the previous financial year.

There was also a 39% reduction in the number of abuse to staff RIDDOR reportable incidents reported to the HSE in 2022/23 (11) compared with 2021/22 (18).

Manual handling RIDDOR reportable incidents have increased by 27% from 4 in 2021/22 to 15 in 2022/23. *(See figure 3)*

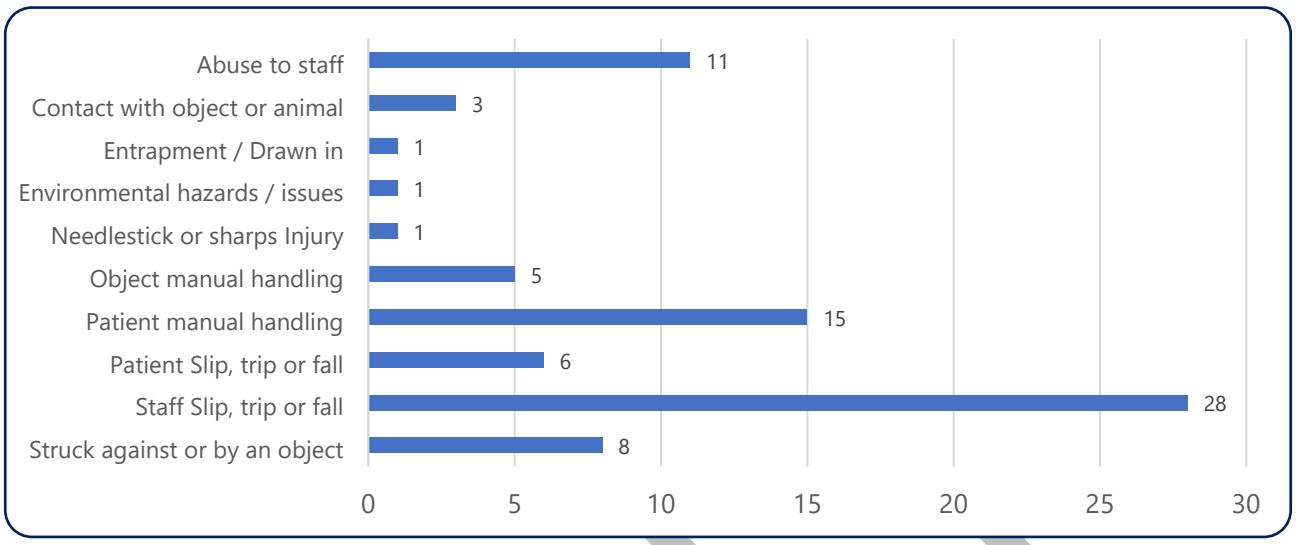


Figure 3: Type of RIDDOR Reportable incidents reported to the HSE for 2022/23

49% (39 incidents) were reported outside of the legal timeframes outlined with the RIDDOR legislation. However, as illustrated in figure 4, compliance has improved since October 2022.

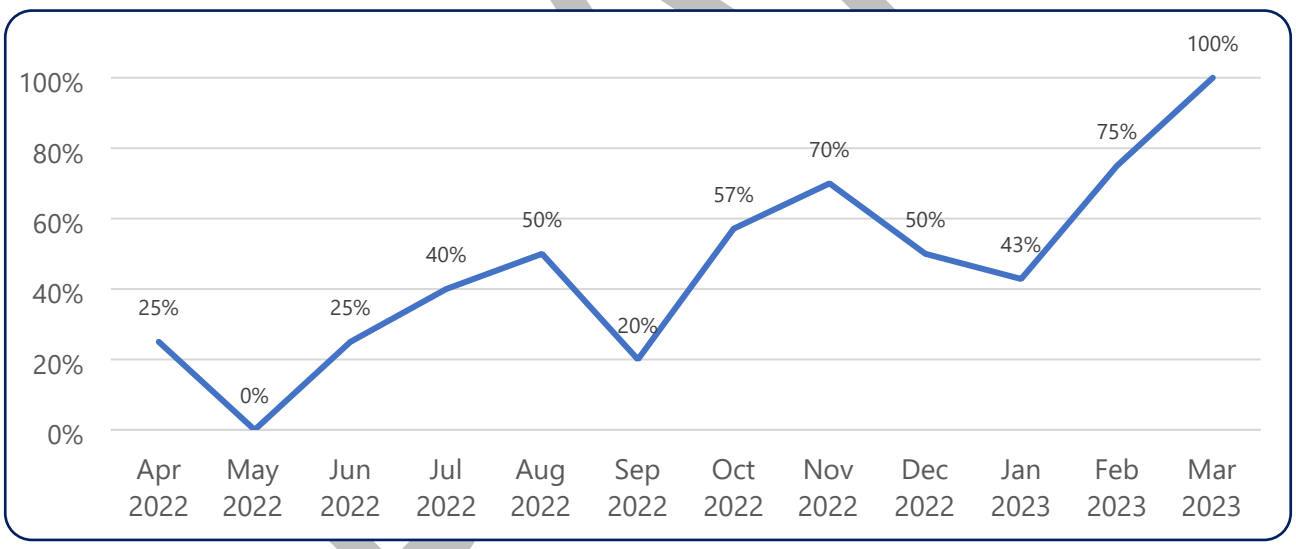


Figure 4: RIDDOR reporting compliance to the HSE

8 LEARNING FROM EVENTS

The Corporate Health and Safety Department has implemented various communication methods to support learning from incidents across the Health Board.

As part of these methods, information is cascaded through Health and Safety performance reports, post investigation meeting de-briefs, amendment to relevant health and safety training packages and organisational alerts.

During 2022/23 there have been seven information sheets issued which relate to the following:

- HSI-2022-004 - Fire safety change of use
- HSI-2022-005 - Catalytic Converter Theft
- HSI-2022-006 - Misuse of Nurse Call Bell Reset Buttons
- HSI-2022-007 - Changes to Hoist and Bath Service & Repair Contract
- HSI-2022-008 - Wedging & Leaving Open Fire Doors
- HSI-2023-001 - Fire Safety arrangements at Royal Gwent Hospital
- HSI-2023-002 - Management of hoist batteries

9 COVID-19 RESPONSE

On 1 April 2022, revised guidance on RIDDOR reporting requirements for COVID-19 was issued. Since 1 April 2022 only cases of COVID-19 due to either deliberately working with the virus (such as in a laboratory) or being incidentally exposed to the virus from working in environments where people are known to have COVID-19 (for example in health and social care) are reportable. Cases due to general transmission (either worker-to-worker, or from contact with members of the public) are no longer reportable.

During the period April 2022 to March 2023 the Health Board have not been required to submit a COVID-19 related RIDDOR to the Health & Safety Executive.

Throughout the year there has been a requirement to provide support to areas in relation to the Health Boards response to the COVID-19 Pandemic and the transition from Pandemic to Endemic. The Corporate Health and Safety Department have provided advice and guidance through the Reducing Nosocomial Transmission Group and other local forums. In addition to this, further support has also been provided to the Monkey Pox Pathway.

Support has continued to the Mass Vaccination Programme in relation to Health & Safety, Fire Safety and Security.

10 HEALTH & SAFETY

10.1 National Meetings

The All Wales Health and Safety Management Steering Group represents Health & Safety professionals working in NHS Wales in all areas of health and safety management, providing a forum to network, share best practice and work collaboratively to develop improvements in health and safety.

The group represent all NHS organisations, recognising the importance of providing informative and stimulating meetings, workshops, and seminars for the continued professional development of all our members.

The purpose of the All Wales Health and Safety Management Steering Group is to:

- Discuss all areas of health and safety management to ensure compliance with the legislative and regulatory frameworks in place for managing health and safety effectively.
- Share lessons learned and best practice identified for effective health and safety management.
- Encourage strong leadership in health and safety and championing the importance of a common-sense approach to motivate focus on core aims distinguishing between real and trivial issues.
- Where appropriate, advise the Health Boards and Trusts on where and how, its health and safety management may be strengthened and developed further.

The aims of the group are to:

- Support members to develop the health and safety management arrangements within healthcare organisations.
- Provide a forum in which health and safety risk and issues can be debated, to ensure effective communication of ideas, sharing of experiences and areas of best practice.

Subgroups and workstreams have been established to review current health and safety practice is specific areas and develop minimum standards for implementation across NHS Wales.

An All-Wales Health & Safety Workstream has been developed in relation to Face Fit Testing, the purpose of this workstream is to standardise the Education & Training for all Health Boards in Wales for persons completing the Face Fit Tester Train the Tester Training. The working group seek to develop both a Qualitative and Quantitative Tester course, both courses would be delivered by the Health Boards RPE Competent Person, e.g., Health & Safety, Infection Prevention & Control Team.

Following the development of the course material, the working group will be looking to seek course accreditation from FIT2FIT, who are the only accreditation provider endorsed by the Health & Safety Executive.

In addition to the development of Education and Training, an All-Wales Face Fit Testing Standard Operating Procedure is currently in development. The purpose of the Standard Operating Procedure is to support the standardisation of Face Fit Testing across NHS Wales, including method of Face Fit Testing, Recording of Results, Fit Test Certificate and Documentation.

10.2 Health and Safety Incident Reporting

The following data provides a detailed breakdown of the type of health and safety related incidents that have been reported in 2022/23. *This excludes violence and aggression and fire incidents as these are reported on in the relevant sections of this report.*

Figure 5 indicates a decrease in the number of reported incidents affecting staff, contractors or visitors over the last five financial years. The number of reported incidents shows an 8.5% decrease from the previous year.

The reduction in reported incidents in 2021/22 and 2022/23 coincides with the implementation of a new incident reporting system.

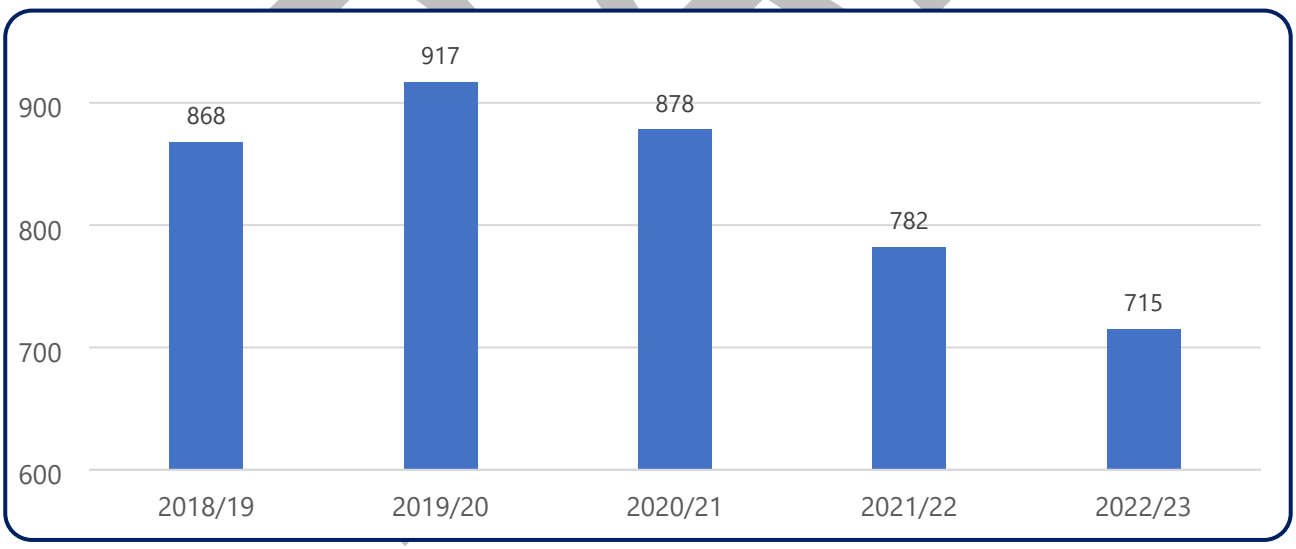


Figure 5: Number of reported incidents affecting staff, visitors and contractors for the past five financial years

Contact with needles or medical sharps is the most reported health and safety incident category affecting staff or contractors (191 incidents), however, 14% of these incidents (26) were from clean / unused sharps. *(See figure 6)*

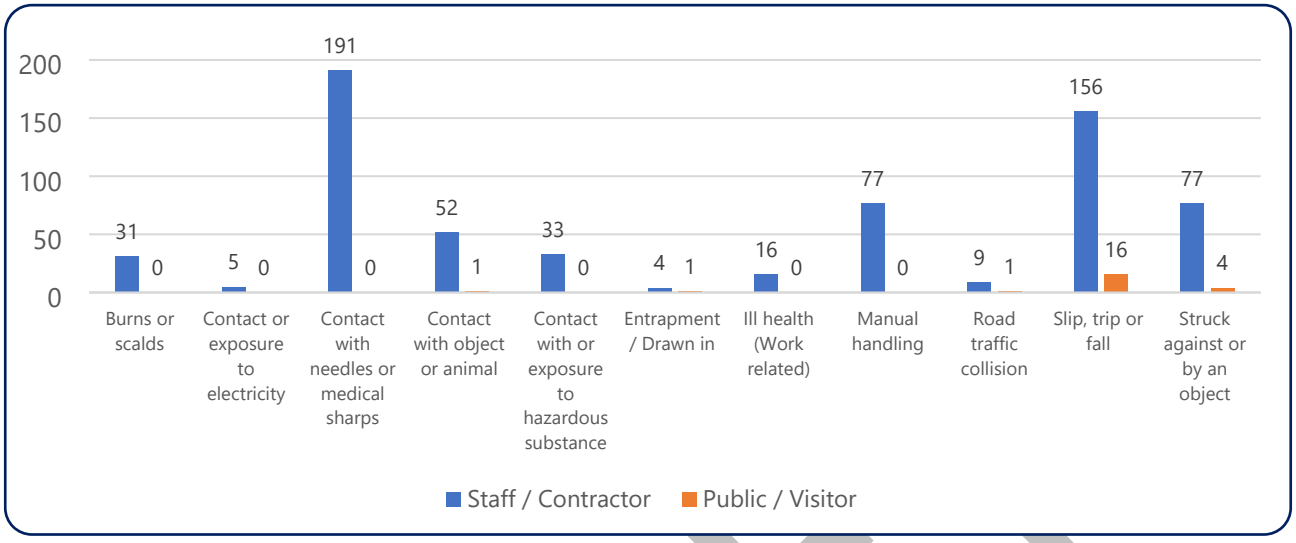


Figure 6: Type of incidents by person affected for 2022/23

The number of sharps incidents reported in 2022/23 has reduced by 14.7% from the previous financial year (224 reports). However, the incidents from contaminated / used sharps devices have remained stable. *(See figure 7)*

It is difficult to obtain data on the number of tasks or procedures carried out across the Health Board using needles or medical sharps. However, based on the incidents reported and the significant number of tasks and procedures the incident rate would be very low. This is also supported by the fact that only one incident during 2022/23 has been reported under RIDDOR to the HSE of a sharps injury that was contaminated with a blood borne virus.

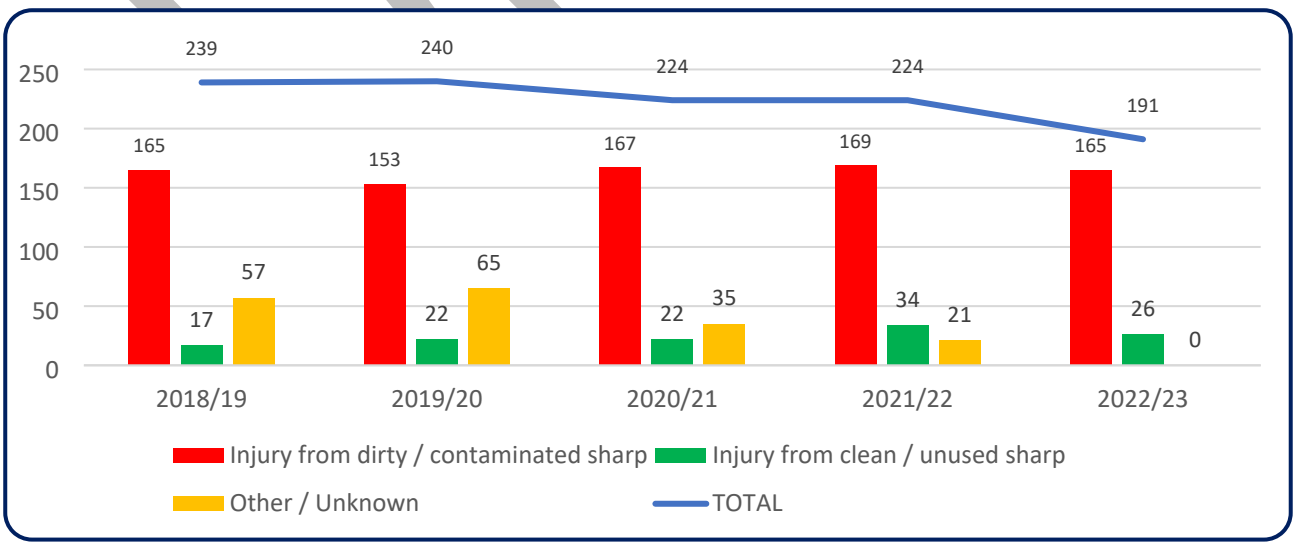


Figure 7: Total number of sharps incidents by type for 2022/23

To identify learning outcomes from sharps incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix system.

The revitalisation of the health and safety monitoring programme will assess each clinical areas compliance against the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The outcomes of the monitoring will be reported to the Health and Safety Committee.

Slip, trip or falls is the second highest reported health and safety incident category affecting staff or contractors (172 incidents). *(See figure 6)*

The number of slips, trips and falls incidents reported in 2022/23 has increased by 3.6% from the previous financial year (166 reports). *(See figure 8)* These types of incidents continue to be the highest reported to the HSE in accordance with RIDDOR and personal injury claims.

In 2020/21 there were 135 slips, trips and falls incidents reported against staff, visitors and contractors. This is a significant difference compared with other years and is likely to be attributed to the COVID-19 pandemic.

Most of the reports in 2022/23 were categorised as 'Fall on a slippery or wet surface' (49), 'Trip or fall over an object or obstacle' (29) or 'Fall on uneven ground' (12) which is in keeping with the previous year's reporting.

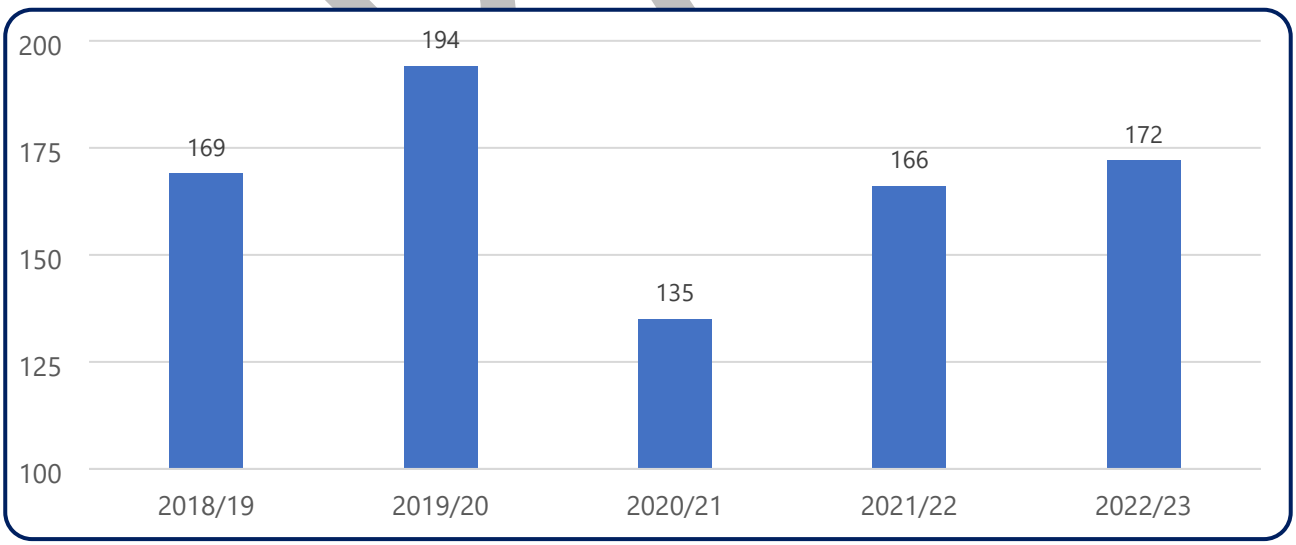


Figure 8: Number of reported slips, trips and falls incidents affecting staff, visitors and contractors for the past five financial years

The Corporate Health and Safety Department have invested in Pendulum Floor Slip Test Equipment and Training. The Pendulum slip tester measures the frictional resistance between a rubber slider mounted on the end of a pendulum arm and the test surface. This provides the Health Board with a method of checking the resistance of wet and dry surfaces to slipping and skidding.

The equipment and training will assist with the active monitoring and support the prevention of slips, trips and falls.

10.3 Face Fit Testing

The Covid-19 Pandemic has brought an increased requirement for the use of Personal Protective Equipment (PPE) and Respiratory Protective Equipment (RPE) within healthcare settings. Where personal protective equipment and respiratory protective equipment is used, it must be able to provide adequate protection for individual wearers.

Fit testing ensures that the equipment selected is suitable for the wearer. Face fit testing is a mandatory requirement as prescribed by Health & Safety Executive Control of Substances Hazardous to Health Regulations Approved Code of Practice (ACoP) L5 and associated guidance documents that support the relevant statutory provisions.

As part of the Health Boards Face Fit Testing Strategy, quantitative face fit testing has been introduced. The Pass or Fail criteria is based on the overall "Fit Factor" and does not rely on the participant's ability to detect a taste, the test method is less subjective and deemed as a more accurate test method, compared to qualitative face fit testing and can provide greater assurances that the selected item of RPE fits the wearer and provides the required protection.

The delivery of Face Fit Testing continues to remain a key priority for the Corporate Health and Safety Department. Since March 2020 the Department have conducted over 15,000 individual Face Fit Tests.

To enable the Health Board in maintaining compliance with Face Fit Testing requirements a "Face Fit Test Train the Tester course" has been developed. The purpose of this course is to provide individuals with the required skills, knowledge and experience to conduct Face Fit Testing in accordance with the relevant standards and best practice guidance. To Date the Corporate Health and Safety Department have trained 188 individuals to the required standard.

10.4 Respiratory Protective Equipment (RPE) Health & Safety Inspection

As part of the Health & Safety Monitoring Programme, Workplace Inspections in relation to Respiratory Protective Equipment (RPE) have been conducted during 2022/23. The purpose of the inspection is to identify the measures in place to support the management and use of Respiratory Protective Equipment. All inspections have been recorded on the Audit Management and Tracking (AMaT) platform.

Health Board Compliance is 50.2%. This is based on a total of 39 inspections completed in 2022/23. Diagrams 9 identifies the compliance for the inspected sites.

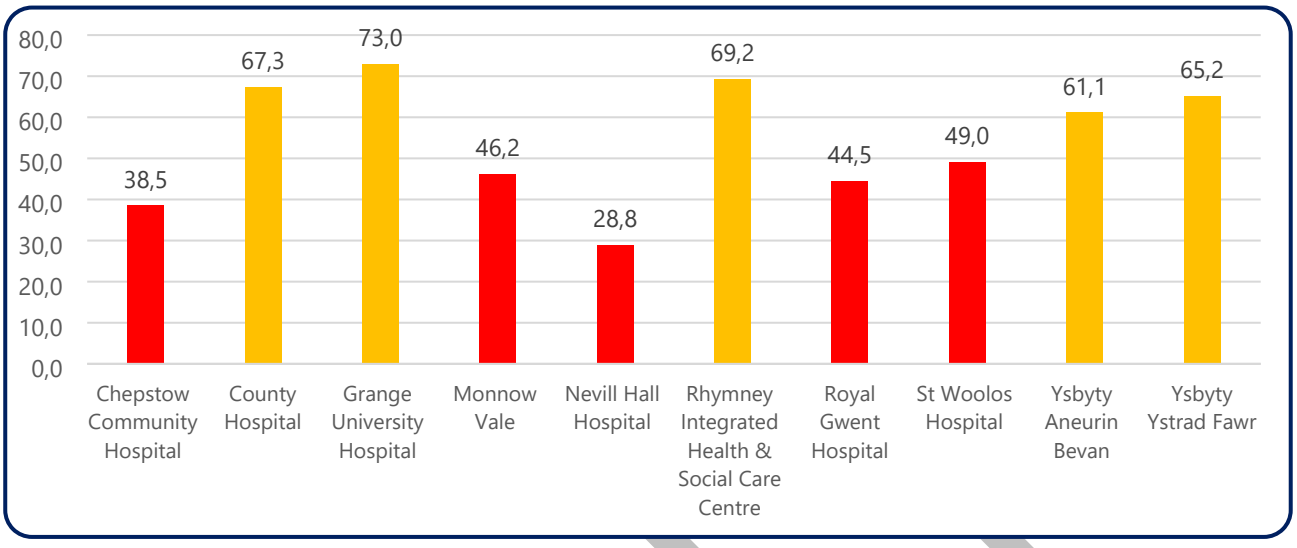


Figure 9: Average RPE Inspection Score by Site

All actions in relation to non-compliance have been recorded on the AMaT platform and assign to the local Ward / Department Manager.

Areas who have generated low compliance scores will be reinspected during the 2023/24 inspection period.

Common themes of improvement arising from the RPE monitoring include the following:

- No Fit Test compliance register available demonstrating what RPE workers have been Fit Tested to locally.
- No access to local Face Fit Test Train the Tester within the Ward / Department.
- No access to ABUHB "Respirator Guide" displayed within staff areas.
- No access to ABUHB "Respirator Fit Check" Guide displayed within staff areas.
- Limited recorded maintenance checks being completed on reusable RPE.

The themes arising from the RPE monitoring which scored high were as follow:

- Staff are aware when RPE is required in the workplace.
- Staff are aware of Fit Testing requirements and how to access Face Fit Testing.
- Staff can correctly explain RPE Donning Doffing Procedures.
- Powered air-purifying respirator (PAPR) Units are available for use locally.
- PAPR Units are being stored correctly and are in suitable condition.

10.5 Launch of Transparent Facemask Pilot

The transparent facemask pilot is part of a National initiative for the use of transparent facemasks within health and social care settings in Wales. The use of Facemasks has played a vital role in reducing the transmission of respiratory infection within healthcare settings, however for some patients and service users, this has reduced the effectiveness of face-to-face communication.

The aim of the pilot is to inform the future design of transparent facemasks, to understand how effective they are in different settings across health and social care.

11 FIRE SAFETY

Fire safety is an exchangeable term with fire precautions. The principal requirements of fire safety legislation are:

- To reduce the probability and severity of a fire occurring within a building.
- To provide buildings and environments that ensure that persons can safely evacuate a premises in the event of a fire occurring.

Any disruption to services in NHS settings can have serious life changing, or even life limiting implications for service users. Therefore, property protection and business continuity are key aims of the fire safety policy as applied within the Health Board.

When carrying out assessments and providing fire safety advice the fire safety team are mindful to limit disruption and hinderance of service delivery as far as they are reasonably able.

The principal legislation governing fire safety in the UK is The Regulatory Reform (Fire Safety) Order 'RRO', that came into force on 1st October 2006. The RRO places liability on responsible persons within an organisation to take general fire precautions for the protection of the relevant persons.

The legislation applies a system of vicarious liability to organisational leaders. The responsible persons in the Health Board are principally directorate and departmental leaders.

The Executive Director of Therapies & Health Science is the Executive Director with delegated responsibility to ensure compliance with Firecode guidance, current fire safety legislation and responsibility for ensuring that fire safety issues are highlighted at Board level. In particular they will ensure, by delegation to The Fire Safety Manager that fire safety policy is promulgated, and that Fire Risk Assessments are completed to record the general fire precautions required for all areas.

Individual Board Level Directors and The Board as a collective are responsible for ensuring compliance with the Health Board Fire Safety Policy and that the general fire precautions are applied within the scope of their areas of control.

The following summary profile gives brief details of this Health Boards development towards compliance with the minimum mandatory requirements for the NHS in Wales.

11.1 Preparation and upkeep of the organisation's fire safety policy

A major review of Fire Safety Policy was conducted in the preceding financial year with a view to rationalise the policy document to give a concise overview of the Health Boards approach to fire safety. More detailed fire safety procedures have been converted to a suite of fire safety protocols.

11.2 Provision of Officers with Specific Fire Safety Responsibilities

Health Boards are required to provide a structure of Fire Safety Management within their organisations aligned with WHTM 05:01.

The structure is based on assigning responsibility for specific fire safety functions to specific functional roles within the organisation. The nominated offers are accountable for fire safety functions assigned to them.

Roles and responsibilities within the Health Board are recorded in *Fire Safety Protocol 031 Roles and Responsibilities for Implementation.* An update to this protocol is required, it is due for review in 2023/24. The review will benefit from a more forensic approach to assigning responsibilities and a more robust method of communicating responsibilities to the appropriate roles.

In addition to the designated roles mentioned above, it should be understood that leaders are accountable for adherence to fire policy in any areas that are under their control or influence.

11.3 Fire Safety Risk Management

The Health Board is legally required to carry out and record regular Fire Risk Assessments. The legislation requires that assessments are to be *suitable and sufficient* and reviewed on a regular risk-based approach.

Although there is no prescribed frequency for review of fire risk assessments it is accepted by Health Boards and Fire and Rescue Services in Wales that the frequencies in the table below should be applied.

Type of Area to be Assessed	Frequency of Assessment
Buildings or parts of buildings that provide sleeping or inpatient accommodation	12 months
Other than above but areas provided for public access such as outpatient facilities	24 months
Other than above. Areas not provided for public access such as offices, plantrooms etc.	36 months

In addition to *regular* reviews of fire risk assessments there is a requirement that risk assessments are reviewed whenever there is a material change in the use of the area. Because the assessment takes account of fire safety management, any transfer of departments or change of function within an area generates additional, non-programmed assessments and can result in multiple assessments for single areas within a 12 month period.

A programme of Fire Risk Assessments aligned with these frequencies is in place with 66% of the programmed assessments achieved in 2022/23.

The reason for the shortfall is explained, in part, by diversion of resources to carry out non-programmed work to cater for staff reorganisations. The programme was also affected by fire team staff absence that has an un-proportional effect in a small team.

All areas within the Health Board have been assessed. To ensure that resources are targeted to areas of most need the shortfall is being addressed by a process of slippage i.e. assessments with a 12 month review date will be reviewed within 15 months. (all assessments with a longer review frequency where completed to programme)

Recent efforts have been made to rationalise the fire risk register to allow better targeting of capital on fire safety improvement works. Historically the register had risks logged against doors etc. due to the fact that they were not modern fire doors regardless that they were perfectly functionable fire doors. Over recent years the fire safety team have re-evaluated such risks and where doors were found to be functional, the assessments have been recorded and the risks removed from the system.

Most fire risks held on the system are legacy fire risks at older building stock including Royal Gwent Hospital and Nevill Hall Hospital. These premises remain a priority for resolution and are likely to dominate the Fire Safety Discretionary Capital spend for the foreseeable future.

11.4 Planning and Implementing Fire Safety Improvement Works

The duties of the Fire Safety Manager include planning and implementing a programme of improvement works to remove or mitigate fire risks carried by the organisation.

Over recent years major improvements have been made in the following areas to ensure the Health Board meets minimum safety standards and fulfils its legal requirements:

Site	Area	Improvement
Nevill Hall Hospital	Ground Floor	Replacement fire alarm system
Nevill Hall Hospital	Conference Centre	Replacement fire alarm system
Nevill Hall Hospital	Education Centre	Replacement fire alarm system
St Woolos Hospital	Casnewydd Unit	Replacement fire alarm system
Royal Gwent Hospital	E Block	Replacement fire alarm system
Royal Gwent Hospital	Clytha Square Buildings	Replacement fire alarm system
Royal Gwent Hospital & Nevill Hall Hospital	Staff Residences	Replacement fire doors
County Hospital	Rowan & Oak Wards	Replacement of obsolete fire detection
Ysbyty Aneurin Bevan	Whole site	Replacement fire alarm panels and graphics interface

In addition to the above there has been a continued incremental improvement across all building stock.

11.5 Key Fire Risks

The fire alarm system required at a building depends on a number of factors including the size and complexity of the building, the use of the building and the profile of the building users.

Currently, at all Health Board premises, the alarms systems are fit for purpose and are sufficiently reliable to ensure the levels of safety of building users.

However, fire alarm systems degrade over time and require constant maintenance and repair. Components, such as detectors have a limited working life and need to be regularly replaced. Manufacturers periodically replace older technology with new versions of systems that can render whole systems obsolete.

Obsolesce means that the systems become increasingly more difficult to manage and replacement parts become increasingly more difficult to acquire.

The fire alarm systems at the Royal Gwent Hospital and St Cadoc's Hospital sites are obsolete and require replacement.

Improvements schemes are planned at both sites to start in 2023 however current capital allocation is insufficient to allow full rectification of the problems at The Royal Gwent Hospital in a timely manner.

Nevill Hall Hospital was greatly improved by the replacement of the fire alarm system on the ground floor in 2020/21. Further improvements are required on the first floor of the main building to replace older detection devices.

Management of fire barriers fitted across hospital sites is problematic. Historically the safeguarding of fire barriers against contractor damage has been human resource intensive, modern software solutions that are more economical are unavailable due to a lack of availability of up-to-date plans. The option of physically checking partitions following all construction work on sites is heavily reliant on human resources that is not currently available.

Improvement schemes are planned in 2023/24 to repair fire partitions in Nevill Hall Hospital and Casnewydd Unit at St Woolos Hospital.

A compartmentation survey is required at The Royal Gwent Hospital to identify the current condition of passive fire protection.

11.6 Emerging Risks

Capital investment will be required within the following financial years to mitigate risks in the following areas.

- Replacement of end-of-life fire alarm panels and detection Level 1 at Nevill Hall Hospital.
- Replacement of end-of-life fire detectors Levels 3 & 4 at Nevill Hall Hospital
- Replacement of end-of-life fire detectors at Ysbyty Ystrad Fawr
- Replacement of the fire alarm system in the old hospital buildings at St Woolos Hospital (the system is not acceptable to modern standards, however clarity on the future use of the buildings is required before a commitment to spend circa £300k on a replacement system can be made)
- Establishment of a system to manage compartmentation to avoid a damage and repair cycle.
- Risks associated with aging electrical infrastructure on older sites.

- Risks associated with aging ventilation infrastructure (Fire Dampers) for inpatient areas on older sites.

11.7 Planned Improvements

The following improvement schemes are planned to commence in the financial year 2023/24.

- Partial replacement of the fire alarm system at Royal Gwent Hospital Site including a full system of network panels and full replacement of the system on Levels 5, 6 & 7 C & D Block.
- Full replacement of the fire alarm system at St Cadocs Hospital.
- Repairs to fire partitions levels 3 & 4 at Nevill Hall Hospital.
- Replacement of 30-minute fire doors with 60-minute fire doors on ward entrances levels 3 & 4 at Nevill Hall Hospital.

11.8 Future Challenges and Priorities for the Fire Safety Team

The strategic goals for the Fire Safety Team are to improve fire strategies at older hospitals while replacing older, complex and costly alarm systems with modern systems incorporating graphics information displays that are easier to manage and more economical to maintain.

A lack of available information on safety systems at these buildings continue to pose challenges in the move away from generic fire safety strategies to the provision of detailed, site specific fire safety building strategies. Continued improvement will rely on the team investigating systems and producing reliable documents such as:

- Fire Zone Plans
- Fire Alarm Cause and Effect Matrices
- As Fitted Fire Alarm System Device Drawings
- Fire Damper Plans
- Detailed Fire Evacuation Plans
- Detailed Fire Evacuation Notices for Staff and Visitors
- Detailed Fire Response procedures

11.9 Fire Safety Advice and Support for Internal and External Partners

The Fire Safety Team provides advice and support to both internal and external partners across a variety of issues affecting fire safety.

Internal queries include advice and assessment of risk posed by shutting off areas to allow building work and application of building regulations for the repurposing of individual areas within a hospital.

External queries range from assessment of the suitability of fire safety building materials, design of cause and effect for fire alarm systems to active consultation with project managers on fire safety building regulations and fire strategies during the planning phase of new builds.

On completion of projects the fire safety team provide training, risk assessment and updated fire safety strategies for new or repurposed areas and buildings.

The team has been involved in the following projects currently being progressed or completed within the last financial year:

- Adoption of Chepstow Community Hospital from PPI
- Same Day Emergency Care (SDEC) at the Grange University Hospital
- Extension to Emergency Department (ED) at the Grange university Hospital
- Specialist Inpatient Services Unit (SISU) at Llanfrechfa Grange
- Hospital Serialisation Disinfectant Unit (HSDU) at Llanfrechfa Grange
- Repurposing of Wards 2/1 and 2/2 at Nevill Hall Hospital
- Repurposing of Wards 2/3 and 2/4 at Nevill Hall Hospital
- Satellite Radiology Unit at Nevill Hall Hospital
- Newport East Wellbeing Centre and Temporary Accommodation
- Repurposing of Ward B6 North at Royal Gwent Hospital
- Repurposing of Ward B4 West at Royal Gwent Hospital
- Upgrade to Pharmacy at Royal Gwent Hospital
- Decontamination Suite at Royal Gwent Hospital
- Crisis Hub at St Cadocs Hospital
- Replacement Roof Glen Usk Suite at St Cadocs Hospital
- Tredegar Wellbeing Centre

11.10 Collaborative Working and Fire Safety Membership Groups

In addition to their duties for the Health Board the fire safety team are actively engaged as members of The National Association of Healthcare Fire Officers (NAHFO). Fire advisors attend regular meetings of the Wales Branch of NAHFO where they receive updates on fire safety building regulations and legislation and discuss common issues and best practice with colleagues from the other health boards in Wales and Shared Services fire advisors.

The fire safety team are also involved in the All Wales Fire Safety Managers Group. The group is engaged in the development of a number of All Wales Fire Safety protocols, the Health Board currently chair the working group on Control of Ignition Sources and contribute to groups working on Fire Safety Training and Fire Safety Considerations for Bariatric Patients on Healthcare Premises.

11.11 Fire Safety Incident Reporting

There have been three more fires in 2022/23 than in 2021/22. However, the total number of fires reported (5) is still significantly less than those reported in the years previous.

The number of unwanted fire signals (UwFS) reported in 2022/23 has continued the downward trend from previous years (See figure 10). The reduction in unwanted fire signals is largely due to the ongoing investment in the fire alarm systems across the Health Board estate.

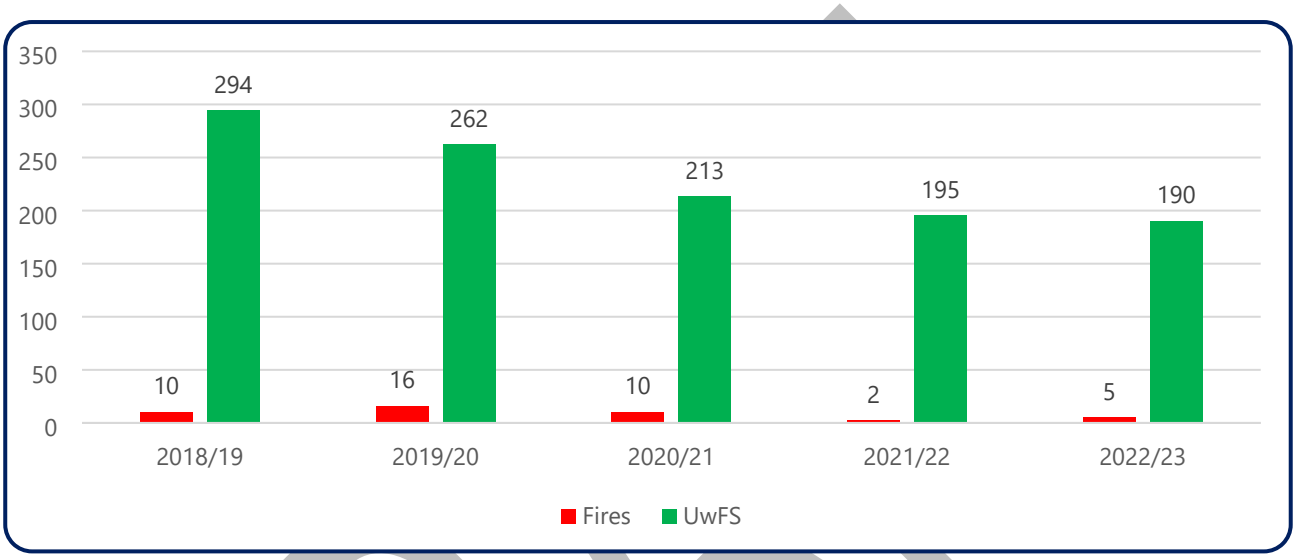


Figure 10: Number of reported fire safety incidents for the past five financial years

The Fire Safety Team investigate all fires, unwanted fire signals and incidents that are related to fire or any report or incident that may affect fire response.

The purpose of the investigations is to provide data to facilitate a reduction in false alarms and a reduction in the number and severity of fire incidents.

Data acquired from investigations has led to improvements to the fire alarm system at County Hospital to reduce false alarms.

During 2022/23 the Health Board experienced two fires in ventilation fans attached to the fixed electrical systems at St Cadocs Hospital and the Royal Gwent Hospital. In response, a review of the testing of fixed electrical systems within the Health Board has been instigated.

12 MANUAL HANDLING & ERGONOMICS

The Manual Handling Team continue to provide mandatory training to support the education strategy, including providing expert advice as required i.e. selection of key equipment.

Based on current demands the Team's activity is primarily focused on training. However, with the prospect of additional resources to bolster the team plans are being considered to actively audit areas to improve compliance with The Manual Handling Operations Regulations 1992 and relevant standards, guidance i.e. The All-Wales NHS Manual Handling Passport.

12.1 All Wales Manual Handling Group

Manual Handling subject matter experts across NHS Wales meet on a quarterly basis to identify and support each NHS organisation with manual handling learning, best practice and action plan going forward. The group are planning to review the current All Wales Passport in 2023/24.

12.2 Manual Handling Incident Reporting

The number of manual handling incidents reported in 2022/23 has remained consistent with previous years reporting (See figure 11). However, there has been a shift in the number of patient handling incidents and inanimate load handling incidents. Patient handling incidents reported this financial year is the highest reported for the past five years with an increase of 68.75% from 2021/22. This increase is also reflected in the number of patient handling incidents reported to the HSE in accordance with RIDDOR.

There has been a 47.7% reduction in inanimate load handling incidents in 2022/23 compared with the previous year.

To identify learning outcomes from manual handling incidents and demonstrate continuous improvement a standard will be set via the Health and Safety Committee that all incidents will require an investigation which is recorded on the focused review in the Datix system.

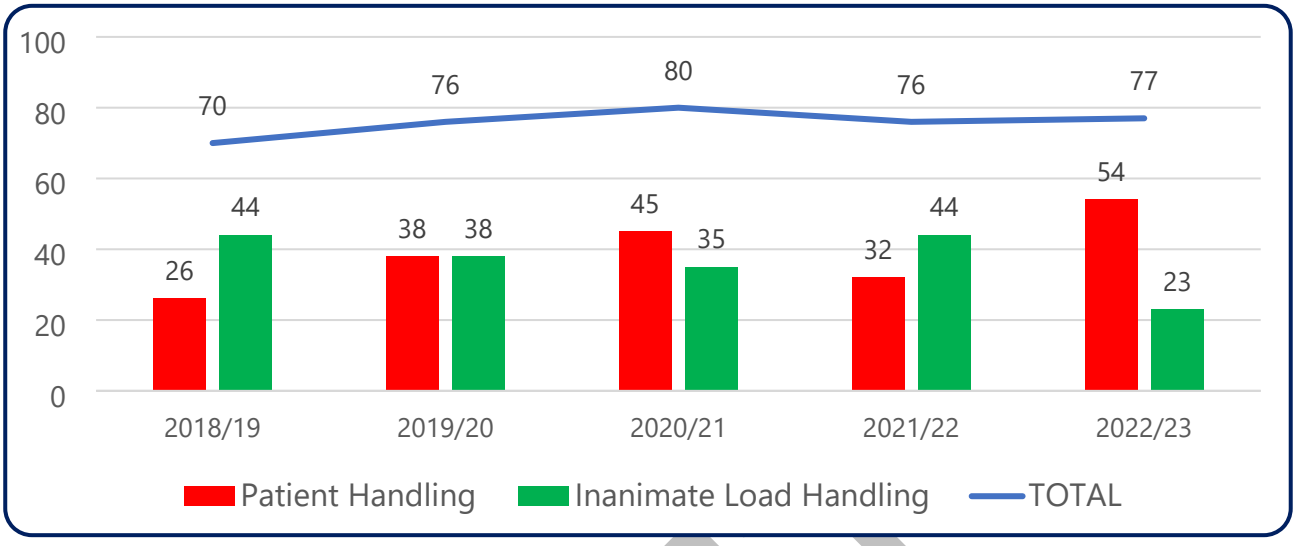


Figure 11: Number of reported manual handling incidents affecting staff for the past five financial years

12.3 Manual Handling Equipment

All manual handling equipment and its accessories require the necessary testing, inspection or examination to ensure compliance with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER) or the Provision and Use of Work Equipment Regulations 1998 (PUWER).

The service and maintenance of the manual handling equipment is contracted to an external provider. The service contract supports the Health Board to meet its legal requirements and identifies the need for investment in new equipment.

An 'Insight' assessment has been commissioned during 2022/23 at the Royal Gwent Hospital. The assessment assesses the mobility levels of patients, the type, age and condition of patient handling equipment available and service and routine maintenance information.

The results provide the following recommendations:

- Patient handling equipment assessments.
- Identification of aged/obsolete equipment with limited/no service support.
- The need for new equipment to meet patient functional levels and care processes.

12.4 Flat Lifting Equipment

A patient flat lift is a type of lifting equipment used to safely lift a fallen person in a supine position, to easily transfer them to a bed or stretcher. Patient flat lifts are air-assisted lifting devices and require a compressor to inflate them and lift the fallen person.

In 2022/23 the Manual Handling Team conducted an audit of flat lifting equipment. The audit identified that there is currently no structured system for the management, servicing, training and physical use of flat lifting equipment for fallen persons throughout the Health Board.

The recommendations of the audit have been presented to the Health Board Falls & Bone Health Committee. These include:

- Establish a central database of equipment as an asset register
- Evaluate the associated maintenance contracts and designated ownership with the Health Board
- Undertake a gap analysis and subsequently identify any additional needs
- Establish training plans to ensure we have the capabilities for the equipment use

12.5 Manual Handling Patient Handling Risk Assessments

The Manual Handling Team have contributed to the implementation of the patient handling Welsh Nursing Care Record (WNCR).

12.6 Display Screen Equipment (DSE)

Since the outbreak of Covid-19 more Health Board Staff are working in an agile manner across the Health Board at various sites and from private premises, whilst the increased flexibility of agile working can provide many benefits to both the individual and Health Board, the legal requirement for the Health Board to ensure the health, safety and welfare of its employees continues to apply in agile working situations.

To ensure that the risks associated with agile working are properly identified and managed, a series of guidance documents and policy amendments have been developed as a means to support individuals who are identified as agile workers. This includes amendments to the Health Boards Policy for Workstation Display Screen Equipment (DSE) and Display Screen Equipment Risk Assessment Form.

The Corporate Health and Safety Department in collaboration with the Occupational Health Department have conducted DSE risk assessments for the more complex cases.

13 VIOLENCE & AGGRESSION

It is recognised that NHS staff (Hospital, Ambulance, Community and Primary Care) are among those most likely to face violence and abuse during the course of their employment and there is a strong public interest in prosecuting those who verbally and physically assault NHS staff deliberately.

With this in mind an agreement entitled 'Obligatory Responses to Violence in Healthcare' between NHS Wales, the Police and Crown Prosecution Service (CPS), has been established which followed a similar agreement made between the respective parties in England.

As part of this process, the NHS Wales Anti Violence Collaborative (AVC) has been established which has representation from NHS Wales, the Police, CPS, Welsh Government and Unions.

The NHS Wales Anti Violence Collaborative (AVC) meets with all parties on a periodical basis to review the implementation and effectiveness of the updated agreement. The Chair of the AVC is the Head of Safety & Learning, NWSSP Legal and Risk Services.

The 'Obligatory Responses to Violence in Healthcare' agreement sets out the responsibilities of the partners when dealing with violent or aggressive incidents relating to NHS staff. Its focus is on those incidents that need to be addressed by the criminal justice system that includes:

- Improving the reporting of violent incidents.
- Strengthen the investigation and prosecution process by improving the quality and timeliness of shared information.
- Improve victim and witness care and confidence.
- Raise the issues of violence and aggression against NHS staff as well as the action that will be taken by all parties.

In April 2021 a Welsh Health Circular '*Implementing the agreed approach to preventing Violence and Aggression towards NHS staff in Wales*' was issued. The purpose of this circular was to set out plans and a timeline to fully embed the requirements to implement and report upon violent incidents as set out in 'Obligatory Responses to Violence in Healthcare' within all NHS organisations.

The Health Board is committed to the delivery of a safe and secure environment for staff and patients, so that the highest possible standard of care can be delivered. The Health Board plans to launch a new awareness campaign in 2023/24.

13.1 Violence & Aggression Incident Reporting

Reported incidents of violence and aggression have reduced in 2022/23 from the previous year by 16%. (See figure 12). However, the reported value has seen an increase year on year.

Approximately 53% of violence and aggression incidents in 2022/23 were reported from the Mental Health and Learning Disabilities Division.

From 2018/19 to 2021/22 physical assaults averaged approximately 850 incidents per year, however, the data shows us that there has been a reduction of approximately 50% in 2022/23. Further analysis has identified that this is not accurate and is a result of reporters coding incidents on the Datix system as 'Aggressive / Threatening Behaviour' instead of 'Physical Abuse'. To ensure quality data is available the Corporate Health and Safety Department will validate all reported incidents of violence and aggression.

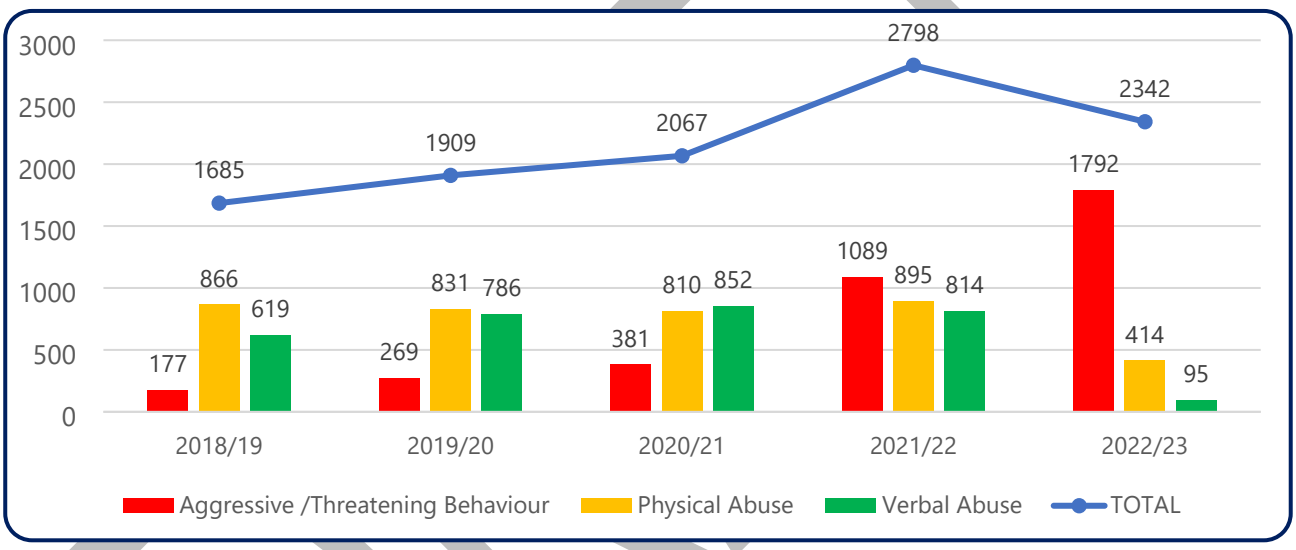


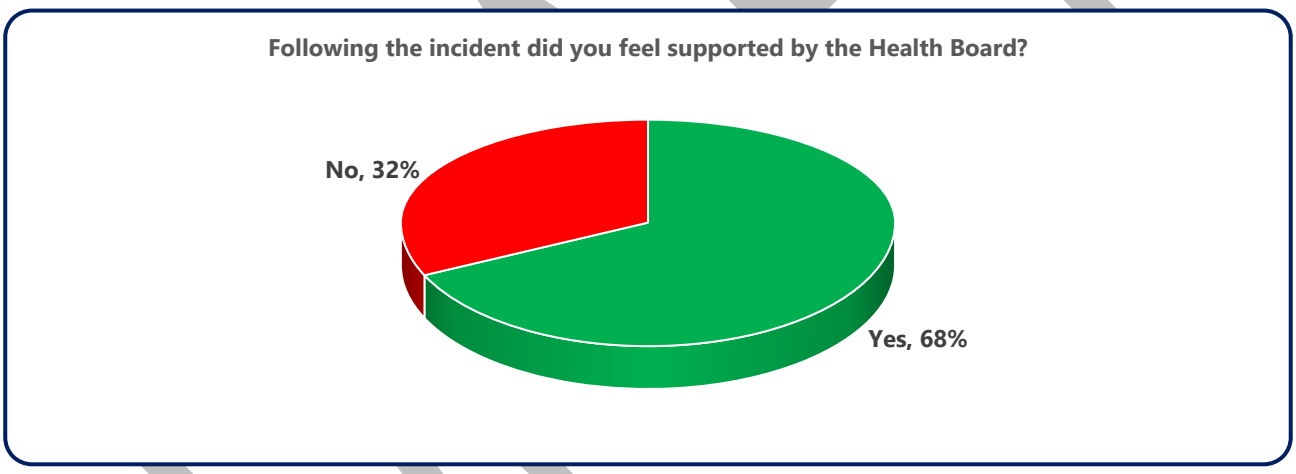
Figure 12: Number of reported violence and aggression incidents for the past five financial years

13.2 #BEKIND Campaign

Following an identified increase of Violence & Aggression incidents between 2020/21 and 2021/22, the #BEKIND Campaign was launched which is designed to shine a light on the increase of Violence & Aggression incidents that Health Board staff are facing and to encourage the public to think about their actions when interacting with staff and to hopefully reduce the number of abusive incidents staff face, and to ensure where such incidents do occur, staff receive the required support.

The campaign has been supported with digital messaging that has been shared across internal and external platforms such as AB Pulse, Facebook & Twitter etc.

As part of the campaign an all staff survey was launched as a means to capture some of the experiences Health Board staff have faced when dealing with members of the public, and where these occasions have led to Violence & Aggression. The survey saw a positive response, of which the information collated will be used to support the Health Boards ongoing management of Violence & Aggression.



13.3 Management of Unacceptable Written and Verbal Communications

The Management of Unacceptable Written and Verbal Communications guidance note has been developed to help Health Board employees effectively manage situations in which they may be subjected to abusive or unacceptable behaviour. The guidance note provides support for both individuals experiencing these behaviours, and managers as a means to support persons who have been subjected to these behaviour types.

13.4 Support for NHS Staff Members

The Violence & Aggression Case Management team continue to support staff who have been subjected to incidence of workplace violence & aggression and where matters relating to personal safety are identified.

Where incidents are reported via Datix Cymru, a Violence & Aggression Case Manager is assigned to the incident and will provide advice in relation to the investigation of the incident, signposting to relevant support services. A new collaborative approach to supporting victims of crime has been implemented and includes Wellbeing Services, Occupational Health and Connect Gwent to offer specialist and bespoke support to Health Board employees.

13.5 Engagement with Gwent Police

During 2022/23 the Health Board has improved its working relationship with Gwent Police, which has resulted in increased collaboration and wider partnership engagement.

As part of these improved relationships the Health Board has also been able to secure a dedicated Gwent Police Inspector to attend the All-Wales Violence & Aggression Case Management Meeting. This will strengthen the Health Board and Gwent Police in exercising their duties under the Obligatory Responses to Violence in Healthcare (ORV).

13.6 Police Outcomes

Following a review of reported incidents, the Health Board is engaging with the Once for Wales Programme Team to progress enhancements to Datix Cymru to enable accurate recording of outcomes e.g., civil, criminal sanctions in relation to violence and aggression incidents.

The alignment of the terminology used by the Police and Crown Prosecution Service (CPS) with the terminology used by the Health Board when recording outcomes of crimes will support more accurate and consistent reporting and enable more effective partnership working.

14 SECURITY

14.1 Security Management Review

In 2022/23 the Health Board commissioned Local Security Management Specialists (LSMS) from Avon & Wiltshire Mental Health Partnership NHS Trust to conduct a security management review.

The review evaluated the security requirements at five of the hospital sites *(Grange University Hospital, Nevill Hall Hospital, Royal Gwent Hospital, St Cadocs Hospital and Ysbyty Ystrad Fawr)* including external access control, access to buildings and the protection of internal assets.

Consideration was also given to the operation of the security contract:

- Current service provision and coverage of all sites.
- Identification of any gaps and hazards with service delivery that present risks to the Health Board.
- Making proportionate recommendations for improvements as a means to control or mitigate identified risks.

Whilst the site operational issues identified within the review have been progressed. The strategic actions to improve security management in the Health Board still require addressing *i.e. development of a Health Board Security Policy & Strategy, appoint a designated Security Specialist etc*. The strategic actions will be a key priority for the Estates and Facilities Division.

14.2 All Wales Healthcare Security Group

An All-Wales Healthcare Security Group chaired by Welsh Government has been established. Security Managers from across NHS Wales form the membership of the group and are provided with information and guidance on threat levels to support the operational management of security.

14.3 Protect Duty (Martyn's Law)

Martyn's Law is pending UK wide legislation that will place a requirement on those responsible for certain publicly accessible locations to consider the threat from terrorism and implement appropriate and proportionate mitigation measures. Health Board premises would meet the criteria of Martyn's Law where a maximum capacity of 100 or more people assemble.

14.4 Management of derelict Health Board buildings

The Llanfrechfa Grange Site has been subjected to increased issues relating to trespass, antisocial behaviour, vandalism, and theft of Health Board assets. The derelict Health Board estates situated at the site have been the predominant target and focus of the unwanted activity.

In response, the Executive Team approved funding which enabled the installation of security screens to further protect the properties from unwarranted access.

14.5 Baby Abduction Action Cards and Lockdown Procedures

A review of the baby abduction and lockdown protocols on the Maternity Ward, Grange University Hospital (GUH) identified weaknesses within the internal procedures and a lack of consistency between the wider site lockdown procedures.

In conjunction with the Maternity Services Management Team, a new Baby Abduction Protocol / Lockdown Procedure was developed, which includes baby abduction action cards, which are now consistent with the wider GUH lockdown procedures. A walkthrough and staged exercise of the new procedures provided greater assurances of an appropriate response, should there be a requirement for the procedures to be enacted during an emergency situation.

15 CONCLUSION

This report highlights the level of health, safety and fire focussed activity that has been undertaken during 2022/23 to improve the management of health, safety and fire in the Health Board.

The Health and Safety Committee continues to promote the health and safety programme.

The Corporate Health and Safety Department works to actively support the delivery of safe and compliant systems within the context of a health and safety culture. Failure to embed an interdependent and mature health and safety culture presents a risk to the Health Board.

The internal health and safety monitoring programmes are continuously improving as is the ongoing health and safety training programme.

There are challenges in relation to the current level of resource available within the Corporate Health and Safety Department to support the delivery of the legal requirements of health, safety and fire.

An improvement plan will be developed for 2023/24 to address the risk areas for focus. Implementation of the actions, outlined in the improvement plan will support the Health Board to demonstrate continuous improvement and compliance with its legal responsibilities.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Nursing and Midwifery Strategy 2023-2026
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Linda Alexander, Deputy Director of Nursing

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Aneurin Bevan University Health Board (ABUHB)is launching its 2023-26 Nursing and Midwifery Strategy. The Strategy sets out an ambition and vision to support continued growth, development and innovation in Nursing and Midwifery practice.

Cefndir / Background

We recognise the unique and critical role of the nursing and midwifery profession within our health board and community. Through collaboration with colleagues, this ambitious strategy has been developed. which focuses on what is important for patients, the communities that we serve and the development of the profession.

This approach recognises the complex environment in which we work where nurses, midwives, healthcare support staff and other team members are called upon to undertake critical and varied duties alongside the new opportunities and expectations represented by changes in national government policy and within the profession. The strategy is framed by a series of five strategic ambitions for the next three years.

Asesiad / Assessment

Five strategic ambitions will guide and underpin the delivery of the strategy over the next three years.

Each ambition is centered on providing excellent and compassionate care to everyone who touches our services.

The vision will demonstrate a commitment to improving health and well-being for all, delivering excellence through safe, effective, and compassionate nursing and midwifery practice across the lifespan of a person.

The five strategic aims are:

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

The strategy provides the direction and blueprint for everyone working within nursing and midwifery to strive to develop the profession and provide excellence in care for which we can all be proud. The ambitions interlay with other Health Board strategies which must be read, considered, and delivered alongside the Nursing and Midwifery strategy.

The development and delivery of the strategy represents a collaborative approach. It is essential that the ambition produces meaningful priorities that can be recognised, understood and implemented as a profession.

The strategic ambitions will be achieved through the delivery of a detailed overarching action plan with identified clear milestones and lines of accountability.

Overall progress on the delivery of the strategy will be monitored by the Executive Director of Nursing. Progress will feature as a regular agenda item at the Senior Nursing & Midwifery Leadership Group.

Argymhelliad / Recommendation

The Board is asked to:

- NOTE that the Nursing and Midwifery Strategy has been developed in collaboration and key priorities have driven the ambition of the strategy; and
- APPROVE the Nursing and Midwifery Strategy 2023-26.

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

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

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

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

A Profession of Excellence

A Lifetime of Compassion

Nursing & Midwifery Strategy 2023-2026

GIG CYMRU NHS WALES

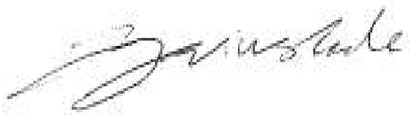
Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Foreword

I am delighted to present our Nursing and Midwifery Strategy 2023-2026 and would like to express my sincere thanks to all nurses and midwives for their dedication, hard work and continued commitment. This Nursing and Midwifery Strategy outlines Aneurin Bevan University Health Board's (ABUHB) ambition, objectives and actions to deliver high quality, compassionate care with the right people with the right skills. It describes how all nursing and midwifery staff have an important part to play in improving patient experience and delivering our Health Boards values, beliefs and behaviours. People accessing our services want to feel safe, cared for, respected and involved in their care. They want to be assured that nurses' actions will be in their best interests and will help them improve, recover to their full potential, feel in control of their lives and live life to the full. To enable nurses to provide consistent high quality nursing care, they have to consistently deploy and develop their existing and new nursing knowledge and skills.

What is essential and central to the strategy is that as nurses and midwives we must ensure the fundamentals of care are embedded to deliver the ambitions of the strategy. The term 'fundamental nursing care' describes the actions we as nurses undertake to meet the physical and emotional needs of patients' and their significant others

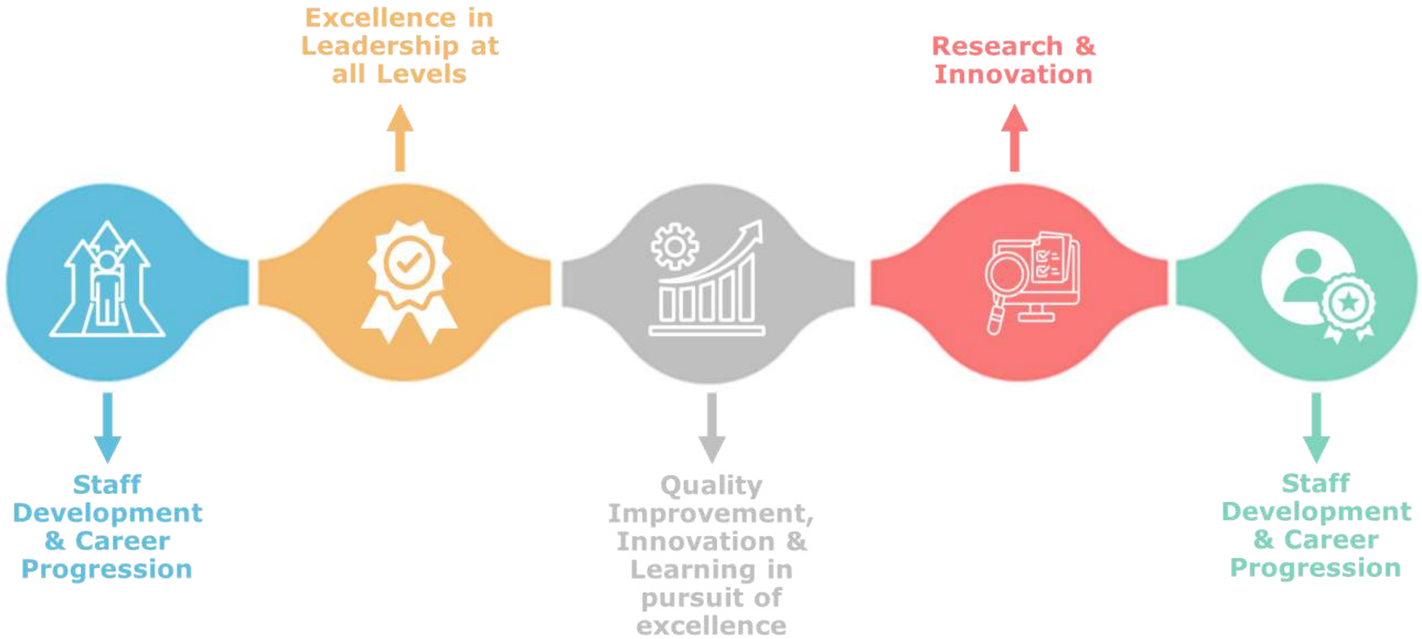
Nurses must work in collaboration, not only with each other and other professionals, but also with those in receipt of care and their carers. We are investing in our nurses to stay and expand the nursing career opportunity. Our values of care and compassion are the attributes that are most valued by our service users, their carers and the public. These must underpin everything we do. We envisage that this strategy will encourage pride and enthusiasm about being part of the nursing and midwifery team within Aneurin Bevan University Health Board.



Jenny Winslade
Executive Director of Nursing

Introduction

We recognise the unique and critical role of the nursing and midwifery profession within our health board and community. Through collaboration with colleagues, we have developed an ambitious strategy, which focuses on what is important to realise our vision for patients, community and the development of our profession. This approach recognises the complex environment we work in, where nurses, midwives, healthcare support staff and other team members are called upon to undertake critical and varied duties alongside the new opportunities and expectations represented by changes in national government policy and within the profession. It's an exciting time to be either starting or be engaged in a career in nursing and midwifery and we aspire to ensure ABUHB is the employer of choice. The strategy is framed by a series of five strategic ambitions for the next three years.



We are excited to be supporting and enabling the delivery of this ambitious strategy which has excellence and compassion at its centrality. Embedding the ambitions will facilitate ABUHB to be ever-improving, with positive impact on the outcomes and experiences for patients, nurses and midwives. This is a springboard to further our work as a strong multi-professional clinical workforce, empowering individuals and teams to respond and lead on the ambitions outlined for the future.

Strategic Context – What is driving us?

Key Priorities for 2023/24 have influenced the ambitions of the Strategy. It has been developed to reflect both national and local policy drivers.

Nursing Priorities 2023/24

Collectively lead the strategic development of the Nursing & Midwifery profession, empowered with the authority to act.

Priority 1

To create and develop a kind, compassionate, competent and skilled workforce within a supportive and learning environment.

Priority 2

To promote the profession of nursing and midwifery to future generations by exploring new initiatives and exemplary practice within the framework of the Nursing Strategy.

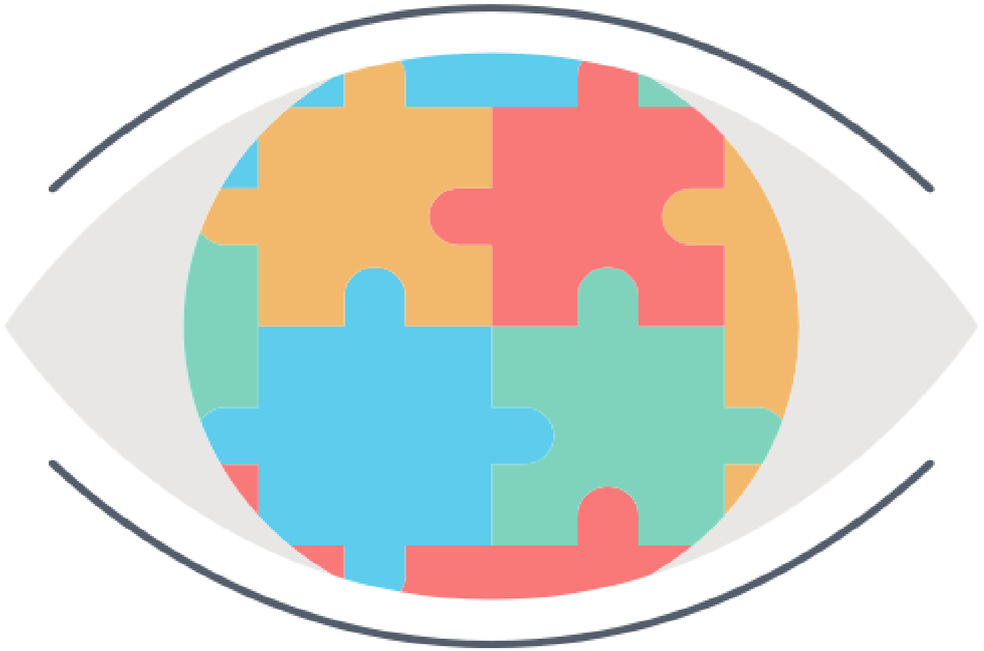
Priority 3

To provide equity for Nursing & Midwifery amongst peer professions.

Priority 4

To deliver outstanding, quality care with kindness and compassion where and when our patients/clients need it.

Our vision and strategic ambitions



Five strategic ambitions will guide and underpin the delivery of the strategy over the next three years.

Each ambition is centred on providing excellent and compassionate care to everyone who touches our services.

Our vision demonstrates a commitment to improving health and well-being for all:

Delivering excellence through safe, effective and compassionate nursing and midwifery practice across the lifespan of a person.

Strategic Ambition

#1 Staff Development & Career Progression

We will offer high quality lifelong learning, development & educational opportunities with a focus on support and career pathways, so our nursing and midwifery workforce can be empowered in their development and deliver excellent, compassionate care.

#2 Excellence in Leadership at all Levels

We will lead and manage in a professional and consistent way, supporting staff and promoting their wellbeing, building a strong and positive leadership culture at all levels.

#3 Quality Improvement, Innovation and Learning in pursuit of excellence in patient safety, outcomes and experience

We will seek to innovate and continuously improve. Our nursing and midwifery workforce will be involved in quality improvement.

We will ensure patient participation and engagement is central in all we do and will promote population health and well being.

#4 Research & Innovation

We will demonstrate a commitment to sharing knowledge and expertise, increasing research and quality improvement embedding a culture of inter-professional evidenced based practice. We will raise the profile and contribution of the profession to advancements in care, and improving outcomes for our patients.

#5 Professional Identity & Influence

We will be proud of our professional identity, empowering all to flourish in an environment of inclusivity which reflects the diversity of the communities we serve, championing compassionate patient care and providing a strong nursing and midwifery voice to influence service delivery.

A Profession of Excellence, a Lifetime of Compassion

Strategic Ambition 1: Staff Development & Career Progression

We will offer high quality lifelong learning, development and educational opportunities with a focus on support and career pathways, so our nursing & midwifery workforce can be empowered in their development and deliver excellent, compassionate care.

OBJECTIVE 1

We will create and foster a learning environment which supports career support, guidance and development.

1. Providing consistent and meaningful annual appraisals supported by clear development plans, actions and monitoring.
2. Develop a standardised welcoming induction process that frames a culture of compassion, value and worth that sets the scene for a career pathway at ABUHB, in collaboration with relevant partners.
3. Establish the concept of career coaches for future leaders.
4. Enhance opportunities for networking and shadowing both internally and externally.
5. Every ward/department will have an annual training needs analysis and implementation plan.
6. A learning profile for each ward / dept will be developed, training and education relevant to that learning environment will be provided.

OBJECTIVE 2

Training, development and career progression is responsive, evidence based and aligned with patient and service needs.

1. Develop mentorship and coaching opportunities.
2. Offer reverse mentorship.
3. Develop opportunities for internal and external secondments as part of a talent spotting programme to develop and retain experienced nursing and midwifery professionals.
4. Develop a strategy for succession planning.
5. Explore opportunities within Research and Development.
6. Develop a consultant nurse, advanced practice skills repository to identify key areas of expertise, leadership and competency.
7. Engage in and invest in our nursing & midwifery staff to ensure they feel valued and supported in their roles to realise their potential.
8. Develop a clinical supervision framework building on national guidance for nurse and midwifery advocacy in collaboration with the organisational wellbeing team.
9. Ensure accessibility of clinical supervision and routes of access.
10. Development of an advocacy/supervisory repository of skills within the organisation.
11. Develop a framework for succession planning across the nursing & midwifery leadership career pathway.
12. Co-produce educational programmes with our staff.

Strategic Ambition 2: Excellence in Leadership at all Levels

We will lead and manage in a professional and consistent way, supporting staff and promoting their wellbeing, building a strong, inclusive and positive leadership culture at all levels.

OBJECTIVE 1

Leadership skills and behaviours are clearly defined, consistent and high quality

1. Develop a clear and structured pathway for leadership development at all levels, supported by individualised learning opportunities.
2. Strengthen the leadership academy and specifically alumni as the cornerstone of visible, inclusive leadership.
3. Develop the leadership skills and confidence of our workforce at every level through shared governance and accreditation.
4. Champion a just culture where staff feel psychologically safe to share their concerns.
5. Deliver shared governance and ward accreditation to champion excellence in care standards.
6. Actively promote self-care, health and wellbeing at work.
7. Use applied leadership skills by drawing upon critical thinking skills to manage, inspire and influence others to achieve their maximum potential.

OBJECTIVE 2

Embed an inclusive and compassionate leadership culture

1. Develop a focussed approach to inclusive leadership practices and behaviours, recognising and valuing our diversity.
2. Develop clinical leadership visibility and accessibility for nurses / midwives at all levels, developing support for managers to effectively fulfil their roles.
3. Improve retention of experienced late career professionals, to include “legacy mentor” roles.
4. Build forums and nursing and midwifery networks for professional information sharing and opportunities for peer support and supervision
5. Develop opportunities and access to coaching and reverse coaching resources and opportunities to aid leadership.
6. Review competencies at all levels to ensure they are aligned with the principles of compassionate leadership.
7. Develop a leadership programme for all levels of nursing and midwifery focusing on developing compassionate leadership skills incorporating core principles and consideration of human factors, creating a culture of professional accountability.

Strategic Ambition 3: Quality Improvement, Innovation and Learning in pursuit of excellence in patient safety, outcomes and experience

We will seek to innovate and continuously improve. Our nursing and midwifery workforce will be involved in quality improvement. We will ensure patient participation and engagement is central in all we do and will promote population health and well being.

OBJECTIVE 1

Promote and lead on quality improvement and innovation ensuring excellence in practice

1. Nurture an open and collaborative workforce known locally, regionally and nationally for quality improvement.
2. Build on our sense of pride in the place that we work and the care we are delivering ensuring staff feel a sense of genuine belonging, empowering them to influence and shape the way care is delivered.
3. Actively engage with our staff, to learn from them, ensuring they feel valued, listened to, respected and supported to contribute and shape care provision.
4. Continue to develop capability and capacity for improvement specifically for front line staff, supporting staff of all levels to access opportunities and training to facilitate clinical effectiveness and improvements in care.
5. Develop a reputation for excellence in care through innovation, research and Quality Improvement.
6. Embed a culture of listening, learning, safety, improvement and innovation.
7. Work with other disciplines to foster a culture of continuous improvement.

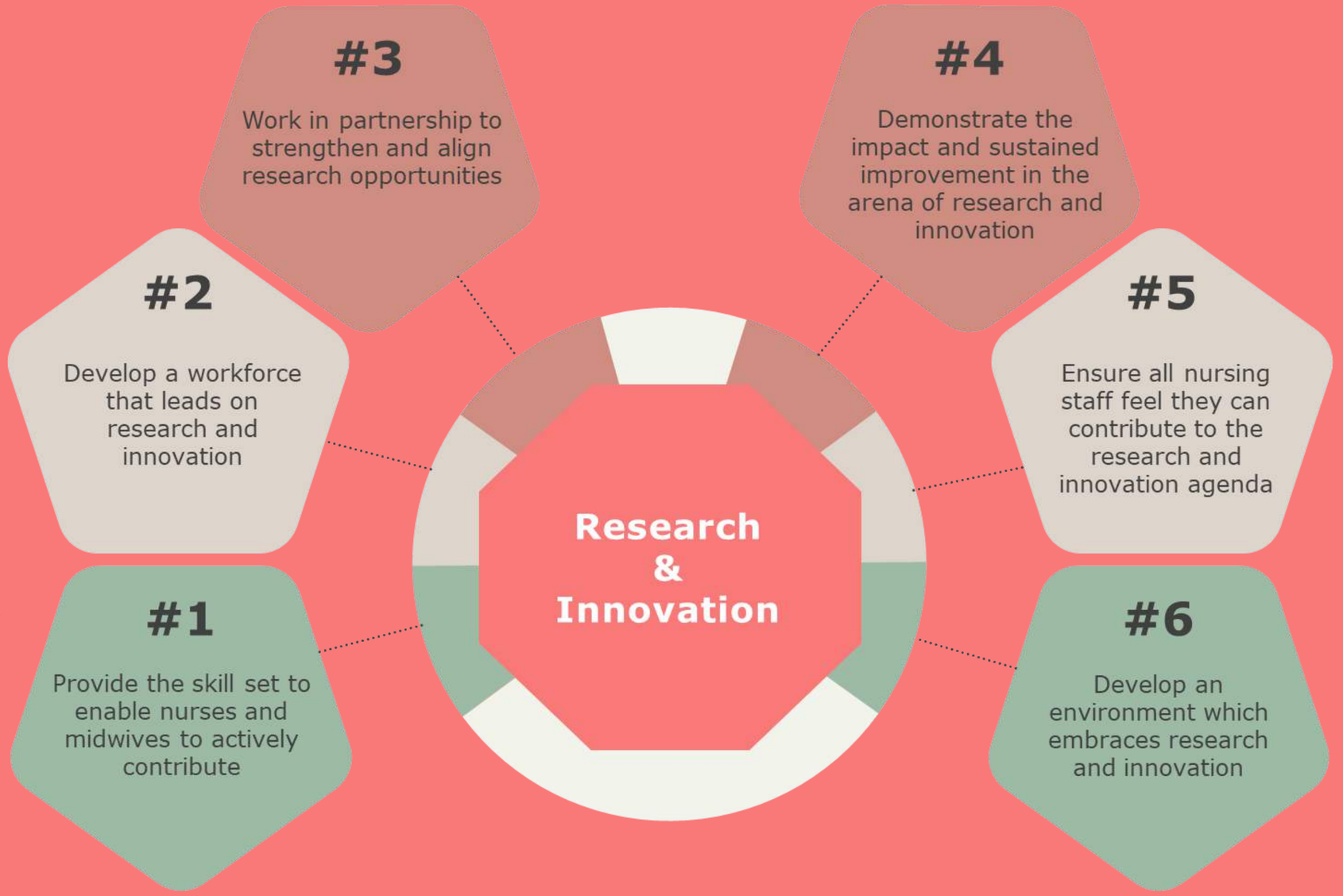
OBJECTIVE 2

Improve patient outcomes and fundamentals of care

1. Identify key areas of improvement across the Health Board using quality indicators and learning from Serious Incidents and complaints.
2. Ensure patient safety and quality walkarounds are undertaken with improvements and learning embedded as an outcome.
3. Embed the use of the Ward Accreditation across the Health Board in order to promote peer review and the opportunities this presents.
4. Continue to strengthen our approach to the collection and analysis of nursing and midwifery quality metrics, and outcomes for both inpatient and outpatient areas.
5. Educate and empower nursing to be able to use data and take ownership of identifying and acting upon areas for improvement.
6. Empowering Our Staff to be able to lead / support multi-professional teams to drive local improvement.

Strategic Ambition 4: Research and Innovation

We will demonstrate a commitment to sharing knowledge and expertise, increasing research and quality improvement embedding a culture of inter- professional evidence based practise. We will raise the profile and contribution of the profession to advancements in care and improving outcomes for our patients



OBJECTIVE 1

Support a research positive culture among nurses to lead, undertake and disseminate findings to influence practice

1. Explore opportunities (external and internal) to promote the nursing and midwifery contribution and leadership to practice transformation and research impacting on patient care.
2. Encourage and support staff to write for publication.
3. Increase knowledge of research available and support teams to feel that research is accessible to all.
4. Create a nursing and midwifery led symposium to share best practice.
5. Continue to attract, cultivate and retain a research informed and active workforce, who autonomously engage in, lead and translate research into practice at any level.
6. Enable and encourage research activity within clinical roles and the progression of clinical academic careers.
7. Strengthen our research capacity through innovative research related training and development opportunities, through internally led programmes and partnership with Higher Education Institutions.
8. Share expertise and experience, development opportunities and maximise opportunities for cross organisational collaboration on research priorities

OBJECTIVE 2

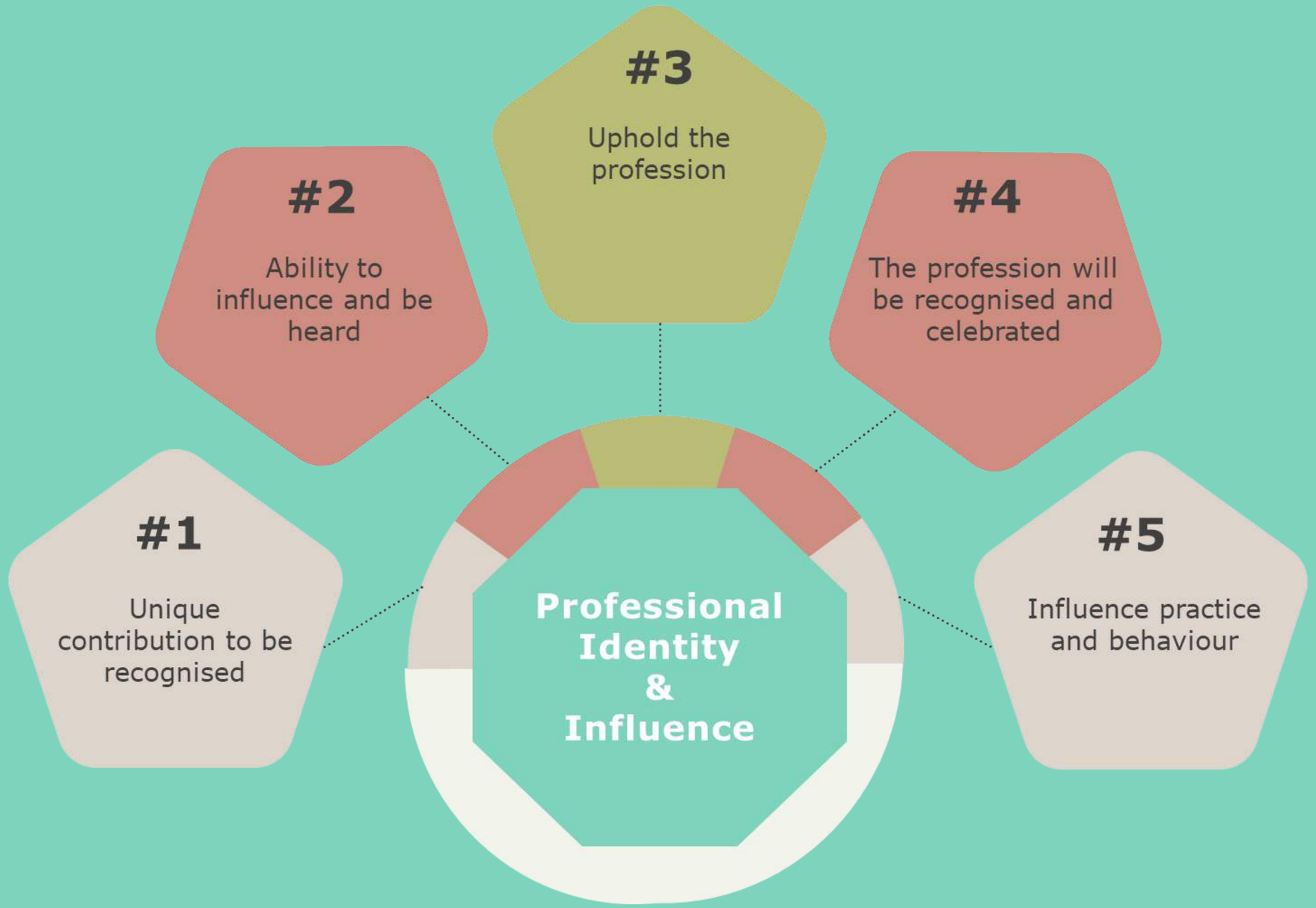
Nurses and Midwives to lead on digital enablement

1. Empower nurses, midwives and allied health professionals to shape and drive digital transformation through education, leadership and support, to allow them to provide clinical expertise in all aspects of the patient journey.

2. Explore and implement new innovative digital technologies to provide safer effective care for our patients, supported through real time reporting and improvement, freeing up time to care and improving patient outcomes.

Strategic Ambition 5: Professional Identity & Influence

We will be proud of our professional identity, empowering all to flourish in an environment of inclusivity which reflects the diversity of the communities we serve, champion compassionate patient care and providing a strong nursing and midwifery voice to influence service delivery.



OBJECTIVE 1

Our professional identity and unique contribution will be recognised and celebrated

1. Every nurse and midwife will, have a voice, feel engaged, valued and proud to be an ABUHB Nurse & Midwife.
2. Nursing and midwifery will have a clear nursing identify within the wider multi-professional team, confidently influencing and advocating for holistic, person centred needs.
3. The Nursing and Midwifery Profession will be recognised and celebrated across the Health Board.
4. ABUHB values and beliefs will be articulated confidently and clearly by nurses and influence practise and behaviour.
5. Celebration and networking events to showcase the work of nurses and midwives will be encouraged and supported.
6. A tracker of nursing publications and award submissions will be developed to demonstrate excellence and presentations at regional and national conferences.
7. Ensure all fields of nursing are represented at the Annual Nursing, Midwifery and SCPHN Conference.
8. Nurses will be encouraged and supported to present at both National and Internationally conference demonstrating research and innovation in practise

OBJECTIVE 2

To uphold and promote professional standards and compassionate care

1. We will role-model the profession as carers of choice by presenting a positive and professional image, building confidence and pride.

2. Explore and implement new innovative digital technologies to provide safer effective care for our patients, supported through real time reporting and improvement, freeing up time to care and improving patient outcomes.

3. We will empower, develop and support the workforce to bring compassion and the unique perspective of nursing and midwifery to the team environment.

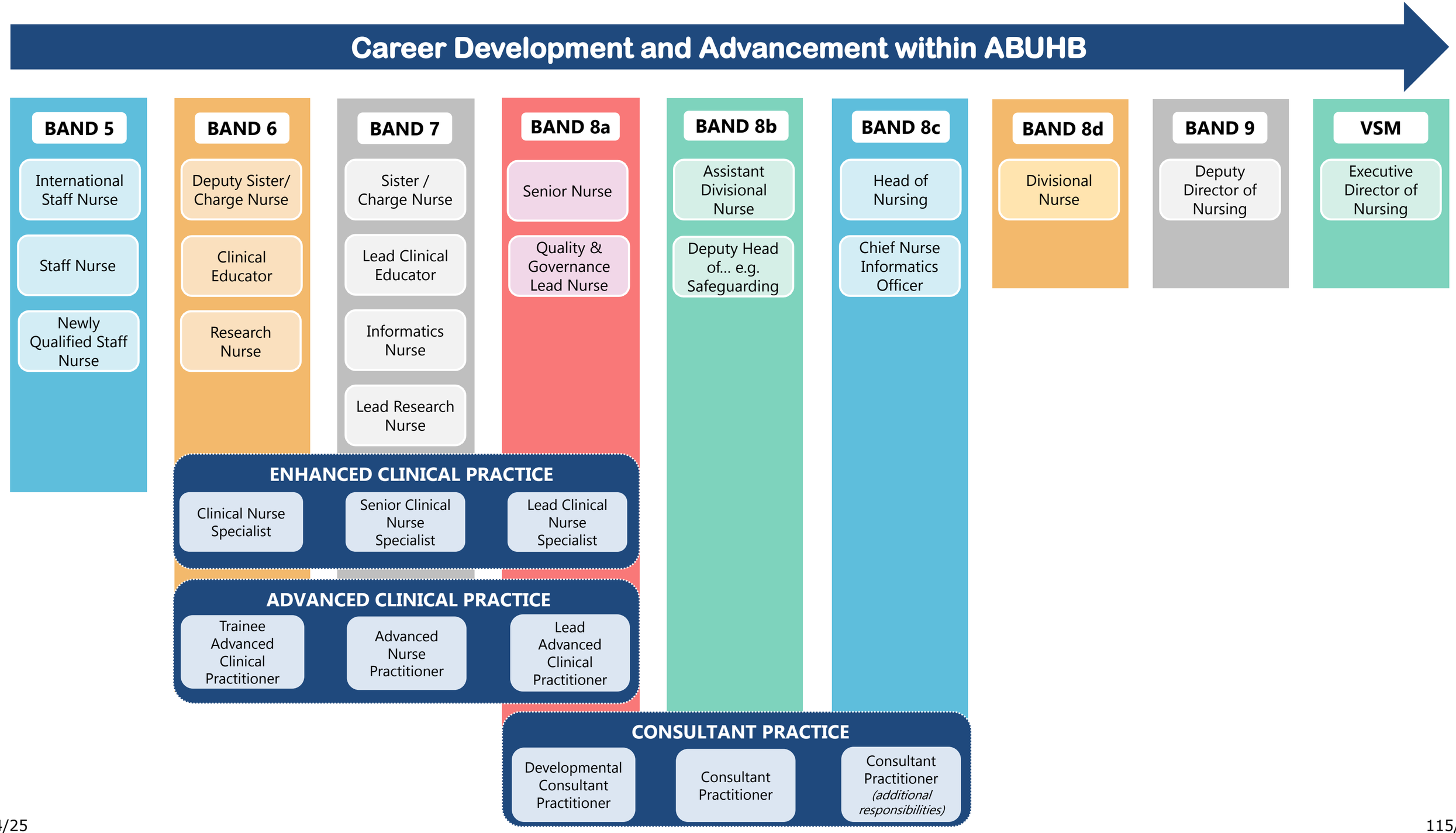
The strategy document is just the beginning. It provides direction and blueprint for everyone working within nursing and midwifery to strive to develop the profession and excellence in care of which we can all be proud. The ambitions interlay with other Health Board strategies which must be read, considered and delivered alongside the Nursing and Midwifery strategy.

It is important to us that the development and delivery of the strategy represents a collaborative approach. It is essential that the ambition produces meaningful priorities that we can all recognise, understand and are proud to implement as a profession.

The strategic ambitions will be achieved through the delivery of a detailed overarching action plan with identified clear milestones and lines of accountability.

Overall progress on delivery of the strategy will be monitored by the Executive Director of Nursing. Progress will feature as a regular agenda item at the Senior Nursing & Midwifery Leadership Group.

Career Development and Advancement within ABUHB






Staff Development & Career Progression

Excellence in Leadership at all Levels

Quality Improvement, Innovation and Learning in pursuit of excellence

Research and Innovation

Professional Identity and Influence

Patient






Agenda Item:3.3

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Quality and Safety Systems: Framework for Speaking up Safely NHS Wales
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sarah Simmonds Executive Director Workforce & OD Jennifer Winslade Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis, Tracey Partridge Wilson, Shelley Williams, Peter Brown, Adrian Neal

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Further to events that occurred in the Countess of Chester Hospital connected with the recent Letby Case, the Welsh Government took the decision to release a Framework for Speaking up Safely in NHS Wales (appendix 1) on the 25th of August 2023. The Board is asked to adopt this Framework.

In support of the implementation of the framework all NHS Boards, Trusts and Special Health Authorities were asked to undertake a self-assessment against the organisational requirements, detailed in section 6, and to develop an action plan to address any gaps between current practice and the expectations of the Framework. The response is attached in appendix 2.

The Board is asked to note the assessment and actions and provide any comments and feedback. In particular, the Board is asked to nominate an independent Board Member to be appointed as the Health Board's Speaking Up Safely Champion.

Cefndir / Background

The principles and practices associated with Speaking Up Safely outlined in the Framework document should be considered within the broader NHS Wales and UK policy context. Speaking Up Safely is an initiative which supports, rather than replaces, existing policy, such as: -

- NHS Wales Policy: Raising Concerns (Whistleblowing) Policy.
- NHS Wales Policy: Respect & Resolution.
- Welsh Government Law: The Health & Social Care (Quality and Engagement) (Wales) Act.
- UK healthcare regulation: codes of practice e.g., NMC, HCPC and GMC.
- UK Law: Public Interest Disclosure Act 1998.

The framework has been developed, scrutinised, and approved in social partnership to provide an all-Wales consistency in cultural expectation, approach and escalation process whilst strengthening local initiatives.

Asesiad / Assessment

The required assessment is being led by members of the Workforce and Organisational Development and Quality and Patient Safety (QPS) and Safeguarding Leads, including support from Health and Safety and other relevant colleagues. The framework has also been publicised widely and comments invited from staff and shared with Trade Union Partnership Forum and LNC representatives for comment.

The assessment considers the requirements as outlined in appendix 2.

Given the pace with which we are required to demonstrate progress with this work it is helpful to consider the wider context. The Speaking Up Safely Framework action plans from three Health Boards and one Trust have been reviewed and indicate a broadly similar approach is emerging across NHS Wales. All reviewed action plans follow the step-by-step recommendations of the recent Welsh Government issued self-assessment, though there are differences in the baseline position within each organisation i.e., all organisations are at different stages of their Speaking Up Safely development. In summary, the ABUHB draft plan contains all the components found in other Health Board action plans; it also contains areas that are distinctive.

These areas are: -

1. Our intention to integrate a Speaking up Safely programme into our existing Quality, Safety and Employee Experience programmes.
2. Our plan to utilise a research, development, and evaluation approach.
3. Our understanding that the work needs a minimum of three years to be developed and to embed effectively.

Importantly two of the reviewed Health Board action plans make explicit reference to the need for a strategic review/business plan to support the appropriate allocation of resources to ensure the programme is successful.

In addition to undertaking an assessment, the Health Board has recently undertaken a number of actions as part of existing work programmes in support of the Speaking up Safely agenda. These include: -

- Ongoing work in support of Duty of Quality and Duty of Candour.

- Statements from Director of Workforce & OD and Medical Director in relation to a zero-tolerance approach to sexual harassment and unacceptable behaviours.
- Cross-organisational workshop hosted (3 October 2023) with UK expert Professor Aled Jones to discuss the Speaking up Safely approach and culture change required within the Health Board. Actions include agreeing an organisational approach, narrative, and potential costs (people, resource, technology, staff engagement). Future work will include how this work can dovetail within wider organisational culture change and organisational values and behaviours approaches.
- ABUHB has currently created an email address as a facility for staff to contact the organisation regarding speaking up concerns. This is ABB.RaisingConcerns@wales.nhs.uk.
- Embedding of staff networks for a range of protected characteristics.
- Scoping external "Guardian Service" although costs were significant.
- Review of people's experience through HR processes via the Avoidable Employee Harm programme of work.
- Review of processes and structures of QPS teams.
- Active by-stander training.

An assessment against the requirements including key actions is attached in appendix 3.

Costs and impact of the action plan will be incorporated into the work of the steering group to be established as noted in the action plan. However, a summary of costs could include:

- External avenue for staff to raise concerns- a provider has been sourced with an estimated cost of £14,400 per annum (including VAT). This is part of an employee assistance programme which is currently being considered.
- Cost of time of key personnel to participate in steering group- it is anticipated that this will be from existing employees involved in the work.
- Costs/impact of supporting time for existing staff to be identified as Speaking up Champions. This will be further explored by the steering group.
- Staff protected time to support the maturity of our staff networks has been agreed as 1 hour per week for leads and time to attend for core members.
- Review of leadership programmes can be built into our existing programme of work.

Argymhelliad / Recommendation

The Board is asked to:

- ADOPT the Framework for Speaking up Safely in NHS Wales (appendix 1);
- NOTE the self-assessment and associated actions and provide any comments and feedback; and
- NOMINATE an Independent Board Member to act as the Health Board's Speaking Up Safely Champion.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources 7.1 Workforce 3.1 Safe and Clinically Effective Care 5. Timely Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Workforce and Culture
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

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

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: Included in report
• **Workforce**	Not Applicable

• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**N/A at this time – all Wales document**
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives Choose an item.

Codi Llais **heb Ofn**
Speaking up **Safely**

GIG CYMRU NHS WALES

Llywodraeth Cymru
Welsh Government

Speaking up **Safely**

A Framework for the NHS in Wales

Supporting people to **speak up safely and with confidence**

Contents

1. Background – NHS Wales and policy context

The principles and practices associated with Speaking Up Safely outlined in this Framework document should be considered within the broader NHS Wales and UK policy context. Speaking Up Safely is an initiative which supports, rather than replaces, existing policy, such as:

- **NHS Wales Policy: Raising Concerns (Whistleblowing) Policy**
- **NHS Wales Policy: Respect & Resolution**
- **Welsh Government Law: The Health & Social Care (Quality and Engagement) (Wales) Act**
- **UK healthcare regulation: codes of practice e.g., NMC, HCPC and GMC**
- **UK Law: Public Interest Disclosure Act 1998**

The Speaking Up Safely Framework has also been informed by international guidelines[1,2] and research evidence[3,4,5]

2. Introduction

Following the publication of '*A Healthier Wales'* and the subsequent '*Workforce Strategy for Health and Social Care'* it became clear that NHS Wales needed to develop its approach to organisational culture and behaviour. NHS Wales organisations have committed to developing healthy working relationships, an approach which aims to foster more compassionate, collective, healthier and fairer behaviours, workplaces and organisations. It is recognised that there are key all- Wales NHS opportunities to lever change including leadership development, changing targets / focus (such as colleagues' experiences of work) and using people 'policies'.

This Framework sets out the responsibilities of organisations, their executive teams and boards, along with those of managers and individual members of staff (and volunteers) in creating a culture in which 'Speaking Up', alongside timely and appropriate response to any concerns raised, is supported within a safe environment. This Framework will be supported in its implementation by a series of toolkits.

Having effective arrangements which enable staff to speak up (also referred to as 'raising a concern') helps to protect patients, the public and the NHS workforce, as well as helping to improve our population's experience of healthcare. It is essential to ensure that all individuals have a voice, are listened to, and receive a timely and appropriate response.

This Framework will support organisations to create that culture; one where individuals feel safe and able to speak up about anything that gets in the way of delivering safe, high-quality care or which negatively affects their experience. This includes, but is not limited to, matters related to patient safety, safe staffing, the quality of care, bullying and harassment (and cultures which enable this), as well as financial malpractice or fraud. To support this, leaders and managers need to be willing to listen, and to be open to constructive challenge. Speaking up and bringing these issues into the open is a brave

and vulnerable thing to do, and therefore should be welcomed and seen as an opportunity to listen, learn and improve.

This is the Framework that organisations, departments and teams are required to follow in order to establish and sustain a culture where no individual will suffer victimisation or detrimental treatment as a result of speaking up, and where organisations learn and improve as a result of listening and responding to concerns raised.

Not all sections of this Framework will be relevant to everybody. However, while it is clear who the relevant sections are intended for, depending on your role within the NHS you may wish to familiarise yourself with sections which may not initially be relevant to you.

3. Principles of Speaking up Safely

3.1 All those engaged with the NHS have a contractual right and duty to raise genuine concerns with their employer about malpractice, patient safety, financial impropriety or any other serious risks they consider to be in the public interest. In addition, staff have duties imposed upon them to raise such concerns by their respective professional regulatory bodies.

3.2 All organisations recognise the need to continuously improve to make every effort to address and correct issues threatening patient safety as quickly as possible, to work with colleagues to this end and to ensure that at all times they do all they can to act on the side of the solution. Consciously creating culture of 'Speaking Up Safely' is key to this aim.

3.3 All organisations, departments and teams have a duty to create a culture where individuals know how to raise a concern, are aware of the process that will follow, and where they can be confident that if they do raise a concern, they will receive support without experiencing personal or professional detriment.

3.4 It is not necessary for an individual to have concrete proof of an act that they wish to report - a reasonable belief is sufficient. Individuals are encouraged to raise any concern at the earliest opportunity so that there is time to assess the issues within a supportive environment.

3.5 Individuals who speak up do not have responsibility themselves for investigating the matter (where this is required). It is the organisation's responsibility to ensure that where appropriate, an investigation takes place.

3.6 Organisations also have responsibility to ensure that those responding to concerns are prepared and supported to respond promptly or are able to delegate to someone who can. Managers will have training on how to deal with concerns that have been raised.

3.7 Organisations should encourage individuals to raise concerns using the designated procedure in the first instance. If an individual is not sure whether or not to raise a concern, they should discuss the issue with a manager or the Workforce & OD department or for those registered with a trade / professional union, with their representative or their trade / professional union's employment advice service.

3.8 In line with NHS Wales policy, individuals are encouraged to raise the concerns within the organisation at the earliest possible opportunity. This Framework seeks to ensure that the

organisation has the appropriate mechanisms and culture in place through which concerns will be appropriately addressed.

3.9 If an individual speaks up or raises a concern in Welsh, it will not be treated any less favourably than if it had been raised in English. Individuals speaking up in Welsh can expect any subsequent written correspondence or response in Welsh. If meetings are arranged about the concern, the organisation will actively offer to conduct the meeting in Welsh.

3.10 Any matter raised will be reviewed thoroughly, promptly and confidentially, and the individual raising a concern will receive appropriate feedback (see Toolkits 2 & 3).

3.11 If an individual raises a genuine concern, they will not be at risk of losing their job or suffer any detriment. Where an individual (who has raised concerns) may nonetheless be at risk of or fear detriment or any potential harm by continuing to work in their existing role or place of work, suitable action will be taken, in agreement with the individual, which could include redeployment.

3.12 Victimisation or harassment of an individual for speaking up / raising concerns will be considered a serious disciplinary offence, as will any action to 'cover-up' or wilfully ignore concerns.

3.13 Individuals are encouraged to raise concerns openly. However, there may be circumstances when individuals may request that their identity is not revealed. In this case, the organisation will not disclose their identity without their consent unless required to by law. There may, however, be times when the organisation may be unable to resolve a concern without revealing the individual's identity, for example where personal evidence is essential. In such cases, the organisation will discuss with the individual whether and how the matter can best proceed. Where the concern is a matter of staff or patient safety in line with Duty of Care, there may well be a need for escalation and anonymity may not be able to be maintained. Where this cannot be avoided, however, this will be made clear to the individual who has raised the concern.

3.14 Where an anonymous concern is received, a designated contact will still examine the contents of the concern with relevant senior managers and investigate where necessary. However, without the investigator being able to talk to the individual(s) who has(have) raised the concern and without possibly being able to attain any additional facts as a result, it needs to be recognised that it may be difficult for a full investigation to be undertaken. In these circumstances, supporting and protecting the individual, or giving them feedback, may be very difficult. Accordingly, the individual may not be able to be provided the assurances offered above. Organisations should routinely consider, log and monitor anonymous concerns.

3.15 All managers will have discussions within the PADR (Performance and Development Review) process about speaking up if staff members have any concerns, as well as within their own PADR in respect of dealing with concerns when they arise.

3.16 Organisations should identify an Independent Member / Non-Executive Director to act as a 'Speaking Up Safely Board Champion' and an Executive Director as 'Speaking Up Safely Executive Lead', as a minimum, and may wish to appoint additional roles for speaking up. As a minimum, organisations should ensure that those with responsibility for speaking up are sufficiently independent to provide staff with confidence when speaking up.

4. Expectations

4.1 Employees

All NHS Wales employees have a role in identifying issues and speaking up. Registered staff also have a professional responsibility to identify and speak up appropriately. The following are expectations of all employees in the NHS.

1. Behave in a way that encourages individuals to speak up.
2. Where you have concerns, ensure these are raised in a timely and appropriate manner in line with local policies and procedures.
3. Encourage and be supportive of those who speak up.
4. Do not victimise, bully or discriminate.
5. Embrace speaking up as an opportunity to learn and grow as an individual and as a team, as well as for the organisation as a whole.
6. Utilise Toolkit 2 in this Framework when speaking up.

4.2 Line Managers

All managers have a responsibility for creating a 'psychologically safe' culture which enables individuals to highlight problems and make suggestions for improvement. Speaking Up Safely is a fundamental part of that. An organisational or departmental culture of bullying and harassment, or one that is not welcoming of new ideas or different perspectives, will prevent individuals from speaking up, put patients at risk, affect many aspects of the well-being and working lives of staff, and reduce the likelihood that improvements can be made. Managers, as leaders, should understand the impact their behaviour can have on an organisation's culture and therefore how important it is that they reflect on whether their behaviour may inhibit or encourage someone from speaking up (See toolkit 3).

Line Managers will: -

- Be able to articulate both the importance of workers feeling able to speak up and how they will enable this within the organisation's vision.
- Speak up, listen and act (see Toolkit 3).
- Be visible and approachable and welcome staff who wish to speak up.
- Have insight into how their power and position could silence individuals, and how their own unconscious bias and belief systems could impact on how they receive individuals who speak up.
- Thank workers who speak up.
- Demonstrate that they have heard when workers speak up by providing feedback.
- Seek feedback from peers and workers to help them reflect on how effectively they demonstrate the organisation's values and behaviours.

- Accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.

4.3 NHS Boards

NHS Organisations in Wales are expected to implement the Speaking Up Safely approach outlined in this Framework (see Toolkit 1). The Board should take into account the toolkits attached and align with the All-Wales branding that ensures individuals who move from one NHS Wales organisation to another can easily identify with the 'Speaking Up Safely' approach.

The Board should demonstrate its commitment to creating an open and honest culture where workers feel safe to speak up by:

- Having named Executive and Independent Member / Non-Executive Directors Leads responsible for speaking up.
- Acting as role models within the organisation.
- Including speaking up and other related cultural issues in board development programmes and Staff Partnership Fora.
- Having a sustained and ongoing focus on the reduction of bullying, harassment and incivility.
- Sending out clear and repeated messages that it will not tolerate the victimisation of workers who have spoken up, and taking action should this occur, with these messages echoed in relevant policies and training.
- Investing in sustained and continuous leadership development.
- Ensuring the organisation has an appropriately resourced Speaking up Safely approach and champion model.
- Supporting the creation of an effective communication and engagement strategy that encourages and enables workers to speak up, and promotes changes made as a result of speaking up.
- Inviting individuals who speak up to present their experiences in person to the board and staff partnership fora.
- Monitoring the extent to which concerns are being raised and addressed, and identifying learning and improvement needs as a result.

4.4 Independent Member/Non-executive Director 'Board Champion'

The Independent Member / Non-Executive Director Champion for Speaking Up Safely is a senior, independent lead role specific to organisations with boards.

They should:

- Hold the Board and the Executive Team to account in the delivery of a Speaking up Safely culture.
- Seek assurance that the Board responsibilities and expectations of this Framework are implemented.

- Be a ‘fresh pair of eyes’ to ensure that investigations are conducted with rigor and to help escalate issues, where needed.
- Have appropriate knowledge of Speaking Up Safely and be able to readily articulate:
    - why a healthy speaking-up culture is vital.
    - the indicators of a healthy speaking-up culture.
    - the indicators that there is sufficient support for speaking up and wider culture transformation.
    - the red flags that should trigger concern.
- Constructively challenge the most senior people in the organisation to reflect on whether they could do more to create a healthy, effective speaking-up culture. This might involve constructively raising awareness about poor behaviours.
- Be accessible to staff to provide support and guidance on how to and where to go to for advice and representation in Speaking Up Safely issues (with a clear delineation of roles). Independent members will not advocate, advise or represent employees in speaking up safely concerns.

Organisations / Hosted Organisations without Boards are likely to benefit from having an equivalent role.

4.5 Executive Leads for Speaking up Safely.

Having an Executive Lead for Speaking Up Safely helps demonstrate the organisation’s commitment to speaking up. Importantly, this person should be widely considered a credible role-model of the behaviours that encourage speaking up. They should be able to show that they are clear about their role and responsibility, and to evidence how they have helped improve the organisation’s speaking-up culture.

The Executive Lead should be accountable for:

- Co-designing, with the wider Executive Team, a plan for Speaking Up Safely, and implementing a Speaking Up Safely culture.
- Implementation and delivery, with the wider Executive Team, of a Speaking Up Safely Culture.
- Evaluating speaking-up arrangements and gaining assurance that the experience of workers who speak up is a positive one.
- Ensuring there is appropriate resource for Speaking Up Safely.
- How the organisation periodically reviews its speaking up safely arrangements.
- Ensuring there is a link to learning from events / incidents processes, and organisational governance arrangements.
- Liaising with the Independent Member / Non-Executive Director Champion.
- Providing the Board with assurance around all of the above.

5 Implementing and Improving a Speaking up Safely Culture

5.1 Implementation of Speaking up Safely Culture

In order to implement this Framework, it is expected that organisations have a clear vision for the speaking up culture that links the importance of encouraging individuals to speak up with patient safety, staff experience and continuous improvement. Co-designing, implementing and improving a Speaking Up Safely culture should always be undertaken in social partnership. Toolkit 1 provides further information.

Organisations will need to, in social partnership, develop a plan of how to deliver this Framework. This should be led by the Executive Lead for Speaking Up Safely. The plan should also be informed by key Speaking Up Safely stakeholders, such as Trade Unions, HR, OD and those representing minority communities. The Board should discuss and agree the plan and be provided with regular updates. The plan and ongoing review are co-produced with the organisation's staff partnership arrangements, staff networks and organisational engagement arrangements.

Among other things, the Executive Lead for Speaking Up Safely and the IM / NED Speaking Up Safely Champion will:

- Review the plan annually in social partnership, including how it fits with the overall organisational strategy, using a range of qualitative and quantitative measures.
- Assess what has been achieved and what more there is to do, using a continuous improvement approach.
- Identify the barriers to Speaking Up and how they will be overcome.
- Identify whether the right indicators are being used to measure success (see Toolkit 4).
- Help drive collaboration on an All-Wales basis to deliver, as far as possible, a consistency of approach to Speaking Up Safely across organisations, noting local and organisational context.

5.2 Be assured your Speaking Up Safely Culture is Healthy and Effective

The Board must be continuously assured that individuals will speak up about things that get in the way of providing safe and effective care and that this will improve the experience of patients and staff. Boards should not assume that the Speaking Up Safely culture is static; culture can improve, regress or stagnate for a variety of reasons, and sub-cultures will exist within organisations. Boards must monitor trends in the reasons for staff speaking up. Boards will also need further assurance when there have been significant changes, where changes are planned, or there have been negative experiences such as:

- Before a significant change (such as a merger or major service change).
- When an investigation has identified a team or department has been poorly led, or a culture of bullying has developed.

- When there has been a significant service failing.
- Following a Healthcare Inspectorate Wales inspection where concerns have been identified.
- Following a triangulation of data from a range of sources such as turnover, exit interviews, TU colleague feedback, staff surveys, grievances, work-related stress sickness, and clinical / operational indicators (See toolkit 4).

It is the Executive Lead's responsibility, supported by and in conjunction with the wider-Executive Team, to ensure that the Board receives a range of assurance and regular updates in relation to the Speaking Up Safely plan and implementation of this Framework.

The organisation's Speaking Up Safely arrangements must be based on the most recent NHS Wales policy and legal requirements (see examples on page 1 of this document). If the Board is not assured its staff feel confident and safe to speak up, it should consider requesting remedial action to address any concerns.

The Board should use a range of resources for developing and monitoring its Speaking Up Safely culture. Toolkit 4 should be considered as a basis for the information that organisations should collect to inform their understanding of the cultures within their organisation.

5.3 Be open and transparent with external stakeholders.

A healthy Speaking Up Safely culture is created by organisations and Boards that are open and transparent and see speaking up as an opportunity to learn. Executives are required to routinely discuss challenges and opportunities presented. The Board will welcome engagement with, and feedback from, these stakeholders. The Board is required to regularly discuss progress in this area (respecting the confidentiality of individuals), along with themes and issues arising from the Speaking Up Safely approach. Regular and in-depth reviews of leadership and governance arrangements in relation to Speaking Up Safely will help organisations to identify areas for further development.

6 Requirements for Organisations

Organisations will: -

6.1 Appoint, as mentioned earlier within this Framework) an Independent Member / Non-Executive Director as Speaking Up Safely Champion as well as an Executive Lead.

6.2 Ensure adequate investment that provides sufficient resource to support the continuous development of the organisational Speaking Up Safely approach and associated culture change.

6.3 Embed Speaking Up Safely in the functions of a board committee, which can be an existing committee, to support the champion / lead for speaking up in terms of guiding the organisation's approach. Membership of the committee should consist of a range of key stakeholders, including (but not limited to) some of those identified in Section 3.

6.4 Ensure that clear and easy to follow processes are in place to allow individuals to raise concerns (including anonymously). The NHS Wales Procedure for Staff to Raise Concerns is a necessary minimum standard but is not in itself sufficient for facilitating and supporting a Speak Up Safely culture.

6.5 Identify those groups which experience the most barriers when speaking up and ensure that processes are inclusive and equitable.

6.6 Ensure that the response mechanism / process is continuously monitored, clear and timely (equally as important as the procedure to raise concerns – see Toolkit 4).

6.7 Ensure that individuals speaking up do not suffer detriment as a result of raising concerns.

6.8 Undertake regular reviews of responses, as well as of the leadership and governance arrangements in place, and provide regular reports to the appropriate committee.

6.9 Ensure that arrangements are in place to monitor concerns / issued raised against the protected characteristics of the Equality Act 2010 and the implementation of any learning as a result of this.

6.10 Request feedback from all individuals who have spoken up and evaluate the feedback received (consider inviting a sample of individuals who have spoken up to attend committees and Board meetings to discuss experiences and share learning).

6.11 Fully implement the All-Wales branding / messaging for Speaking Up Safely (*once developed*).

6.12 Continuously / consistently promote and raise awareness of speaking up and listening / responding as a pro-social / desirable behaviour.

6.13 Ensure that appropriate training to deliver a Speaking Up Safely culture is rolled out to leaders, managers and staff throughout the organisation, as part of leadership and management development arrangements.

7. Footnotes

1 ISO 37002:2021 Whistleblowing management systems — Guidelines https://www.iso.org/standard/65035.html

2 UNODC (2021) Speak up for health! Guidelines to enable whistle-blower protection In the health-care sector

3 Jones A et al (2022) Evaluation of the implementation of Freedom to Speak Up Local Guardians in NHS Acute Hospital Trusts and Mental Health Trusts in England https://fundingawards.nihr.ac.uk/award/16/116/25

4 Jones, A et al (2021) Interventions promoting employee “speaking-up” within healthcare workplaces: a systematic narrative review of the international literature. *Health Policy* 125(3), pp. 375-384.

5 Jones, A. and Kelly, D. M. (2014) Whistle-blowing and workplace culture in older peoples' care: qualitative insights from the healthcare and social care workforce. *Sociology of Health & Illness* 36(7), pp. 986-1002.

Toolkit 1: Co-designing and Implementing a Speaking up Safely Culture

Introduction

This Framework provides an outline of the process of Speaking Up, but organisations will need to develop their Speaking Up Safely culture. There may also need to be local difference to the process of speaking up in each organisation. This toolkit provides a guide that NHS organisations must follow to co-design and implement a Speaking Up Safely culture.

1. Rationale and benefits of developing a Speaking Up Safely culture / What needs to be in place in an Organisation.

Organisations need to ensure that their values and cultures create healthy speaking up environments in the workplace that provide the space for people to be listened to and taken seriously. This is essential in a safety culture and should be part of normal business for every individual in every organisation.

For staff in the NHS to feel safe speaking up, the following elements need to be implemented:

- Staff can have open conversations with managers, and managers listen.
- There is mutual trust between the person raising the concern and the person listening.
- Leaders display and encourage the behaviours required for staff to feel listened to.
- The approach uses psychological safety principles to create the conditions for people to be able to speak up.
- Organisations will ensure individuals are not penalised for highlighting mistakes, failures or concerns. Where psychologically safety is lacking, employees are less likely to speak up and challenge inappropriate behaviours of colleagues or superiors.
- Organisations should recognise that individuals with protected characteristics are often more likely to be on the receiving end of poor practices, harassment or bullying. They are also least likely to speak up due to the fear of reprisals. This needs to be considered in the local approach and implementation.
- Feedback should be provided to individuals who raise concerns especially in relation to actions implemented.

2. What organisations should do to co-produce their Speaking Up Safely culture and local processes.

Organisations will be expected to co-produce their Speaking Up Safely culture and systems with trade / professional union partners, staff with protected characteristics, those with lived experience, and staff from ethnically and culturally diverse backgrounds. This approach is required to ensure the process is relevant and purposeful to those who may speak up.

A set of resources and guiding principles for how best to do this is provided on the Speaking Up Safely page on the NHS Employers Website here: **ONCE APPROVED, INSERT LINK**

Organisations should consider the following key principles when planning and co-designing a co-production approach (Baeck, 2013): This section will go onto a dedicated SUS webpage on the NHS Employers website. **ONCE APPROVED, INSERT LINK**

- Encourage active participation, the sharing of experience, and welcome diverse ideas and suggestions.

- Engage in genuine dialogue around diverse perspectives and be open to the idea that all parties can be mutually influenced by the experience and ideas of others. Avoid the perception that decisions have already been made by a small number of senior people.
- Consider how you can host events and conversations where differences of power, status, perceived expertise and privilege are minimised between those participating, i.e., leaders, staff, partners and stakeholders, and those with and without protected characteristics.
- Actively listen so that there is a shared experience of inquiry, reflection, dialogue and shared discovery.

Consider the following when planning your co-production approach:

People – who needs to be in the conversation with us?

Invitation – how will we invite people into the conversation with us so as they want to be involved, and are able to participate?

Power & Privilege – how will we acknowledge and work constructively with differences of power and privilege to ensure equity of contribution?

Inviting all to have their say – how do we structure this conversation so that everyone gets time and has their voice heard?

Interface – where and how will we meet (in person, online)?

Agreeing the practicalities – how often should we meet, and for what time duration?

Finding shared meaning – what are the common themes or *sense o*f shared purpose that ties this all together?

Goals – what are we hoping to achieve together?

How to respond best to disagreement and conflict – how we will respond to any breakdowns in communication? What is our agreed way of doing this?

3. Guidelines for Planning Essential elements for co-producing a Speaking up Safely Culture

- Map what staff, partners and stakeholders would see as the organisational barriers and enablers to Speaking Up Safely; co-produce interventions to reduce and remove barriers, monitor the effectiveness of these interventions, and share and implement enablers of speaking up.
- Widely and consistently communicate the agreed systems, processes for and learning from Speaking Up Safely.
- Ensure procedures for receiving, reviewing and responding to speaking up concerns are timely, transparent and regularly evaluated to ensure they are fit for purpose and able to reassure staff that the process will support them when raising their concerns.
- Use the lived experience of staff and others to help recognise the ways in which power and privilege manifest in the organisation and can become barriers to staff speaking up.

- Provide bias and cultural awareness training and / or supervision for those who will hear the concerns staff members raise – to ensure the diverse needs of staff with protected characteristics can be openly received, are not potentially dismissed due to possible differences in peoples' lived experiences, beliefs and views.
- Build anonymity into speaking up processes for those staff who fear detriment from publicly speaking out.
- Develop the skills of leaders to be able to listen to concerns openly, transparently and without prejudice and enable leaders to act on concerns raised. Leaders should demonstrate their skills in these areas in order to support a speaking up culture.
- Ensure there is timely access to staff support and wellbeing services – as speaking up can impact on the psychological health of staff.
- Review organisational data (as per Toolkit 4) with social partners through the organisation's board-level committee structure.
- Where staff experience detriment from speaking up, actively utilise restorative justice practices to address this, as per the All-Wales Respect & Resolution policy and process.

4. The following questions should be considered when co-producing the approach.

- Who needs to be in this conversation – who has an important perspective, experience, or stake in the development of a Speaking Up culture?
- What processes can be developed for acknowledging and addressing issues when they arise? How can the organisation collaborate with staff, partners, and other stakeholders to ensure these processes are fair and supportive?
- How is learning shared across the organisation – at individual, team and service level, as well as more widely?
- How will the organisation engage with staff from diverse backgrounds, ethnicities and cultures to;
    - ensure their lived experiences improve your speaking up processes?
    - address issues related to bias, discrimination and inequity?
    - review whether organisational policies and processes might be unintentionally causing inequity and inequality?
- How can the organisation explore the ways in which hierarchy, entitlement, power and privilege might be marginalising and disadvantaging individuals / groups?
- How can the organisation encourage and support this type of reflective conversation?
- How will the organisation identify barriers to speaking up within it? What actions can be taken to address and resolve any barriers when identified?

Toolkit 2: How to Speak Up

Introduction

Our NHS Wales workforce goes above and beyond every day, and its dedicated efforts and commitment to services is inspirational. Yet there are times when things just don't go right, where there are issues or concerns, or there is a fear for patient care and colleague well-being. The need for Speaking Up Safely is a vital component for any NHS organisational culture and highlighted in reports from Francis (2015) and, more recently, Ockenden (2022).

The Francis report highlighted:

"Every organisation involved in providing NHS healthcare should actively foster a culture of safety and learning in which all staff feel safe to raise concerns.

"Raising concerns should be part of the normal routine business of any well-led NHS organisation.

"Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.

"All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling".

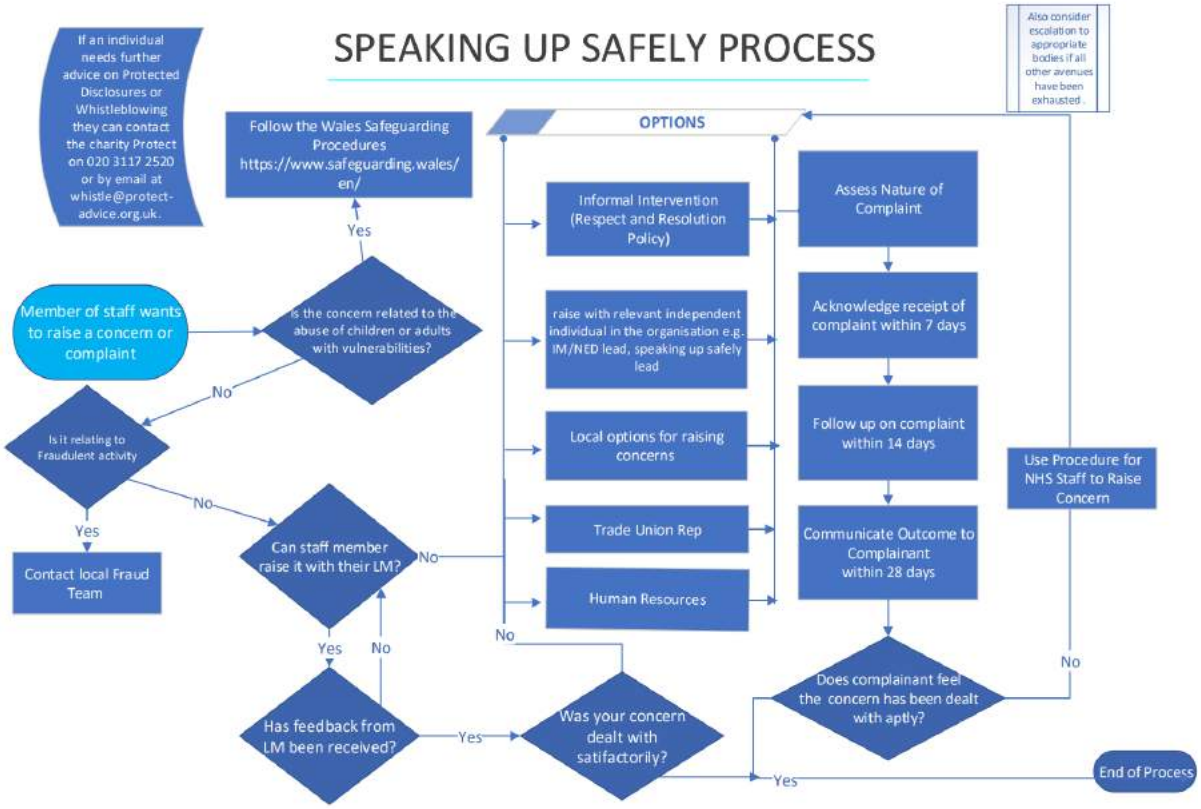
How to speak up in your organisation

Organisations across NHS Wales are committed to embedding speaking up safely as part of their cultures. It is recognised that to enable this, various methods and means will be utilised to ensure staff feel safe and comfortable in speaking up. This will vary across organisations as they implement local methods to support this agenda. There will be transparency where possible, on any actions taken because of staff speaking up to show they have been actively listened to.

The need for speaking up safely to be firmly embedded into everyday life and cultures across NHS Wales is a priority. The way and means of doing this will evolve with new initiatives added to ensure that issues can be safely explored.

"Culture change is not a one-off event but requires constant attention and development."

- Sir Robert Francis QC, 2015



Frequently Asked Questions

1. **I have a concern and I need to speak to someone, who do I tell?**

Staff should be able to raise concerns with their line manager on routine discussions on service delivery and patient care, (e.g., problem-solving, service review, performance improvement, quality assessment, training, and development) as these are the most effective mechanisms for early warning of concerns, wrongdoing, malpractice or risks. Line managers are best placed to act on, deal with and resolve such concerns at an early stage.

However, in some circumstances, this may not be appropriate and there are other methods you can use to raise a concern if you cannot speak to your line manager. These methods can be found here: **ONCE APPROVED, INSERT LINK**

2. **What support can I access when I want to raise a concern?**

Trade / professional unions (TUs) – these can provide support, advocacy and representation at all stages.
Well-being support – refer to your local well-being support services within your organisation, which can be found on local intranet, or via your line manager / TUs / HR department.
Independent Member (IM) / Non-Executive Director (NED) – IMs and NEDs provide scrutiny and seek assurance that the speaking up culture is working in an organisation. You can speak to an IM / NED about speaking up, but they won't advocate or represent you on your specific case. However, they may advise you of the best way to get support in raising your issue.
Your local organisation will have more specific advice on what support you can obtain when you want to raise a concern.

3. **Do I have to have evidence of wrongdoing to raise a concern?**

You do not need to have absolute proof of the activities you want to report; a reasonable belief is sufficient. We encourage all individuals to raise their concerns as early as they can. Any evidence that you do have such as letters, memos, diary entries, DATIX etc. will be useful to assist any further investigations.

4. **Will I be responsible for investigating the concern?**

No, your concern will be investigated by a nominated individual, if appropriate to do so.

5. **How will I know if my concern has been dealt with?**

Once an individual has told someone of their concern, whether verbally or in writing, the information will be assessed to see what action should be taken. This may involve an informal, review or a more formal investigation.

The individual will be told who is handling the matter, how they can contact them and what further assistance may be needed. If there is to be a formal investigation the manager to whom they have reported their concern will appoint an Investigating Officer.
If an internal investigation takes place this will be undertaken thoroughly and as quickly as possible considering the matters to be investigated. At their request, the individual will be written to summarising their concern and setting out how it will be handled along with a timeframe.

6. **What happens if I don't agree with the outcome of my concern, or I don't feel that it was dealt with properly?**

The individual raising the concern will be entitled to a verbal response, as a minimum, and where appropriate, a written response may be required (noting any request to remain anonymous).
The person responsible for providing this response will be either the manager to whom the concern was addressed, or the individual identified to provide such responses in any local processes in place to ensure that concerns can be raised.
If you feel that your concern has not been dealt with appropriately, please contact your local Workforce & OD team for more information on how to escalate your concern.

7. **I want to raise a concern, but I want to remain anonymous because I'm worried that I'll be treated differently if I make myself known.**

Individuals are encouraged to raise concerns openly. However, there may be circumstances when individuals may request that their identity is not revealed. In this case, the organisation will not disclose their identity without their consent unless required to by law.

There may, however, be times when the organisation may be unable to resolve a concern without revealing the individual's identity, for example where personal evidence is essential. In such cases, the organisation will discuss with the individual whether and how the matter can best proceed.

Where the concern is a matter of staff or patient safety in line with Duty of Care, there may well be a need for escalation and anonymity may not be able to be maintained. Where this cannot be avoided, however, this will be made clear to the individual who has raised the concern.

8. **What happens if someone raises a concern that they know isn't true?**

We acknowledge that in a very small number of cases, allegations may be made which are malicious or vexatious. Making allegations that are known to be false will be considered a serious matter. If it is concluded that an individual has deliberately made false allegations maliciously or vexatiously, or for personal gain, then the organisation may begin an investigation under the Disciplinary policy and procedure.

9. **What does the term 'Whistleblowing' mean?**

Whistleblowing is the term used when a member of staff raises a concern about a possible risk, wrongdoing or malpractice that has a public interest aspect to it, usually, because it threatens or poses a risk to others (e.g., patients, colleagues or the public).

This may include:

- Systematic failings that result in patient safety being endangered, e.g., poorly organised emergency response systems, or inadequate/broken equipment, inappropriately trained staff.
- Poor quality care.
- Acts of violence, discrimination or bullying towards patients or staff.
- Malpractice in the treatment of, or ill-treatment or neglect of, a patient or client.
- Disregard of agreed care plans or treatment regimens.
- Inappropriate care of, or behaviour towards, a child /vulnerable adult.
- The welfare of subjects in clinical trials.
- Staff being mistreated by patients.
- Inappropriate relationships between patients and staff.
- Illness that may affect a member of the workforce's ability to practise in a safe manner.
- Substance and alcohol misuse affecting ability to work.
- Negligence.
- Where a criminal offence has been committed / is being committed / or is likely to be committed (or you suspect this to be the case).
- Where fraud or theft is suspected.
- Disregard of legislation, particularly in relation to Health and Safety at Work.
- A breach of financial procedures.
- Undue favour over a contractual matter or to a job applicant has been shown.
- Information on any of the above has been / is being / or is likely to be concealed.

If an individual needs further advice, they can contact the charity Protect on 020 3117 2520, or by email at whistle@protect-advice.org.uk.

Protect can advise individuals how to go about raising a matter of concern in the appropriate way at https://protect-advice.org.uk/. Alternatively, the Department of Health also provide a free, independent confidential advice service for NHS and Social Care employees and employers in England and Wales known as Speak Up. They can be contacted on 08000 724 725 or via their website at https://speakup.direct/

You can find more information in the All Wales Procedure for NHS Staff to Raise Concerns.

Toolkit 3: What to do if someone has ‘spoken up’ to you.

1. Introduction

There are three areas to consider when someone speaks up to you:

1. Recognition and validation of the courage to speak up.
2. Non-judgmentally and actively listening to the concerns.
3. What happens after speaking up to both the person with the concern and anybody implicated in that concern.

1. Recognition and validation of the courage to speak up.

1.1 It is a big step for individuals to come to you raising a concern. It takes both courage from the individual and demonstrates their trust in you. You should thank them for choosing to share and for trusting you with this, reassure them that you know they must have thought long and hard before coming forward and that you are here to listen and agree what happens next.

1.2 In most cases, individuals who raise a concern believe there are grounds for their concern. It has taken a lot of courage for them to raise the concern/s and it is important not to dismiss this, even if your view may differ.

1.3 Validation of someone's concerns does not mean that you necessarily agree with them; it simply means you understand the impact their view and experience has had on them.

2. Non-judgmental and active listening

2.1 Active listening means demonstrating you are hearing and understanding what you are being told. This can be achieved by using skills such as reflecting and summarising; and being present – a private space without interruptions and distractions would be beneficial. You can find out more about active listening here (link to be inserted here) **ONCE APPROVED, INSERT LINK**

2.2 Be open to the concerns. While concerns can sometimes feel personal or suggest that you are being criticised, it is often the case that it is organisational elements which need to be considered. Take time to move your attention to what the individual is saying and think about how they might be feeling; there will be time for you to think about it from your own perspective after the discussion.

2.3 Take it as an opportunity to learn and develop your team/service; even if it was not the service' or team's or an individual's intention to cause concern, it is important to recognise the impact on individuals.

2.4 Be aware that you may have a different perspective and different lived experiences from the individual raising the concern, but don't dismiss them because you don't agree with their perspective. Think about how to see it from their point of view.

2.5 Be aware of your own positions of power and privilege in the conversation, and how can you ensure these power and privilege dynamics are minimised to enable the person to feel comfortable speaking up you.

3.Action as a result of them speaking up.

3.1 Once someone has spoken up, it is important to ensure both they and anyone impacted by the concern are aware of, and have access to, support. (Insert each organisation's support processes here.) **ONCE APPROVED, INSERT LINK**

3.2 The concern may be highly emotional or challenging, so it's important to recognise that we often benefit from taking a pause before acting unless there is immediate risk.

3.3 As a manager, you may not have all the answers. Nor do you always have the power to make the changes that the person who raises the concerns wishes to see.

3.4 Agree how often and by what means you will keep the person informed of the process and of the steps taken from the point of them discussing their concerns with you.

3.5 It is important that you implement what elements you can and, as a minimum, implement everything that you say you will do. This is vital in maintaining trust.

3.6 For those elements on which you cannot have an impact, it is suggested these are escalated through appropriate channels.

3.7 Whatever happens, it is hugely important this is fed back to the individual who has spoken up. It is important that individuals don't feel that they haven't been heard or their concerns haven't been taken seriously; this is just as vital for our services, so that others can feel confident to speak up, as it is for the individual who has done so to you.

Remember most people in public service do so as they have a shared goal - to ensure the experiences of patients and staff are improved and are the best they can be. Starting conversations from this shared perspective will always be helpful.

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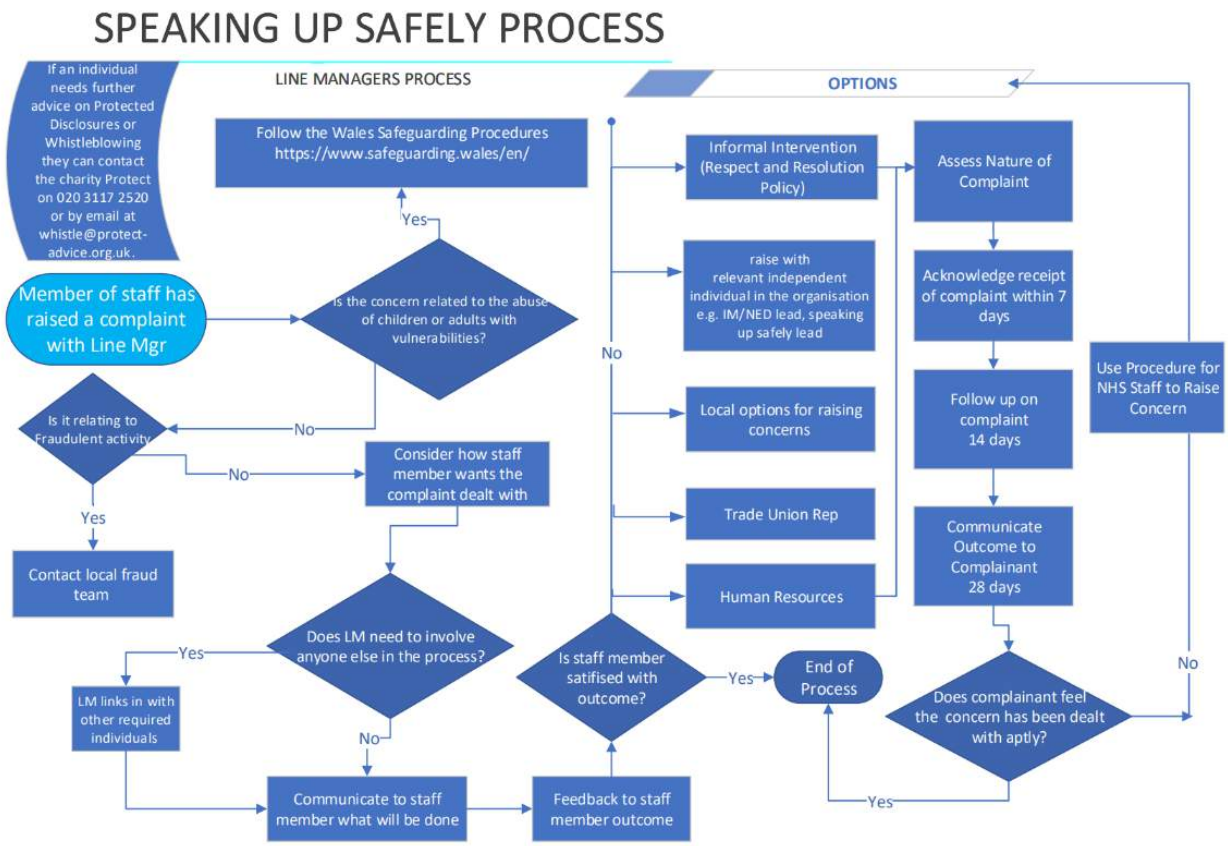
2. The Process

The above outlines how you should approach conversation, but there are important steps you must take as a manager. These are outlined in the attached line manager process. Managers must:

- Listen to the concern that is being raised. If the concern is related to the abuse of children or adults with vulnerabilities, the Safeguarding Wales Processes should be followed.
- Once the concern has been raised, consider how the person want it dealt with. If you need to involve anybody else in the process, do so at this point. Or deal with it yourself if possible.
- Once it has been raised, it is important you communicate regularly with the individual to inform them of the outcome or action you have taken as a result of the concern being raised. You should also consider how you will share any learning about the concern more widely.
- If the issue is not within your ability to be managed, this should be clearly communicated with the individual.
- Once the outcome of the concern has been discussed with the individual, they should be informed of the other ways available to them to raise the concern if they are not satisfied with the outcome, as per the Line Managers Process.



The aim is to foster a culture where concerns are openly raised, are dealt with promptly and appropriately and escalated appropriately if required. There are specific legal requirements on organisations should the concerns be considered as Whistleblowing or a Protected Disclosure. More information on whistleblowing is available in the FAQs in toolkit 2 and you can find more information in the All Wales Procedure for NHS Staff to Raise Concerns.

A protected disclosure is defined in law by the Employment Rights Act (ERA) 1996. For a concern to be classed as a protected disclosure it needs to meet certain requirements under the ERA (1996) and tends to show one or more of the following:

- That a criminal offence has been committed, is being committed or is likely to be committed.
- That a person has failed, is failing or is likely to fail to comply with any legal obligation to which they are subject.
- That a miscarriage of justice has occurred, is occurring or is likely to occur.
- That the health or safety of any individual has been, is being or is likely to be endangered.
- That the environment has been, is being or is likely to be damaged, or
- That information tending to show any matter falling within any one of the above has been, is being or is likely to be deliberately concealed.
- If you suspect the concern the member has raised potentially meets these requirements, you should discuss with the local Workforce and OD department for further advice and guidance.

Toolkit 4: Recording and Monitoring of Concerns

Data Point 1: Type of Concern and Characteristics

Note this data should be aggregated and reported to the Board Committee with responsibility for Speaking Up Safely at least annually.

- ✓ Type of concern: Patient safety, Bullying/harassment, Incivility, Fraud, Management Concerns, System and Process, Discrimination/Inequality, Behaviour/Relationship, Worker Safety, Other. N.B.
- ✓ Establish whether other existing processes are more appropriate: Respect and Resolution; Fraud; Incident Reporting.
- ✓ Establish Employee characteristics: staff/temporary staff/student; staff group; department and directorate; protected characteristics; N.B. organisations have identified this as a potential point of tension with anonymity.
- ✓ Is the concern raised anonymously?
- ✓ Establish the lead/s for responding to the concern.

Data Point 2: Monitor the Response

- ✓ Monthly progress check with lead for response and the Workforce & OD Team.
- ✓ Feedback fortnightly to the person speaking up.

Data Point 3: Closing

- ✓ Triangulate with other concerns.
- ✓ Indicate case as closed.
- ✓ Identify and agree the outcome with the Workforce & OD Team.
- ✓ Identify the learning and/or improvement resulting from the concern.
- ✓ Evaluate the experience of the person speaking up and the person responding.

Further Resources

The following resources will be useful in delivery of Speaking Up Safely culture.

Compassionate Leadership Principles

Respect & Resolution Policy and Processes

National Institute for Health Research (NIHR)/Cardiff University – research into the role of the Freedom to Speak Up Guardian in England

National Guardians Office for England: https://nationalguardian.org.uk/

HIW Guidance on Speaking Up: https://hiw.org.uk/speaking-keep-people-safe

HEIW – Healthy Working Relationships: https://nhswalesleadershipportal.heiw.wales/healthy-working-relationships

Just and Restorative Culture: NHS England » A just culture guide; The Mersey Care Just and Learning Culture

Epistemic Injustice: Epistemic Injustice | Department of Philosophy | University of Bristol

BMJ Research Article on Speaking Up and Culture within the NHS: Interprofessional model on speaking up behaviour in healthcare professionals: a qualitative study | BMJ Leader

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

To: Chief Executives NHS Wales

Our Ref: JP/SH/SB

25 August 2023

Dear Chief Executives

Quality and Safety systems

You will be aware of the tragedies that occurred in the neonatal unit of the Countess of Chester Hospital. Dreadful crimes were committed that were a betrayal of the trust put in health services. Our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked by these crimes, which are beyond belief for all those working so hard across the NHS to save lives and care for patients and their families. The Welsh Government will cooperate fully and transparently with any inquiry to help ensure we learn every possible lesson from this case.

We reflected on this case at NHS Leadership Board this week and in addition to that we agreed that, even in advance of more formal review and Inquiry, we should all take stock and assure ourselves that the mechanisms that we have in place to support quality and safety governance are robust and well implemented across our organisations.

It is important all Boards are assured that quality, safety and governance systems are functioning as intended throughout the organisation. Escalation of quality and safety concerns often results from active listening within our organisation and the wider system as concerns can and should emerge through various routes. Listening to concerns and triangulating the information available throughout organisations will ensure good governance practice. This should include clear lines of accountability and escalation from Departmental Quality and Safety meetings through to the Board and its committees. Without this assurance it is not possible for the Board to be confident they are receiving the appropriate information to inform their decision making and any actions required.

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Ffôn • Tel 0300 0251182
Judith.Paget001@gov.wales

Gwefan • website: www.gov.wales

We already have a range of mechanisms in place, to enable early flagging of concerns and overall monitoring and assurance mechanisms both in relation to neonatal care but also the wider health system and commissioned services. The arrangements should be utilised to their best effect to ensure that in Wales our workforce at every level is empowered and enabled to raise concerns.

The Health and Social Care (Quality and Engagement) (Wales) Act 2020, which came into force on 1 April 2023, introduced a Duty of Candour and a Duty of Quality. The Duty of Candour builds upon our ongoing work to embed a culture of openness and transparency across NHS Wales and strengthens the Putting Things Right processes. It places an organisational duty on all bodies to inform and support patients and their loved ones when things go wrong; ensure incidents are investigated, and share learning to help prevent recurrence. The requirement to report and publish annually on compliance with the duty will also improve openness and transparency.

The Duty of Quality applies to all NHS organisations to ensure quality-driven decisions improve the quality of health services and focus is maintained on improving outcomes for people. It includes new health and care quality standards which encourage organisations to review and strengthen their internal arrangements for reporting, learning and improvement. The Leadership Board received an encouraging update on the work that has been undertaken across NHS Wales organisations to implement robust and coherent quality management systems with attention to outcome data driving continuous learning and improvement. This work to deliver fully on the Duty must continue so that service issues are rapidly recognised and acted upon.

An additional safeguard in an open safety culture is the scrutiny of deaths provided by the Medical Examiner service in Wales, due to become statutory from April 2024. In Wales this service has the added strength that it is operated at a national level and operates independently of the organisation providing care, so can provide valuable and early feedback to organisations about any issues that may be associated with care before death. It is vital that the valuable feedback from the Medical Examiner is triangulated with the other quality indicators that must be monitored within organisations.

We must also support staff to feel confident to speak up and assured that they will not suffer any detriment as a result of voicing their concerns. As part of effective governance, all NHS Wales Boards should already receive reports regarding the use of the Procedure for NHS Staff to Raise Concerns which has been recently subject to a high-level all-Wales review and a revised version issued. In addition, a working group commissioned by Welsh Partnership Forum, has been considering additional mechanisms that might be suitable in NHS Wales to support more consistent governance arrangements and outcomes for staff in speaking up safely across NHS Wales organisations. This has included examining models currently used in across the UK. As a result, a **Framework for Speaking up Safely in NHS Wales** has been developed and scrutinised and approved in social partnership to provide an all-Wales consistency of cultural expectation, approach and escalation process whilst also strengthening local initiatives.

The Framework will be issued as a Welsh Health Circular and identifies the requirements of NHS leaders and Boards to ensure proper implementation and oversight of our speaking up policies. We have considered whether it would be prudent to delay the release to build in emerging lessons from the Letby case. However, have decided to issue the Framework now and ensure that it kept under active review during the next 12 months to ensure it remains fit for purpose in the light of lessons learned during the early implementation phase.

I have attached the new Framework to this letter. As part of your reflection on the operation of your current quality and safety governance arrangements, the Welsh Government expects all NHS Boards, Trusts and Special Health Authorities to undertake a self-assessment against the organisational requirements detailed in section 6 of the Framework and develop an action plan to address any gaps between your current practice and the expectations of the Framework.

We request that this response and plan to address any areas of development is sent to Helen Arthur, Director of Workforce and OD (Helen.Arthur@gov.wales) Welsh Government by October 30th.

We will look at all the plans and provide feedback and in social partnership through the Business Committee we will provide opportunities to share learning across the system and also keep the Framework under review, as organisations report their ongoing experience with its use to build a more open culture.

These appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter all work towards creating a culture of openness and learning when things go wrong. Their sustained implementation, along with our full co-operation with the inquiry to ensure every possible lesson is learned, will help us all make the NHS the safest possible.

Yours sincerely

Judith Paget

Judith Paget CBE

Helen Arthur.

Helen Arthur

Sue Tranka

Sue Tranka

Chris Jones

Professor Chris Jones

Sarah Simmonds,
Cyfarwyddwr y Gweithlu a Datblygiad Sefydliadol/
Executive Director of Workforce & OD
01633 435 951
Sarah.Simmonds@wales.nhs.uk

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

Our ref: **SS/jac**

26 October 2023

Ms Helen Arthur
Director of Workforce & Corporate Business
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Sent by email: helen.arthur@gov.wales

Dear Helen

Re: Speaking Up Safely Framework

Please see attached the Health Board's self-assessment against the relevant section of the Speaking Up Safely Framework as requested including actions to be undertaken.

The assessment has been carefully considered by our Quality and Safety and Workforce and OD teams engaging with relevant stakeholders.

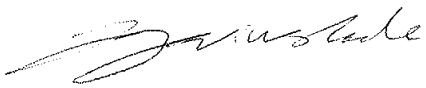
As a Health Board we have undertaken a great deal of work to embed the Duty of Quality and Duty of Candour as well as looking at how we consider and implement our people policies through the lens of a just and learning culture. As part of this ongoing work, we held a multi-disciplinary workshop on the 3rd October to consider how we further develop a safe culture to support raising concerns. The workshop was supported by HEIW and Professor Aled Jones, University of Plymouth, who has undertaken extensive research into this field particularly in relation to organisations who can offer good practice to develop and sustain a long-term culture which supports speaking up safely.

An outcome of this workshop will be to set up a Health Board Steering Group in November 2023 to take forward key actions that will map out and support the delivery of ongoing work that supports quality, safety and employee experience.

If you have any queries on any of the information contained withing our assessment or the actions please do not hesitate to contact us.

Yours sincerely

Sarah Simmonds
Cyfarwyddwr y Gweithlu a Datblygiad Sefydliadol/Executive Director of Workforce & Organisational Development



Jennifer Winslade
Cyfarwyddwr Gweithredol Nyrsio/Executive Director of Nursing

cc: Nicola Prygodzicz, Prif Weithredwr/Chief Executive
Dan Davies, Prif Swyddog Busnes, Chief Business Officer

Enc.

Speaking up Safely Framework

Self-Assessment: Aneurin Bevan University Health Board

Requirements for Organisations will: -

Appoint, as mentioned earlier within this Framework) an Independent Member/Non-Executive Director as Speaking Up Safely Champion as well as an Executive Lead.	An independent member will be formally appointed at November Board as the Health Board's champion. **Action: November 2023** The Executive Director of Nursing and the Executive Director of Workforce and Organisational Development have been recognised as the Health Board's Executive leads.
Ensure adequate investment that provides sufficient resource to support the continuous development of the organisational Speaking Up Safely approach and associated culture change.	The Health Board Quality Strategy (approved at Board in March 2023) highlights the ambitions of the Health Board to become a listening and learning organisation and where staff feel supported to report incidents and errors at all levels clinical and non-clinical. The Quality Strategy focuses on embedding a culture where staff feel listened to, based on transparency, accountability, ethical behaviour, trust and a 'Just Culture' to promote psychological safety. Under the Duty of Candour, the Health Board is committed to understanding when things go wrong in delivery of care and treatment or where our services fail to meet expectations, or the standards expected.

	Through this Duty and the resource apportioned to deliver the Duty of Candour, the Health Board will be honest in informing patients and their families when things go wrong. We are obligated to find out what went happened; and, to make sure we learn from through engagement with the patient, their family and with our staff. Speaking up Safely reinforces a culture of openness, transparency and candour and is a mechanism to support the provision of high-quality care. Based on evidenced best practice, it is realistic to anticipate this work will take a number of years to successfully embed. Within ABUHB we recently started this work at a cross-organisational workshop (October 2023) hosted with UK expert Professor Aled Jones where we discussed the Speaking up Safely approach and culture change required within the Health Board. Following the organisational assessment actions agreed: • Establish a long-term steering group (**November 2023)** • A deliberate communication strategy (**December 2023)** • Identify potential costs (people, resource, technology, • Integrate the evidence from an ABUHB sponsored and recently completed PhD, which looked at the obstacles and enablers to middle managers raising concerns. In addition, future work will include how this work can dovetail within wider organisational

	culture change and organisational values and behaviours approaches (**March 2024)** • Consider existing or new networks to support the Speaking up Safely Framework (e.g., Development of Speaking up Safely Champions/Professional Leads) (**December 2023)**
Embed Speaking Up Safely in the functions of a board committee, which can be an existing committee, to support the champion/lead for speaking up in terms of guiding the organisation's approach. Membership of the committee should consist of a range of key stakeholders, including (but not limited to) some of those identified in Section 3.	The Board's People and Culture Committee has delegated responsibility for seeking assurance, and providing the Board with advice, on speaking up. In addition, there are regular reports, information and findings reported and discussed via Executive Committee, and the Patient, Quality, Safety and Outcome Committee. All committees include a range of stakeholders including Executive leads, Independent Members, Trade Union Representatives, Senior Managers and Subject Matter Experts. In addition, learning and improvement and the test of the transparency will be through the learning committee/patient safety and quality operational group.
Ensure that clear and easy to follow processes are in place to allow individuals to raise concerns (including anonymously). The NHS Wales Procedure for Staff to Raise Concerns is a necessary minimum standard but is not in itself sufficient for facilitating and supporting a Speak Up Safely culture.	A recent 'Raising Concerns' inbox has been introduced for staff to raise concerns (including anonymous concerns) via a central email address making it easy for staff to communicate concerns. This compliments existing process such as the Patient Safety Incident Policy, Raising Concerns Policy, the Respect and

	Resolution Policy and directly with line managers or the HR Team. The Incident Module in the Datix Cymru System also provides a platform for staff to raise concerns with potential to develop a specific Speaking Up Safely Form on Datix to support the process and learning. There is a function within Datix which guides staff through the process of documenting and escalating inadequate nurse staffing levels. This process has been agreed on an All-Wales basis and encourages and supports reporting, particularly where it is considered nurse staffing levels have contributed to the incident. In addition to formal mechanisms the Health Board support a number of actions to informally capture feedback including concerns: • Ask the Chief Executive. • TUPF and local/divisional TU Forums. • Independent listening exercises with teams/sites with feedback and action plans which included staff. • Quarterly Staff Wellbeing surveys. • Peer networks. • Schwartz Rounds. The Health Board will consider one-point of contact for future concerns to be raised in a consistent manner

	including the feasibility of an external Raising Concerns mechanism. **Action: December 2023**
Identify those groups which experience the most barriers when speaking up and ensure that processes are inclusive and equitable.	Empowering the voice of the hard to reach is being considered as part of the communication strategy to promote the framework. The final approach from the Health Board will undergo an Equality Impact Assessment, in partnership with the Health Boards Equality, Diversity and Inclusion lead. Engagement will continue through the Health Board's six established Staff Diversity Networks. Networks share heritage, lived experience, and characteristics linked to the protected characteristics of the Equality Act 2010. Networks can provide opportunities for people to build confidence to speak up in forums outside of the network space, address local concerns and link people to collaborate and innovate intuitively across the organisation. Work is underway to develop staff network maturity and the Executive Team have approved protected time for members to attend, as well as the nomination of an Executive Sponsor for each Network. **Action: November 2023**

Ensure that the response mechanism/process is continuously monitored, clear and timely (equally as important as the procedure to raise concerns – see Toolkit 4).	Following the introduction of the central reporting inbox, an internal target of a twenty-four-hour response has been considered reasonable. There are thematic reviews through Datix to inform actions and the identification of common themes. Compliance with the Duty of Candour is also closely monitored and reported. Incidents reported through Datix are monitored via dashboards and reported to the Datix Project Group. The Corporate Health and Safety team also conduct validation exercise to ensure data quality within Datix. Reporting and oversight will be through the Executive Committee with assurance to Board. The Health Board plans to review our response performance in March 2024. **Action: March 2024**
Ensure that individuals speaking up do not suffer detriment as a result of raising concerns.	Raising concerns is typically seen as high-risk/low reward for staff. Historically within the NHS it is well evidenced that those raising concerns (as whistle blowers) do not fare well and are more likely to leave their organisation. Even though within ABUHB there is no evidence that anyone who has raised concerns has suffered a detriment of any kind we need to better understand the experience of this group to be sure.

	The communication strategy will both help us better understand this need and implementation the Speaking up Safely Framework. Our ambition is to be in a position where speaking up is not seen or experienced as having a potential to cause unintentional harm. That said the Health Board wellbeing service is also available for all members of staff and anyone considered to have raised concerns will be expedited for support. The Health Board has also recently rolled out a programme of work to understand the impact of formal employee relation investigations on staff and those involved and will continue to evaluate this work (Avoidable Employee Harm).
Undertake regular reviews of responses, as well as of the leadership and governance arrangements in place, and provide regular reports to the appropriate committee.	As above, reports to Executive Committee, People and Culture and Patient, Quality, Safety and Outcome Committees will continue to consider reports on concerns raised and improvement actions identified. We are strengthening our governance structures through Board-to-Floor connections that promote cross directorate and multi-professional working including Patient Safety Walkabouts to gather informal staff feedback.

Ensure that arrangements are in place to monitor concerns/issued raised against the protected characteristics of the Equality Act 2010 and the implementation of any learning as a result of this.	All concerns raised through the central process aim to capture and record any protected characteristics (with consent). Recently, this has resulted in an independent review into concerns raised relating to sexual harassment against women, with an action plan for addressing and preventing this behaviour in the future.
Request feedback from all individuals who have spoken up and evaluate the feedback received (consider inviting a sample of individuals who have spoken up to attend committees and Board meetings to discuss experiences and share learning).	Staff and patient stories are regularly presented to Board and Executive Committee to share learning and inform future experiences. Ward accreditation is also being piloted within the Health Board which provides an opportunity for patient and staff feedback. For all staff who raise concerns formally, a variety of meetings are held, including a concluding meeting to consider feedback on how the concern was handled and whether the outcome is considered satisfactory for the person who raised the concern and the Health Board. The Health Board will consider how best to invite, discuss, and learn from these individual's experiences through formal invite to Board meetings in the future. Patient Safety Leadership walkarounds (facilitated by Executive Directors and Independent Members) provide an opportunity for senior leaders to demonstrate a top–down commitment to building a culture of safety. We are actively undertaking these visits as a method for leaders to talk with front line staff informally about culture, patient safety issues, listening to staff thoughts, concerns, and improvement. Walkarounds serve a dual

	purpose – they educate senior leaders about safety issues, whilst demonstrating to frontline workers their commitment to creating a culture of safety. The Patient Safety and Quality Operational Group will be changing into a learning forum which will facilitate shared learning.
Fully implement the All-Wales branding/messaging for Speaking Up Safely (once developed).	A communication and engagement strategy will be developed following the completed All-Wales branding and messaging.
Continuously/consistently promote and raise awareness of speaking up and listening/responding as a pro-social /desirable behaviour.	There are a variety of mechanisms to promote and encourage speaking up such as: • Culture and wellbeing survey. • Staff survey. • STREMS – staff reported experience measures. • Anonymous reporting. • Communication and engagement mechanisms will be put into place. In addition, a staff communication strategy has also been approved by Board for publication.
Ensure that appropriate training to deliver a Speaking Up Safely culture is rolled out to leaders, managers, and staff throughout the organisation, as part of leadership and management development arrangements	A review of all Leadership Programmes, Corporate Induction and Core training offers will be reviewed to ensure a culture of Speaking up Safely is embedded. **Action: January 2024**.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Winter Plan 2023/24
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Executive Director for Strategy Planning and Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Deputy Director Strategy Planning and Partnerships

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

Ar Gyfer Penderfyniad/For Decision

This report presents to the Board the Winter Plan for the 2023/24 winter period FOR APPROVAL.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

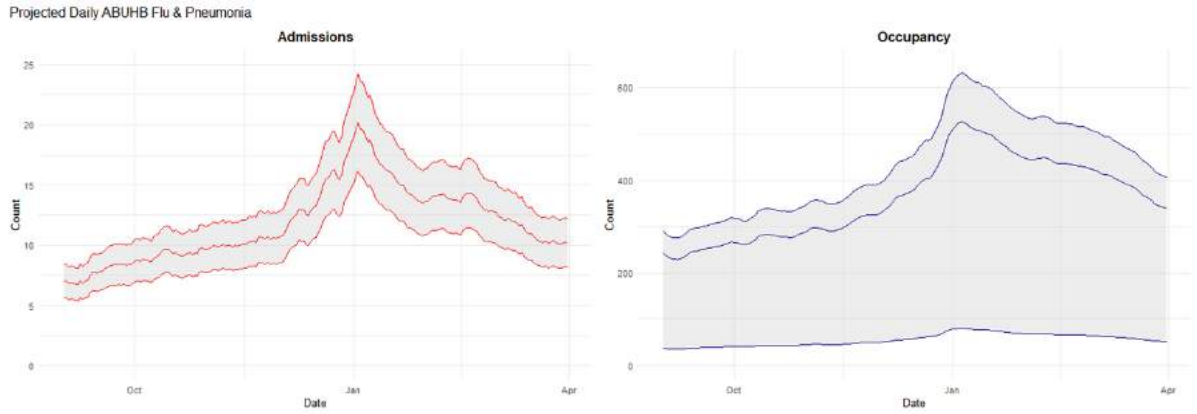
This plan sets out how the Health Board, with partners, will respond to the challenges which will be faced by the care system over the coming months. Building system resilience is part of the core focus of the Health Board and activity in central programmes, such as the Six Goals for Urgent Care, as well as work through the Regional Partnership Board support meeting the additional challenges of the period. Therefore, this plan should not be considered in isolation from the wider work programme of the organisation set out in the IMTP. Partnership, whole system working, and transparency will be essential in planning and meeting the tasks that lie ahead.

Cefndir / Background

The Welsh Government provides respiratory modelling for Wales. This has been tailored to the Health Board population to provide scenarios for planning. Flu & Pneumonia admissions are projected to increase gradually from 5-10 daily admissions in the early autumn, reaching 10-15 by December at the anticipated peak at the beginning of January expected to be 15-25 daily admissions. This will

come down to 10-15 in February but will reduce much more gradually to 7-12 in April.

The occupancy projection corridor ranges from 50-300 in early autumn to the peak of 100-620 in January. The reduction to occupancy is expected to be gradual and ranging from 50-400 in April.



The most likely level of covid admissions to ABUHB is expected to be in the region of 5-12 patients per day. The worst-case scenario sees this being in 2 large peaks, one in mid-September which we have passed, and a second slightly higher peak in December reaching 17 patients/day. COVID-19 Occupancy is expected to be 50-120, with the worst case again having 2 large peaks where COVID-19 occupancy would reach a high of around 225 beds. The optimistic scenario is a steady stream of 2-5 COVID-19 patients per day.

In addition to the respiratory challenge, urgent care pressures, workforce shortages and deepening health inequality persist in the health and care system. The context set out here represents a significant challenge ahead.

This plan aims to focus additional targeted action towards these complex challenges to ensure services can be sustained to meet the needs of our population. The Health Board is not proposing to provide any additional medical beds in the final quarter of the year. To meet the financial and workforce challenges the organisation is seeking to bring its bed base back into the original planned and funded footprint of the Clinical Futures model. This means that the challenges set out above must be met in a different way, delivering on existing programmes, preventing deterioration of illness, building community resilience and maximising flow through the system.

The plan focusses on meeting this challenge through four core areas, Partnership (with actions agreed via RPB), Capacity, Processing Power and Focus as summarised below.

Partnership • Delivering preventative vaccination programme through primary care partners • Building on preventative programmes connecting citizens with support in their communities • Embedding trusted assessor models reducing assessment delays • Rapid home adaptions and provision of equipment • Additional community response support for falls and mental health • Additional discharge support services including spot purchasing of care homes and early discharge support team	**Capacity** • Surge capacity plans in critical care and paediatric respiratory services • Risk assessed model for additional beds on wards (Boarding) • Community hospital bed pull model in place • Expansion of Ambulatory Care service models – Same Day Emergency Care and Direct Access clinics • Plans in place for change of use of planned care capacity • Additional body storage procured
Processing Power • Additional senior decision makers rostered to peak times • Pathways reviews of high-volume services for earlier preventative decision making • Criteria led step down and discharge models • Additional services at hospital front door- including pharmacy and therapies • Established nurse led frailty models • Patient safety events	**Focus** • Cross borough winter planning events- focussing on community response through Neighbourhood care Networks • Two hourly safety flow huddles • Day before discharge planning • Maximising workforce planning and rosters • Effective public communications campaign

Cyllid / Finance

The Health Board is not committing any additional spend to meet the costs of this plan. achievement of the actions set out will be met in line with current budget and savings plans. The only additional expenditure this winter is via the Regional Partnership Board, where slippage and non-allocated spend from the Regional Integrated Fund has been assigned to system resilience plans as set out in section 3.5. The table below provides the costs of individual schemes.

Whilst the Health Board is not committing any additional expenditure against this plan contingency surge planning is taking place should a scenario rise where this is required. Consideration is being given to reallocating resources in this scenario, but it remains a risk that additional expenditure on agency staff to meet demand may be required if the balance of safety demands it.

Gwent System Resilience Plan Health Board Schemes	Lead Provider	23/24 RPB Allocation £'000
SCTH Early facilitator discharge	ABUHB - CHC	255
Step Closer to Home	ABUHB - CHC	367
MH Practitioner & WAST Response	ABUHB - Corp	96
Same Day Emergency Care @ YYF	ABUHB - Medicine	630
CRT Pharmacy	ABUHB - PCCS	175
Health Board Total		**1,523**

Gwent System Resilience Plan Non-Health Board Schemes	Lead Provider	23/24 RPB Allocation £'000
Rebalancing Rights & Responsibilities	Central	70
Additional system capacity (excluding Home First)	LA	600
YYF Trusted Assessor - Stroke Pathway	LA	44
GWICES - Staff Support	LA	20
Falls Response	WAST	228
BRC - ED Resettlement	Third Sector	152
Hospital to healthier home - Staff Support	Third Sector	17
Non-Health Board Total		**1,131**
Total Gwent System Resilience Plan		**2,654**

Argymhelliad / Recommendation

The Board is asked to approve the Winter Plan for the 2023/24 winter period.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Choose an item. Choose an item.

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

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

Winter Resilience Plan
2023-2024

Version 3

Plan on a Page

<table>
<tr><td colspan="2">Winter 2023/24 The Challenge
A third to a half of health system beds occupied by patients with respiratory illness
Staff absence due to sickness and maintaining wellbeing of staff
Continuing implications of costs of living challenges
Maintaining quality and safety across pressured system
Financial savings required</td></tr>
<tr><td colspan="2">Meeting the Challenge
Across the Health Board, action in core programmes, in particular the Six Goals for Urgent Care, focuses on work which will meet the challenge of system pressure,.This plan describes additional activity, building on core programmes, for the winter period.</td></tr>
<tr><td>Partnership
Delivering preventative vaccination programme through primary care partners
Building on preventative programmes connecting citizens with support in their communities
Embedding trusted assessor models reducing assessment delays
Rapid home adaptions and provision of equipment
Additional community response support for falls and mental health
Additional discharge support services including spot purchasing of care homes and early discharge support team</td><td>Capacity
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Risk assessed model for additional beds on wards (Boarding)
Community hospital bed pull model in place
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Plans in place for change of use of planned care capacity
Additional body storage procured</td></tr>
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Pathways reviews of high-volume services for earlier preventative decision making
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Cross borough winter planning events- focussing on community response through Neighbourhood care Networks
Two hourly safety flow huddles
Day before discharge planning
Maximising workforce planning and rosters
Effective public communications campaign</td></tr>
</table>

Winter 2023/24 – Meeting the Challenge

- Utilising capacity effectively, prioritising ambulatory, preventative care and discharge from hospital, flexing resources as needed
- Working through partnership to support citizens in their communities
- Relentlessly focussing on quality and safety
- Delivering within current resources and seeking opportunities to improve efficiency

CONTENTS

1. Context

1.1 Introduction

This plan sets out how the Health Board, with partners, will respond to the challenges which will be faced by the care system over the coming months. Building system resilience is part of the core focus of the Health Board and activity in core programmes, such as the Six Goals for Urgent Care, as well as work through the Regional Partnership Board all support meeting the additional challenges of the period. Therefore, this plan should not be considered in isolation from the wider work programme of the organisation set out in the IMTP. Partnership, whole system working, and transparency will be essential in planning and meeting the demands that lie ahead.

The health and social care system continues to operate under sustained and significant pressure and continues to balance responding to urgent care demand with recovery and the tackling of backlogs for treatment.

Respiratory illness will again pose a threat this year with further anticipated waves of COVID-19, influenza and Respiratory Syncytial Virus peaking in December and early January.

Against the backdrop of persistent staffing deficits across the system, a growing cost-of-living crisis and potential industrial action, services across the region will be required to meet the health and well-being needs of both staff and the population in evermore complex and pressured circumstances. The financial challenge faced by health service cannot be ignored and the response to the challenges of winter cannot be met with traditional approaches to increasing staffing and beds if financial plans are to be achieved.

Within this context, this plan sets out the actions that will provide focus, enabling the processing power needed and considering best utilisation of capacity. In addition, it sets out work in partnership between health and social care through the Regional Partnership Board, to support the system and deliver preventative activity.

Importantly, this plan builds upon local urgent and emergency care plans, delivered through the Health Board's Six Goals for Urgent Care programme, which focuses upon enhancing capacity within the community and providing alternatives to admission.

It is frontline staff who will once again have to bear the challenge of meeting the needs of our citizens in pressured circumstances and this plan seeks to provide assurance to teams that we are doing all we can to support them in acting in the best interests of our citizens.

1.2 Planning Assumptions

Assumptions and planning scenarios for winter are provided by Welsh Government. Full national scenarios can be found here: [science-evidence-advice-winter-modelling-2023-2024_0.pdf (gov.wales)]

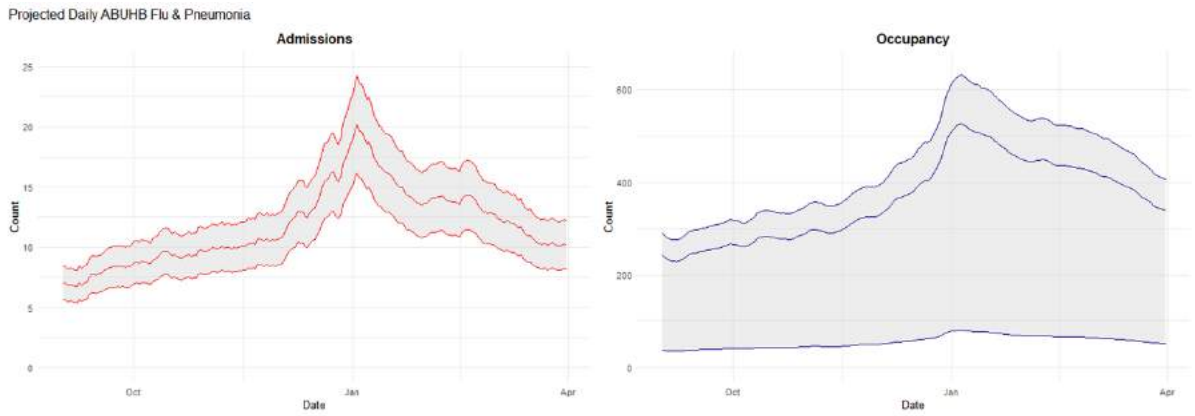
A summary of the modelling at a national level is provided below:

Top line summary - respiratory viruses modelling

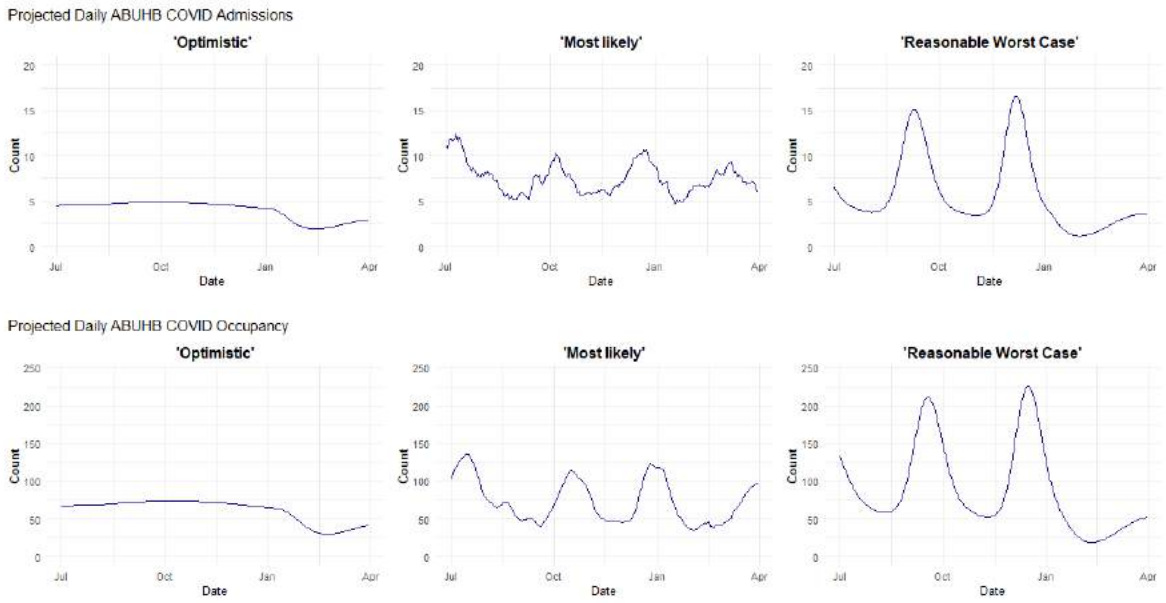
- Modelling scenarios for flu and pneumonia show daily admissions peaking at between 85 (scenario 1) and 125 (scenario 3) and occupancy peaking at 420 (scenario 1) and 630 (scenario 3).
- In scenario 1 for RSV, daily admissions peak at around 30 and occupancy peaks at 60, this scenario is for one large wave. Scenario 2 includes a smaller early wave and a larger later wave, admissions peak at around 10 (first wave) and 30 (second wave), occupancy peaks at around 20 (first wave) and 45 (second wave). As many RSV-related admissions are for short time periods (many less than 24 hours), occupancy peaks are almost simultaneous with admissions peaks.
- Modelling scenarios for COVID-19 were provided by Swansea University and include multiple waves. With the optimistic wave plateauing for most of the season and decreasing towards the end. The most likely scenario peaks every two-months. The reasonable worst case and COVID-19 urgent scenarios have 2 peaks occurring 3 months apart. For the most likely scenario, daily admissions peak at around 55 and occupancy peaks at around 645.
- Combined scenarios include flu and pneumonia, RSV and COVID-19. In the most likely scenario, daily admissions peak at around 145 and occupancy peaks at around 1,060. This compares to a 5-year average daily admissions peak of around 165 and occupancy peak of around 920. In the reasonable worst case scenario admissions peak at around 205 and occupancy peaks at around 1,690. The NHS in Wales has around 10,300 beds so this would represent around 10-16% of beds occupied due to winter viruses.

Taking these assumptions and applying to the Health Board population provides scenarios for planning. Flu & Pneumonia admissions are projected to increase gradually from 5-10 daily admissions in the early autumn, reaching 10-15 by December with the anticipated peak at the beginning of January expected to be 15-25 daily admissions. This will come down to 10-15 in February but will reduce much more gradually to 7-12 in April.

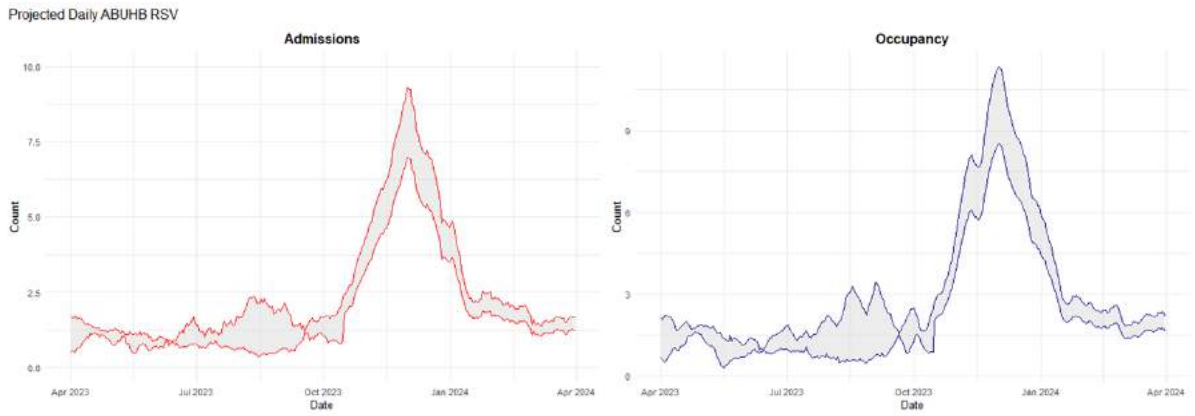
The occupancy projection corridor between given scenarios ranges from 50-300 in early autumn to the peak of 100-620 in January. The reduction in occupancy is expected to be gradual and range from 50-400 in April.



The most likely level of covid admissions to ABUHB is expected to be in the region of 5-12 patients per day. The worst case scenario sees this being in 2 large peaks, once in mid-September, which we have passed, and a second slightly higher peak in December reaching 17 patients/day. COVID-19 Occupancy is expected to be 50-120, with the worst case again having 2 large peaks where COVID-19 occupancy would reach a high of around 225 beds. The optimistic scenario is a steady stream of 2-5 COVID-19 patients.



RSV admissions are projected to be around 1 patient per day until mid-October when they will begin rising until early December. 7-10 RSV admissions are expected at the peak. The peak falls just as sharply and numbers return to around 1-2 per day in mid-January. Occupancy is expected to be 8-12 beds each day at the peak, and 1-2 after mid-January.



It is worth noting that the majority of staff in the health and care system are drawn from the local population so it is likely that staff absence will increase in line with peaks in respiratory illness. A 10% absence assumption has been used as the basis for planning.

The health and social care system heads into winter facing complex and interrelated challenges, which have persisted since the last winter season, all of which impact upon maintaining patient quality, safety and experience, staff morale and maintaining effective flow across the system.

- There are significant staff shortages across social care and particularly in the domiciliary care market leading to deficits in the number of packages of care available to meet demand
- There are significant staffing and capacity challenges across our community services including reablement and occupational therapy, resulting in delayed discharge
- There are approximately 300-350 medically optimised patients in our hospital beds at any one time, with discharge dates that are delayed for a number of reasons
- People are waiting longer than we would like to be seen and treated in our Emergency Departments
- Many of the hospital sites remain in surge capacity since last winter and are reliant upon locum and agency staff, impacting upon sustainability of services
- High levels of patients requiring enhanced care is driving up staffing demand across our hospital sites
- Medical rotas are fragile, and we are recruiting to safe staffing levels
- Services are highly reliant on agency and bank for registered nurses and health care support workers to maintain safe staffing levels across our sites
- Many GP practices are experiencing significant workforce sustainability challenges, impacting upon access
- Many people are waiting longer than we would like to receive their planned treatment

The context set out here represents a significant challenge ahead and we should not underestimate the task before us this winter.

This plan aims to focus additional targeted action towards these complex challenges to ensure services can be sustained to meet the needs of our population. The Health Board is not proposing to provide any additional medical beds in the final quarter on the year.To meet the financial and workforce challenges the organisation is seeking to bring its bed base backing into the original planned and funded footprint of the Clinical Futures model. This means that meeting the challenges set out above must be in a different way, delivering on existing programmes, preventing deterioration of illness, building community resilience and maximising flow through the system.

2. Principles for Winter

Reflecting on the plan from the last winter period and the evaluation provided to Board in July 2023, this year's plan focuses on deliverable action and building on evidence based interventions.

For operational planning these are three core principles:

- Focus – Communication, Tracking, Escalation and Intervention
- Processing Power- Proactive decision making both clinical and non-clinical
- Capacity- utilising effectively

In addition, proactive health protection work in the form of the vaccination programme and communication is underway. Partnership work via the Regional Partnership Board System Resilience plan is also supporting delivery.

Focussing on these principles will ensure that we target the areas of greatest challenge and provide the best opportunity to ensure people access care and support in the right place, first time, whilst optimising effective flow through the system, enabling us to protect elective capacity whilst being able to respond flexibility to surges in urgent care demand.

The following sections outline the plan and key actions aligned to each of these principles.

Traditionally the seasonal pressures of winter are addressed through the creation of additional capacity and workforce expansion. The sustained pressures experienced in social care, urgent care and the necessity of the recovery of planned care and essential financial savings means there are limited opportunities to expand the workforce further.

3. Resilience this Winter

3.1 Prevention and Health Protection

Winter Respiratory Vaccination Programme

An effective vaccination programme is the first line of defence in protecting the population from COVID-19 and flu.

Given that Gwent could see much higher or unseasonal activity and expect to see flu and COVID-19 both circulating, achieving high vaccination uptake is an important priority this coming autumn/winter.

There is likely to be a substantial amount of co-administration for eligible groups in general practice as they deliver the autumn COVID-19 booster and flu vaccination programmes together. This will happen where it is expedient for the practice to do so, rather than it being a mandated requirement within the contract. This approach will also be offered to staff where possible.

Monitoring the delivery of Flu vaccination in Primary Care is overseen by the ABUHB Community Flu Group and by locality leads using the Influenza vaccination online reporting system (IVOR). Monitoring the delivery of COVID-19 vaccination remains the responsibility of the ABUHB Vaccination Programme Board who in turn, report to progress to the Winter Respiratory Campaign Group as part of the Vaccine Programme Wales (VPW).

a) COVID-19 Booster Programme

The aim of the autumn booster programme is to boost the immunity of those at higher risk from COVID-19, improving their protection against severe illness and to protect the NHS over winter 2023-24. The ambition is to achieve 75% uptake overall among all eligible groups.

Our vaccination programme commenced on the 11th September. In line with advice from Joint Committee on Vaccination and Immunisation (JCVI) and the UK Health Security Agency (UKHSA), Welsh Government guidance as set out in the Covid-19 vaccination delivery plan WHC 2023 (029) for Wales is as follows:

Welsh Government milestones	**Deadline**
First vaccines administered	11th Sept 2023
All first offers of vaccination to eligible groups	30th November 2023

Main campaign period complete	17th December
No-one left behind campaign end	March 31st 2024

The eligible groups this autumn are:

- residents in a care home for older adults
- all adults aged 65 years and over
- persons aged 6 months to 64 years in a clinical risk group, as defined in tables 3 and 4 of the COVID-19 chapter of the Green Book
- frontline health and social care workers
- persons aged 12 to 64 years who are household contacts, as defined in the Green Book, of people with immunosuppression
- persons aged 16 to 64 years who are carers, as defined in the Green Book, and staff working in care homes for older adults

The number of residents in the ABUHB area eligible for vaccination as part of the autumn booster programme 2023 is around 260,000. The implementation plan is dependent on vaccine supply, staff resources and any unplanned requirement to surge during the autumn/winter period. The scheduling of invitations is based on priority group and interval since last vaccination.

The autumn booster programme will be delivered through a blended model of Vaccination centres (VCs), Primary Care, Locality District Nursing teams and Vaccination mobile teams vaccinating in care homes, the community and through dedicated outreach services.

Those at greatest risk have been prioritised. All older adult care home residents were visited within the first weeks of the programme starting. This focused effort was successful during the spring booster delivery and has been repeated for the autumn. Eligible Gwent residents that are deemed housebound will be offered the autumn booster vaccination at their home by either the mass vaccination mobile teams or the locality nursing teams, identifying those patients from a district nursing caseload. The Vaccination Service mobile teams will also be responsible for other enclosed settings and will provide in-reach and outreach services with dedicated clinics for vulnerable groups and hard to reach communities.

Detailed implementation and workforce plans are in place, and weekly meetings are established to monitor delivery.

Should eligibility criteria change or there is a requirement to surge vaccinations in response to new variants, plans are in place to deliver population vaccinations based on the experience of the booster programme to date.

Flu Vaccination Campaign

Children under the age of 5 years have the highest hospital admission rates for flu compared with other age groups. Not only does the flu vaccine protect the children themselves, it also reduces the spread of infection by helping to protect family members, particularly elderly relatives, and others in the local community.

The vulnerable populations most at risk of adverse outcomes resulting from influenza are those 65 years and over and those in at risk clinical groups. However, there are specific cohorts, particularly vulnerable people in enclosed settings such as residents in care homes or patients in hospital, where the impact of flu is greatest.

The Primary Care and Community teams deliver the flu vaccination programme to the public, and an outline of their plan for each cohort is included within the table below. Mop up sessions through the vaccination service will also be offered following the success of this the previous year where both pre planned appointments and walk ins were offered through the centres as the season progressed.

Cohort	Plan
2–3-year-olds	A NCN led pilot has been set up in Blaenau Gwent, to offer Fluenz to 3-year-olds in nursery settings. Part of the pilot includes the use of e-consent forms. Based on the initial returns of e-consent forms, it is likely that the uptake will double compared with last year. Mop up sessions will be offered through the vaccination service towards the end of the season as needed
Care Homes and Social care staff	This year an agreement has been reached with community pharmacy to offer staff vaccinations on site within care homes. Shackleton's Pharmacy have offered vaccinations visits to all care homes in Abergavenny and Blaenau Gwent , Also in Blaenau Gwent, another new model for offering vaccination to domiciliary carers

	alongside staff working in a local authority residential home is being trialled.
Pregnant Women	Vaccination supply has been arranged to enable the offer of flu vaccination at ante-natal clinics. A new social media campaign has also been launched specifically targeting pregnant women. A new digital patient record system has been rolled out that enables real time access to maternity records for pregnant women. The system allows push notifications that are currently being used to share UKHSA information about covid and flu to users. For those with hand help notes will have links provided to Healthier Together webpages and printed resources given during ante-natal appointments
COPD Patients	This cohort will be primarily offered vaccination through primary care. Domiciliary appointments will be offered via the vaccination service towards the end of the programme if required.
School Nursing Flu	A well-established flu programme is delivered through the school nursing teams to offer Fluenz to children on site during school hours. A change this year includes the automatic signposting for absent and unwell children to ABUHB vaccination service that will offer appointments through the vaccination centres as needed. Walk in appointments will also be offered as the season progresses E-consent has been used for the second year following some improvements in the process and already a good response rate has been seen.

Staff Vaccination Programme

Vaccination of health and social care staff will protect themselves and the people they care for. Vaccination coverage amongst staff will also help ensure business continuity over the Winter by reducing staff related illness. Protecting our staff is of vital importance.

COVID-19 vaccinations for frontline staff will be offered through our Vaccination Centres and coadministration of flu vaccines offered at the same appointments where vaccine is available. Staff flu vaccines will also be offered via Flu champions, Occupational Health, and pop-up clinics at large scale staff events. Following the success of last year, Vaccination centres will offer walk in appointments towards the end of the year for both COVID-19 and Flu.

Uptake rates will be monitored weekly and Outreach clinics will be targeted at low uptake areas. Activity will be monitored weekly.

Meeting the Operational Challenges

As set out in the context section of this plan, the respiratory challenge could see between one third and half of the organisations total bed base occupied by patients with a respiratory illness. Meeting this challenge will not be achieved with additional resources. Learning from 2022/2023 demonstrates that it is not possible to recruit significant additional staffing for seasonal periods. The Health Board is also planning to bring its bed base back in line with the Clinical Futures model to improve quality and reduce cost. The Health Board will need to be proactive in working with partners to prevent admissions and make effective use of existing capacity to optimise the system for winter.

For operational planning these are three core principles:

- Focus – Communication, Tracking, Escalation and Intervention
- Processing Power- Proactive decision making both clinical and non-clinical
- Capacity – utilising effectively

Schemes set out below will be met within existing budgets and no further funding has been provided for winter unless specified.

3.2 Focus

Focus – Communication Tracking Escalation and Intervention		
Action	**Ambition**	**Anticipated Impact**
Two hourly safety flow meetings	Focussed discussion on clinical quality, staffing challenges ambulance handover and bed availability to enable quick coordinated response	Fast identification of concerns and delays to enable proactive rapid response

Primary and Community Care Division provide a 'day-before' discharge profile	The aim of this guidance is to support colleagues to understand both how and when extra capacity / boarding space can be utilised in a timely, risk-assessed and a controlled manner, to minimise impact and risks to individuals' (staff and patients) safety and our patients' experiences. The PCC Division provide a 'day-before' discharge profile; this should enable early moves the next day and provide early capacity to support system de-escalation, especially when the Grange University Hospital is reporting a Level 4 escalation and high-risk profile.	Support safety flow through the Health Board.
Provision of daytime Urgent Primary Care (YYF)	Realigning the workforce to provide daytime urgent primary care model in YYF Nurse Practitioner led Urgent Primary Care base at YYF, providing integrated front door, launches Monday 6th November.	Integrated approach to care and to ensure the correct pathway for patients.
Coordination in community via Pan borough winter pressures events	Coordination of local actions and signposting via community connection services Communication point for integrated services Coordination with third sector of local support for citizens	Wider awareness, sharing data & information and signposting

3.3 Processing Power

Processing Power – Proactive Decision Making both clinical and non-clinical		
Action	**Ambition**	**Anticipated Impact**

Pathways reviews underway: Head Injury / falls / mastitis / peri-orbital / respiratory	These pathways are being reviewed and inclusion / exclusion criteria examined to guide on pathway viability and pathway navigation options. The Head Injury pathway is being prioritised, especially in consideration of patients who are prescribed anticoagulation therapy their subsequent referral or intervention options for a tertiary centre as opposed to the GUH. This may dictate where patients are signposted going forward, i.e., if they could be more appropriately managed at an alternative site to the Grange Hospital given the availability of Computerised Tomography functionality and availability.	Fewer admissions to the Grange University Hospital for high volume pathway and greater consistency in care. These pathways are being reviewed and inclusion / exclusion criteria examined to guide on pathway viability and pathway navigation options.
Implement Computed Tomography Coronary Angiography pathway for chest pain patients	Revised pathway for chest pain patients	Consistent and defined pathway of care
Fracture Neck of Femur (NOF) Pathway working group	Ensuring appropriately trained staff are available in and out of hours including additional training for night time practitioners	Trained staff 24/7 to support the NOF pathway.
Elderly Frailty Unit front door in Royal Gwent Hospital	Nurse led Acute Frailty Response Model being scoped that aims to provide extended Community Resource Team in-reach at front door.	Improved pathways of care and reduction in unnecessary admissions to Royal Gwent Hospital amongst frailty cohort. Contribute to improving demand and patient flow at the front door and beyond.

		Reductions in lengths of stay and associated effects of deconditioning.
Therapies at the Front Door (7 days) at GUH Community Admission Avoidance Therapies Team	Undertake prompt initial therapy focussed proportionate assessments and interventions at ED and associated short stay units and where necessary and appropriate, to refer onto health, social care & third sector community support services to facilitate a safe and timely return home for the individual.	In Quarter two this service achieved 58.4% of those assessed were discharge home to usual place of residence with 84.4% of those discharged returned home same day/within 12 hours from nearly 500 referrals.
Mental Health Vehicle and Practitioner	Dedicated vehicle for MH&LD patients. Go live end of November with deployment criteria & link into 111 press 2. Funding via Regional Intergrated Funding as set out in section 9.	10% of WAST calls are Mental Health related therefore this initiative will release capacity for Emergency Ambulances, paramedics and within the Emergency Department
Grange University Hospital Pull Pilot – Care of the Elderly and Community Hospital Doctor and Advance Nurse Practitioner to assess, review and identify patients suitable for timely and appropriate transfer to a Community Hospital	Assess patients 24-48 hours post arrival and transferred appropriately to: home, community hospitals or eLGH in a timely way and based on their needs. Reduce the number of palliative patients unnecessarily at the Grange Hosptial, to enable them to be cared for at or as close to home as possible. To raise awareness of clinical/frailty/COTE services available across Community Hospitals amongst Grange Hospital colleagues.	Patients are transferred to the right place first time based on their needs. Reduce the risk of readmission to the Grange University Hospital from a community hospital. Reduction in length of stay and risk of deconditioning.

Develop a nurse and therapist led Acute Frailty Response 'in reach' Team at the Grange University Hospital.	Nurse and therapist led team, with virtual support from a Community Resource Team medic, to provide same day review of patients who present at the Grange University Hospital front door to prevent admissions and support the formulation of plans to optimise patient flow.	Reduction in unnecessary admissions to GUH amongst frailty cohort, with an increased number receiving support at home. Contribute to improving demand and patient flow at the front door and beyond. Reductions in lengths of stay and associated effects of deconditioning.
Urgent Primary and Community Care (UPCC) Maximisation	Trial for all care home Welsh Ambulance Service Trust presentations to go via UPCC for GP assessment. Flow Centre will escalate all Care Home calls from Primary Care to Flow Centre Nurse – Effective from 1st November to consider Frailty Referrals.	Patients are transferred to the right place first time based on their needs.

3.4 Capacity

Capacity – Utilising Effectively		
Action	**Ambition**	**Anticipated Impact**
Community Hospitals guidance with extra capacity / boarding space – risk assessed	Agreed Standard Operating Procedure and guidance in place for risk-assessed boarding (additional bed) decisions. In accordance and in parallel with the ABUHB Full Capacity Protocol, the Primary Care and	Additional capacity when appropriate.

	Community (PCC) Division role in supporting the dynamic de-escalation of ABUHB system-wide pressures is pivotal, by utilising extra capacity and when required, identified boarding space across Community Hospital sites.	
Improve current medical throughput of the Grange University Hospital Same Day Emergency Care (SDEC)	Continue reviewing patient cohorts for suitability for SDEC or ambulatory care services	By widening access through criteria and condition this will reduce the number of patients admitted
Hot slots in clinic (direct access to Gwent Rapid Access Care of Elderly clinics from flow centre)	Not previously possible to refer directly to Gwent Rapid Access Care of Elderly, referrals were primarily via consultant connect	Improve consistency of patient volume by enabling additional referrals directly via the Flow Centre
Implement urgent service change in stroke reconfiguration – November	Implementation by end of November	Defined and centralised pathway of care for stroke patients to safeguard quality
Body Storage - Additional capacity for 58 storages will come online in December	Temporary mortuary capacity procured in line with modelled demand forecast storage Care after death team procedures being implemented • Team assertively managing LOS • input into Local Resilience Forum	Mitigate anticipated increase in demand for body storage
RSV Surge Plan	Capacity: RSV surge: plan in place for 20% and 50% (20%= <4 beds, 50% = 8 beds) increase in paediatric respiratory capacity.	Plans set for managing Paeds surge.

Planned Care Capacity

It is recognised there may be times where escalated action is required and decisions may have to be made in relation to the balance of risk between urgent and planned services. To support this, operational escalation plans are in place and a full hospital protocol is in place alongside clear processes for decision making should this be needed. The Health Board recognises there are significant waits for some planned care services and as far as possible the organisation will seek to protect elective capacity, using the benefits of the model of hospital care to maintain separation from respiratory flows.

Patient Safety Events

Patient Safety Events have taken place at Royal Gwent Hospital, Ysbyty Ystrad Fawr and St Woolos with the aim of identifying patients who are medically fit and ready for discharge, thereby promoting the 'home is best ethos' and also releasing much needed acute beds for the Health Board.

- **Background** – These events are important because we know that delays in patient discharge will increase the risk of patients deconditioning in hospital, with increased risk of infection, falls, etc. This concept brings together a multidisciplinary team to identify what is stopping the patient from going home or moving onto the next stage in their care. This work has been developed as part of the Urgent Emergency Care, Six Goals programme of work.
- **Approach** – A multidisciplinary team (medically led) was identified who work closely with local authorities and community partners to ensure the best outcome for those patients identified as medically fit. After each event follow up actions are taken to ensure agreed steps are progressed and patients are discharged to the next stage in their care.
- **Lessons Learned** – there have been lessons learned along the way and the approach has been adapted as the events have progressed. One of the main benefits is that the Teams have become more aware of what services are available, particularly in the community and how to access them. Engagement with family is another key area, which can facilitate early supported discharge and these areas will be developed going forward.

The safety events will be refined further with a plan to run patient safety events routinely to ensure flow over the winter months when we know demand is much higher.

Surge Capacity

Whilst the Health Board is not planning to surge proactively additional medical bed capacity in this winter period it is prudent to have plans in place should this be needed. The Operations Team is working in collaboration with the Divisions and Workforce colleagues to identify backup surge capacity to mobilise as a last resort. This will involve looking at converting planned care beds to beds for medical patients if the demand arises. These plans are being developed in the line with the data currently available.

3.5 Working in Partnership

Regional Partnership Board System Resilience Plan

As with the core Health Board activity, work across regional partnership supports the health and care system to be more resilient all year round. Actions funded through Regional Integrated Funding (RIF), joint work in community care and mental health partnerships will all have an impact in the winter months. The RPB System Resilience Plan focusses on additional activity which can be taken to support further resilience in the next period. The RPB undertook an evaluation of the winter plan in 2022/23 and used the findings to inform this year's plan.

Priorities, reflected below, were endorsed by Gwent Regional Partnership Board at the July 2023 meeting (when the evaluation was considered). Planning associated with the priorities relates to activity that could be repeated from previous successful winter initiatives as well as opportunities to scale good practice and successful activity within existing strategic programmes were considered. GASP take overall responsibility for developing the System Resilience Plan and a workshop was held in September to consider the learning from the evaluation work to shape regional priorities to aid system resilience.

A summary of the proposed activity to address the system resilience priorities is provided below. Funding for these schemes is met by unallocated provision in the Regional Integration Fund. One of the key lessons from 2022/23 was the inability to recruit and sustain projects on a short term funded basis. Therefore, as the emphasis is on system resilience, not just resilience for winter, schemes have been funded for an 18-month period with a mid-point review in April 2024.

Plan Priority	Activity	Anticipated Impact

Education and engagement	A working group to be established with a focus on robust and ongoing comms and engagement plan: externally facing to individuals and the public, and internal to partnership organisations for professionals working within the system. Currently discharge planning is not included as part of graduate programme curriculums; with annual in-take of graduates into the health and care system, GASP recommend engagement be undertaken with education providers to ensure messaging and curriculum content reflect the learnings of the rebalancing rights and responsibilities training.	Staff awareness of pathways and system resilience initiatives to avoid confusion. Medium to longer term engagement with graduate programmes will ensure new staff to the sector have strengths-based approaches at the core of professional practice, with the anticipated benefit of reducing the number of formal assessments required to leave hospital/remain within the community.
Clear roles and responsibilities for dedicated discharge resource	**Rebalancing Rights & Responsibilities** Implement a training and mentorship programme (learning from the success of the pilot approach during COVID-19); the programme will enable a cultural shift across health and social care, ensuring the right conversations are held, by the right individuals and barriers removed. This approach will also aid the review of D2RA implementation plan in the context of partnership discharge roles, and responsibility for identifying and pulling patients via D2RA pathways.	

	British Red Cross – ED Resettlement Project overview: Building on the success of the pilot within the winter 2022-23 plan, expanding BRC capacity within the ED and integrating additional non-emergency ambulance transport with stretcher capacity for improved care and flexibility	The efficiency gains of the integrated service of expanded capacity in ED Wellbeing and Home Safe (ED WHSS) and Patient Transport are expected to persist, contributing to smoother hospital operations, supporting early discharge and patient flow. ED WHSS will realise benefits from the 01/12/23, with a benefit target of 4000 individuals supported per month.
Implementing Trusted Assessor functionality across the system	**Care & Repair: Hospital to healthier home Project overview:** The H2HH project in Gwent offers rapid home adaptations for elderly patients leaving the hospital due to housing issues. It seeks to expand support and secure flexible funding for complex cases, aiming to enhance patient independence and reduce readmissions. Population group: Older people (60+) 50+ if living with sensory loss. This initiative can be part-enabled by minor capital funding. **YYF Trusted Assessor – Stroke Pathway** This will have maximum impact on the population as stroke services including rehab will be provided at YYF, in addition Caerphilly residents are likely to be cared for in hospitals outside YYF due to the ring fencing of the beds for stroke survivors. Caerphilly will dedicate a Social Work Assistant role to these beds to screen gather information etc for all the other local authorities, this	The H2HH project will support 50 individuals monthly, with a primary focus on expediting rapid adaptations for safe hospital discharge within 2-3 working days. The project will support 55 stroke ring fenced beds in YYF for all Gwent; the Trusted Assessor will work on behalf of all 5 Local Authorities to support assessment of patients within the stroke pathway.

	will work on a trusted assessor basis to share information and facilitate discharges on behalf of all Gwent local authorities.	
Preventative Community Capacity	**CRT Pharmacy** The project provides medicine reviews, medicine deprescribing, home visits and discharge planning. This application proposes expanding the service from 3 counties to the whole of Gwent and developing the service to take on responsibility for providing pharmacy services on wards in County and Chepstow Hospital sites which will positively affect patient flow and discharge. It will also deliver home visits to frail elderly patients identified through HRAC criteria in collaboration with GP practices. Population Group: Older People including Frailty / HRAC and 'at home IV service' **Falls Response** The Gwent Falls and Frailty Response Service (FFRS) has been operating since 2016; the additional funded activity will enable expansion and scaling of the proposal will support 1,000 Rapid Medical / Nursing / High risk cohort patients and an additional 100 Reablement patients per annum when operational If this model operated from November 23- March 25-it would operate for 517 days Priority Ambition Activity Anticipated Impact service	The proposal will support 1,000 Rapid Medical / Nursing / High risk cohort patients and an additional 100 Reablement patients per annum when operational If this model operated from November 23- March 25-it would operate for 517 days and see a total of 2,068 patients Based on analysis, approximately 27 patients per month could be supported.

	offer to enhance the capacity within the team, source an additional vehicle to provide increased regional coverage, as well as a dedicated nighttime Falls Assistant service provided by St John's Ambulance. This would further improve availability and response times and reduce the impact of long lays. Population Group: Predominantly those patients age 55+, however, all patients aged over 18 can be attended if required. MH Practitioner & WAST Response Project overview: Mental health calls represent around 10% of total ambulance service demand in the UK, and that these calls are often more complex, take longer to resolve and are a significant challenge to the generalist workforce. WAST's data shows that when an ambulance is dispatched to a mental health call, the majority (circa two thirds) of these patients will be conveyed to an emergency department. This project will aim to prevent and mitigate these kinds of conveyances and provide support at the point of need in the community. Population group: Adults with mental health concerns.	
Alternative capacity to support discharge	**Additional system capacity (Including Home First)** This proposal is to extend service provision to include weekends, to allow for 7 days working, including	It is anticipated that this ringfenced resource will prevent a reduction in core offer provision during periods of staff shortages, and increase weekend capacity during periods of high demand. Benefits include: LOS reduction

	Home First. Population group: Primarily Older People **Step Closer to Home** The SCTH scheme offers a range of alternative pathways to facilitate discharge from hospital for patients waiting for the next step of their recovery. Learning from continued delivery this iteration of the SC2H model with have 3 pathways: 1. Spot purchasing of care home beds to facilitate discharge 2. Discharging via the New Directions care run in Caerphilly (supporting patients to return to their own home) 3. Facilitated Early Discharge; dedicated capacity to enable discharge to a person's own home with health support to rehabilitate. Population group: All ages, although predominantly older adult. GWICES Project Overview: GWICES is an equipment service established in 2009 to modernise and integrate equipment prescription across Health and Social Care in Gwent. In winter, there is an increase in demand for equipment due to increased hospital admissions and discharges, frailty and need in the community. Population Group: Children and Adults (including disabled people) / medical conditions (perm/temp) This initiative can be enabled by minor capital funding. SDEC at YYF Providing Same Day	Prevent deconditioning/ maintain independence Acute hospital bed capacity 60 additional people per month will be supported It is anticipated to achieve up to 360 patients per month

	Emergency Care at YYF was tested and positively evaluated within the 2022-23 winter plan, supporting the priorities of the Health led Urgent and Emergency Care Programme. Given the benefits to system resilience, SDEC at YYF is included within the partnership system resilience plan for 2023-24 to provide support during the winter period. However, medium to longer term sustainability (2024-25 and beyond) for this initiative will be a requirement for ABUHB to consider.	

4. Workforce

The system is about to enter another winter with greater health and care needs within the population. Despite some success with recruitment and retention campaigns this year due to local and national skills shortages challenges are still being experienced with vacancies and higher than anticipated levels of staff absence. The actions within the Health Board People Plan 2021-25 will be expedited; and support our partners in delivery of the Gwent Workforce Board programme of work.

This section of the plan assesses the key challenges facing the healthcare workforce and actions being put in place to support staff wellbeing, recruitment, and retention throughout winter period and beyond.

4.1. Workforce Challenges

Recruitment and Retention

Despite successful local and overseas recruitment campaigns for Registered Nurses and HCSWs over the last 12 months, the Health Board continues to report a high number of vacancies. Recruitment campaigns continue across all staff groups. All opportunities to attract and retain staff are used. Our priority will be to continue to recruit to vacancies rather than have a reliance on agency workforce recognising the impact that this will have on improving staff and patient experience.

As of September 2023, there are 64.1WTE senior medical posts vacant and 54WTE junior doctors posts out for advertisement. In November, the Health

Board will participate in an All-Wales overseas recruitment campaign to Kerela, India to scope recruitment opportunities for tier 2 doctors.

The Nursing Strategy (2023-26) outlines a variety of recruitment initiatives including 74 overseas nurses which have been appointed. 68 have started work for the Health Board with 39 attaining their OSCE to work as a band 5. These nurses will commence into the rosters from December onwards to support winter staffing.

A centralised HCSW recruitment programme has been piloted in Medicine since August 2023 to fill vacancies and to stay on top of monthly turnover. This has expanded to MH&LD and Scheduled Care for September and October respectively. This programme will be developed to continue to reduce vacancies over the winter period.

Pharmacy is also experiencing high vacancies and an inability to recruit to key posts. There is limited supply of locum and agencies for this workforce. Student recruitment has supported a reduction in therapy vacancies, although several key posts remain vacant along with a number of specialist posts. Therapies are currently supporting additional inpatient capacity and increasing bed capacity further will necessitate the prioritisation of services.

Retaining staff is one of the most important factors for the organisation to deliver care. A retention programme has been implemented over recent months, current turnover is 9.58% compared with 11.47% last year and is still higher (0.5%) than pre-pandemic levels.

The proposed interventions over winter will focus on what people find most rewarding in their roles and what the issues are that make them want to leave.

- Continue to undertake a range of organisational wide retention engagement events.
- Organisational recognition strategy to be launched later this year.
- Review and implementation of policies to support staff work in a more flexible way.

Volunteers

Volunteers are a significant part of the workforce. The organisation will continue to increase this potential through development of new promotional materials and working with careers Wales, public engagement events, education providers and provide volunteer training for a wide range of students, a number of which have already commenced activities on the wards.

Absence

The 12-month accumulative sickness absence rate was lower than last year at 6.38% in September 2023 compared with 6.91% in September 2022. However, this equates to 809 WTE staff lost per month through sickness absence.

Higher levels of absence over the winter period are predicted with sickness absence peaking at 7.8% in December. Based on current sickness levels at 6.5%, the same position as last year and we would expect winter sickness absence rates are predicted to be similar to the previous year. This will require the Health Board to engage temporary staffing solutions through bank and agency staff. To continue to support reducing the reliance on agency staff the following actions will be used to mitigate the effects which are supported by the Variable Pay Reduction Group:

- Plan for early sign off of rosters through the winter period
- Continued support for improving rostering practices
- Continued engagement with bank staff and on- contract agencies
- Resource Bank opening hours 8am to 8pm

Absence relating to stress, anxiety, and depression represent 29% of total absence. The Employee Wellbeing Service has experienced a consistent demand for individual psychological support over the past 10 months with on average 51 staff referrals each month.

Supporting employee wellbeing over the winter will continue to be a priority. The Employee Wellbeing Service and Organisational Development will continue to host evidence-based initiatives that contribute to improving and protecting staff biopsychosocial wellbeing across the Health Board. These include Schwartz Rounds, Taking Care Giving Care Rounds, Peer Support (In Maternity), Psychological Debriefing post SUI, bespoke Team resources, Psychological First Aid (in MH&LD), Psychological Safety Training and Human Factors based training (Theatres). To bolster the capacity of the Wellbeing Service (Psychological Therapy Service) over winter there is also an ambition to secure a 12-month contract with an external employee assistance programme.

In addition, creative mindfulness classes have also started in GUH and YYF following successful Arts Council Bid, and an organisational staff recognition strategy is being drafted to develop the culture of gratitude and thanks amongst employees.

Additional occupational health capacity has been secured to support reducing wating times and ensure staff have access to occupational health advice to enable them to stay well or return to work. Regular staff communication and initiatives will be published before and throughout winter, promoting ways for staff to remain well during the winter months. It is acknowledged that respiratory related infections rise throughout

winter, and we are working with staff and managers to ensure there are options for staff who feel well enough to work to do so, even if this means in a slightly different role (e.g. non-patient facing); this is in line with national COVID-19 absence management guidance.

Financial wellbeing and the impact of the cost of living will continue to affect staff this winter. A comprehensive compendium of services which include a range of support has been completed including signposting to existing bureaus such as Citizen's Advice who can provide information regarding grants and support for those struggling with energy and utility bills.

4.2 Other pressures

There are a number of pressures which are also impacting staff or an ability to resource services:

- The BMA have confirmed the date of their industrial action ballot for Junior Doctors. This will open on Monday 6th November and close on Monday 18th December. They have announced that if they receive the necessary strike mandate, then Junior Doctors will be asked to strike for 72 hours. In terms of compliance with notice periods set out in the Labour Relations Act 1992, this could mean that strike action could take place in January. There is no update yet in respect of ballot dates for Consultants or SAS Doctors. The impacts of junior doctor strike action will result in consultants providing essential junior doctor resulting in wide medical cover system pressures.
- A workforce modelling exercise has been undertaken to assess workforce supply and demand in key workforce groups over the next 12 months which demonstrates that meeting the workforce demand will be extremely challenging due to current vacancies, increasing absence over the winter periods (in accordance with epidemiology predictions).

5. Winter Communications and Engagement

Throughout the Winter 2023/24 period, communications activities with staff, the public and will be strengthened partners. The Health Board will continue to lead the way on the use of Digital Communications, as well as more traditional methods of sharing important messages, to ensure widespread coverage of the population we serve. Our plan will link with the Health Board's Communications and Engagement plans covering the following areas:

- Clinical Futures
- Primary Care
- The Health Board's IMTP

• Six Goals for Urgent and Emergency Care
• The Welsh Government's 'Help Us To Help You' campaign
• The national 'Think 111 First' campaign

The Winter Communications and Engagement campaign will align with the Six Goals for Urgent and Emergency Care and include a particular focus on accessing the right healthcare services and celebrating our staff. The organisation will inform and engage people on the correct mitigation of the configuration of NHS health services in the Gwent, as well as promoting the national Help Us Help You campaign.

The activities of theHealth Board's Communications and Engagement Team will include:

- The launch of a new online direction tool for both staff and the public, with specific information relevant to the Gwent model of healthcare (providing an anchor point to our communications and engagement);
- A poster campaign to help local people make the 'Right Choice' when accessing services;
- A campaign through Health Board channels and local media to raise awareness and promote our work to discharge patients from hospital as quickly as possible;
- Live update videos and social media broadcasts from clinicians;
- Increased face-to-face and digital engagement with local people;
- Improving the health and wellbeing of residents through our Population Health communications and engagement;
- Ensuring our staff are well informed and supported in their roles; and
- Responding to comments and concerns, helping and reassuring people throughout the winter period.

The Communications and Engagement Team will continue to invest a significant amount of time in co-ordinating and responding to patient and public approaches on a day-to-day basis.

The Health Board will continue to hold engagement events around Gwent to enable the organisation to speak directly to residents and seek their views. Any feedback given will be recorded by Engagement Team and fed back directly to the Health Board through a reporting system. Details of engagement events are published and shared beforehand to ensure local people in each area are given the opportunity to come along and speak with us face-to-face. This will help to build mutual understanding and relationships with the communities

The organisation will continue to work with different partners and diverse communities to develop initiatives to engage with all communities. Meetings will take place at regular intervals throughout the winter period to ensure that key Health Board messages are delivered and shared.

6. Infection Prevention and Control

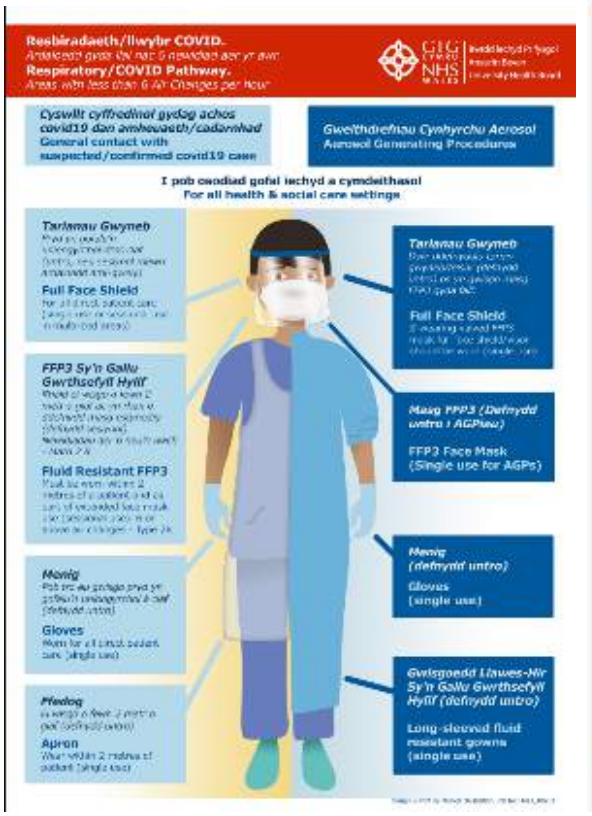
The Health Board has in place robust processes to respond the challenges of managing respiratory infections. The organisation is following national guidelines set out by Welsh Government and Public Health Wales Advice on respiratory viruses including COVID-19 for staff in health, social care and special schools | GOV.WALES.

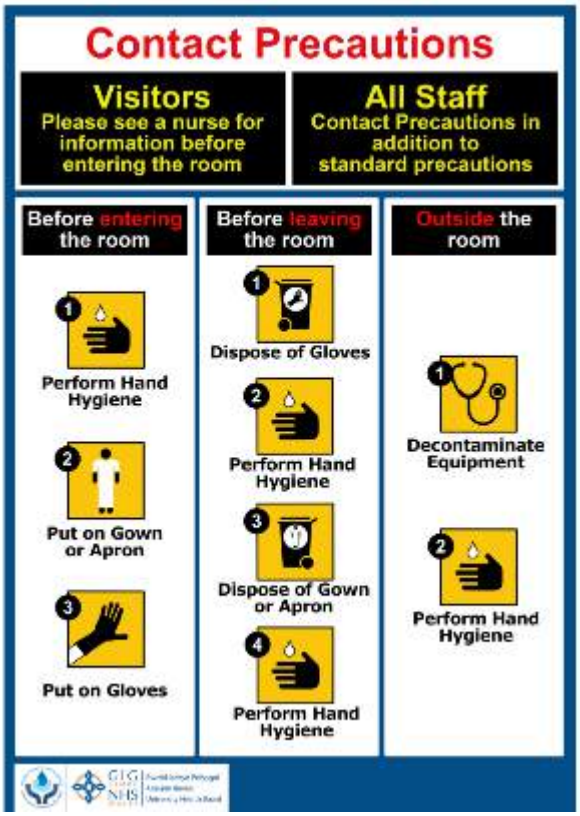
This plan involves ensuring clear pathways are in place to segregate respiratory patients, including:

- Respiratory zones in emergency and assessment areas
- Allocated waiting areas
- Respiratory pathways in admissions units
- Point of Care Testing for symptomatic patients on triage
- Appropriate isolation on wards and utilisation of cubicles
- Isolation/ Cohort contacts of cases

The All Wales testing framework will apply meaning on symptomatic testing on admission and of in-patients. A staff respiratory risk assessment is in place, routine testing of symptomatic healthcare workers is not indicated by Welsh Government.

Personal protective equipment for working in respiratory virus and other infectious areas will be in place. Monitoring of stock and ensuring adequate fit testing are ongoing.





7. Risk

As is clear throughout this plan there are risks to delivery through this next winter period. The table below identifies the more significant risks;

RISK AREA	DESCIRPTION	MITIGATION
Workforce not available to meet service need resulting in harm to patients and staff	Workforce is the Health Boards biggest risk; the availability of bank, agency and locum staff is constrained as these staff are already deployed. Existing staff are tired and there is less flexibility for redeployment with the recovery of services	As set out in the Workforce section: - Continue to recruit to vacancies - Agency and locum staff where no other option - Wellbeing initiatives
Patient harm as a consequences of challenging service access	Patients coming to harm in communities and services as a consequence of delayed or lack of access	As set out in the plan: - Increase community services - Urgent Care Plan - Focus on keeping people at home

		and early facilitated discharge - Surge critical care and Paediatric capacity - Medical Surge bed planning
Patient harm as a consequences of overwhelming respiratory disease demand	A combination of a of Covid-19, high flu and RSV season increasing service demand	As set out in the plan: - Vaccination - Infection Prevention Measures - Flexible services

8. Monitoring Impact

This plan sets out a range of measures seeking the mitigate the impact of winter pressures on the Gwent health and care system. It will be important to understand the impact of these actions and monitor progress against key metrics as markers of success of the plan.

A regular operational beat will be in place on a daily and weekly basis to monitor system pressure and seek to take proactive action to prevent a deterioration of service. The Gwent Adults Strategic Partnership will meet monthly to oversee the RPB actions set out in the system resilience plan.

The Welsh Government has set out a series of expectations for this winter period (Annex 1), which includes a number of proposed measures which have been incorporated in the monitoring measures below.

Robust performance monitoring processes are already in place across all parts of the system including routine reporting and meeting with Welsh Government on the urgent care system. The measurements of success in this period are consistent with reporting across these processes.

Measures	**Ambition**
Percentage of bed days occupied by patients with a length of stay greater than 21 days	Reduction in percentage in line with Urgent Care 6 Goals plans. Stretch target to reduce by 5% by the end of December (when compared to the April 2023 baseline
Reduce 'assessment delays' as a reason for a pathway of care delay in each local authority area	Stretch target of 60% reduction when compared to the August 2023 baseline. A focus on reducing pathways of care delays as a

	priority to enable better outcomes and free up bed capacity
Increase in referrals to SDEC from Emergency Care Practitioner services	A month on month increase in referrals of patients via the 999 clinical support desk, consultant connect, the relevant remote clinical flow / navigation hub and a direct from emergency department triage to SDEC services at each acute site
Ambulance Handovers >4hrs	This is a key metric of the safety flow model to eliminate handovers >4hrs
Increased number of patients discharged before 1pm	Currently only 20-25% of patients are discharged before 1pm, significant capacity and flow gains are achieved by earlier discharge

9. Finance

The Health Board is not committing any additional spend to meet the costs of this plan; achievement of the actions set out will be met in line with current budget and savings plans. The only additional expenditure this winter is via the Regional Partnership Board, where slippage and non-allocated spend from the Regional Integrated Fund has been assigned to system resilience plans as set out in section 3.5. The table below provides the costs of individual schemes.

Whilst the Health Board is not committing any additional expenditure against this plan, contingency surge planning is taking place should a scenario a rise where this is required. Consideration is being given to reallocating resources in this scenario, but it remains a risk that additional expenditure on agency staff to meet demand may be required if the balance of safety demands it.

Gwent System Resilience Plan Health Board Schemes	Lead Provider	23/24 RPB Allocation £'000
SCTH Early facilitator discharge	ABUHB - CHC	255
Step Closer to Home	ABUHB - CHC	367
MH Practitioner & WAST Response	ABUHB - Corp	96
Same Day Emergency Care @ YYF	ABUHB - Medicine	630
CRT Pharmacy	ABUHB - PCCS	175
Health Board Total		**1,523**

Gwent System Resilience Plan Non-Health Board Schemes	Lead Provider	23/24 RPB Allocation £'000
Rebalancing Rights & Responsibilities	Central	70
Additional system capacity (excluding Home First)	LA	600
YYF Trusted Assessor - Stroke Pathway	LA	44
GWICES - Staff Support	LA	20
Falls Response	WAST	228
BRC - ED Resettlement	Third Sector	152
Hospital to healthier home - Staff Support	Third Sector	17
Non-Health Board Total		**1,131**

Total Gwent System Resilience Plan	**2,654**

10. Summary

This winter, our services will face many complex challenges underpinned by significant uncertainty.

Through undertaking the actions set out in this plan and the key principles of partnership, focus, processing power and capacity the organisation will endeavour to meet the challenges of the winter. The organisation will target the areas of greatest challenge and provide the best opportunity to ensure people access care and support in the right place, first time, whilst optimising effective flow through our system.

10.1 Annex 1 Welsh Government Expectations

Priority Area	Action
Primary and community care Health boards should collaborate with partners through the Pan Cluster Planning Groups and Clusters in taking steps to provide integrated health and care services to support people, particularly those who are living with frailty and other long term health conditions, to remain well and independent at home. Equally when hospital admission is required to support them to return home promptly.	• Proactively monitor business continuity and capacity • Have in place robust plans for primary and community care services to support COVID-19 and seasonal influenza campaigns. • Support integration and continuity of key services that relieve pressure on other NHS access points, e.g., Clinical Community Pharmacy Service (CCPS), Pharmacist Independent Prescribing Service (PIPS), Sore Throat Test and Treat (STTT). • Support public information on how to access services and on 'Approach to Respiratory Viruses for autumn and winter 2023/24'. • Maintain and build sustainable and resilient 24/7 community nursing services in line with the Strategic Programme for Primary Care (SPPC). • Continue to accelerate Pan Cluster Planning Groups and Clusters as mechanisms for deploying action and resources to identify people at increased risk of urgent care needs and particularly our severely frail population. • Offer support to care homes to deliver 'what matters' to their residents through the timely provision of information, advice, and assistance, with support from the national Six Goals for UEC programme team. • Increase AHP capacity in the community in line with the WG guidance and ensure alignment with intermediate care including reablement provision. • Assess, and adapt current provision (previously known locally as virtual wards, hospital at home or similar) for people nearing or in crisis in line with the Enhanced Community Care Framework (produced by the Strategic Programme for Primary Care in May 2023). Capture data on the service in line with the associated national data set • Assess and adapt current single points of contact in the community and consider how you enable provision of timely and integrated information, advice, and assistance (including proactive, intermediate and Technology Enabled Care) for health and care professionals and vulnerable populations. • Routinely use the Healthy Days at Home Measure, launched by the Strategic Programme for Primary Care in April 2023.

Urgent and emergency care To support resilient and safe urgent and emergency care services, you will need to increase focus on securing sufficient clinical capacity in the Emergency Department to support timely triage and assessment and prioritise patient flow through acute hospital systems and back out into the community.	• Increasing profile and scrutiny of your organisation's front door, 'goal 5' and 'goal 6' action plans with intent to reduce the percentage of bed days occupied by patients with a length of stay greater than 21 days. • To reduce the risk of deconditioning for frail adult, and to improve patient flow we have set a stretch target: Each hospital site to reduce the percentage of total bed days taken up by patients with a length of stay greater than >21 days by 5% by the end of December (when compared to the April 2023 baseline). • A focus on reducing pathways of care delays as a priority to enable better outcomes and free up bed capacity, and we have also set the following stretch target Reduce by 60% 'assessment delays' as a reason for a pathway of care delay in each local authority area when compared to the August 2023 baseline (by the end of December 2023), whilst ensuring there isn't an increase in delays in other areas of the system (e.g. a decrease in assessment delays but an increase in patients then waiting for the next step in their discharge plan). • Focus on enhancing 'same day emergency care' by enabling more medical and surgical patients to access services via agreed referral pathways through consultant connect, remote flow hubs and via WAST. We, therefore, expect to see: A month-on-month increase in referrals of patients via the 999 clinical support desk, consultant connect, the relevant remote clinical flow / navigation hub and an direct from emergency department triage to SDEC services at each acute site for the remainder of 2023/2024.
Capacity Planning	All health boards are expected to have capacity plans which align to all aspects of the organisations planning and delivery expectations for 2023/24. These capacity plans are responsive to predicted surges in demand across paediatrics, critical care, general medicine and mortuary services.
Paediatric Services	Complete paediatric surge plans as requested by the DCMO in the letter dated 22 August 2023.

Agenda Item: 3.5

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Equality Plan Consultation and Engagement
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Sarah Simmonds, Executive Director of Workforce and Organisational Development
SWYDDOG ADRODD: **REPORTING OFFICER:**	Non Ellis, Equality Diversity and Inclusion Specialist

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

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Equality Act (2010) provides a legal framework to protect the rights of individuals and advance equality of opportunity for all.

Section 149 of the Equality Act (2010) requires us to demonstrate compliance with the Public Sector Equality Duty (PSED) which places a statutory duty on the Health Board to:-

- Eliminate unlawful discrimination, harassment, and victimisation;
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not;
- Foster good relations between those who share a relevant protected characteristic and those who do not.

The Health Board also has a specific duty under the PSED to publish information to demonstrate compliance with the Equality Duties, at least annually. This is achieved through the Annual Equality Report. In addition, the Board have a duty to set equality objectives at least every 4 years which will be achieved via the Strategic Equality Plan (SEP).

This will be the fourth SEP that the Health Board has developed. The first was published in April 2012. Our current SEP was published in 2020 and is active until

March 2024. To be compliant with our PSED the Health Board needs to publish the Strategic Equalities Plan by the end of April 2024.

Since its publication, good progress has been made in developing a programme of work to help ensure that the Health Board delivers against the eight equality objectives that were set in the 2020–2024 SEP. Progress made against delivery has been reported each year in our annual equality reports.

After reviewing and taking account of the progress made over the last four years, a revised suite of equality objectives will be developed which will underpin the details to be taken for the period 2024-2028.

Before finalising the new objectives and publishing them in a revised SEP, the views of various stakeholders on what should be the priorities for the next four years and the potential steps that could be taken to fulfill them will be sought
This paper describes the approach to the development of the revised SEP for 2024-2028.

The Board is asked to endorse the emerging strategic approach to Equality, Diversity, and Inclusion (EDI) and the plan for developing and consulting on the draft SEP for 2024-2028.

Cefndir / Background

In developing the SEP for the next four years the Health Board has reflected on some momentous changes that the organisation and communities have undergone over the past four years; and consider how to deal with the fact that further change is to come.

Since the equality objectives were last reviewed in 2020, the issues raised by movements such as Civility Saves Lives, #BlackLivesMatter and #MeToo, have brought into stark and urgent focus the layered impacts of years of disadvantage and inequality. Moreover, the COVID-19 pandemic has shone a harsh spotlight on the nature and extent of the equality challenges faced by the NHS, including profound health inequalities that persist in society. The pandemic and the key lessons have brought a fresh impetus for the NHS to take action to address inequalities and advance equality of opportunity.

Over the next four years health and health services in Wales will face some of the biggest challenges since the creation of NHS Wales, including: inequalities in health; a changing demographic with increasing numbers of elderly people; increasing numbers of patients with chronic conditions; enduring austerity; fiscal limitations; clinical staffing pressures; and some specialist services being spread too thinly. Furthermore, the NHS in Wales is facing its largest financial deficit set against a backdrop of ongoing industrial action.

This report sets out how the organisation proposes to review and revise the equality objectives in this evolving context, as well as our proposals on how the organisation can engage people and communities and stakeholders across the system landscape, to build on a wide range of experience to make the new equality objectives as effective as possible, focusing on the challenges faced by people by reference to protected characteristics.

The aim is to drive strategic and demonstrable equality improvements with reference to the nine protected characteristics in the Equality Act 2010 for our general population, our employees, and in the exercise of broader activities and functions within the Health Board.

Asesiad / Assessment

The recommendations for improvements outlined in the Annual Equality Report 2022-2023 and Gender and Race Pay Gap Reports 2022, alongside emerging national EDI themes and strategic drivers, will provide a foundation for the next SEP. This will include detailed actions to fully embed EDI and create an inclusive culture over the next four years.

Updating our equality objectives for 2024-2028

Key Drivers
In addition to the PSED, there are a number of other key drivers for the Health Board, including but not limited to:

- People Plan 2022/25 – Putting People First.
- Integrated-Medium Term Plan.
- National Workforce Implementation Plan.
- Human Rights Act 1998.
- Anti-Racist Wales Action Plan.
- LGBTQ+ Action Plan.
- Wellbeing of Future Generations.
- Advancing Gender Equality in Wales.
- Socio-economic Duty.
- EHRC Is Wales Fairer?
- Building a Fairer Gwent: Why Gwent is a Marmot region.

Evidence Sources
The strategic objectives will be informed by a number of key evidence sources in addition to the above, including but not limited to: -

- Local Population Health Needs Assessments.
- Welsh Government Code of Practice for Autism Services.
- Locked Out Wales Report.
- EHRC Is Wales Fairer? Report.
- NICE: Tacking health inequalities in children and young people.
- UK Government: Health disparities and health inequalities.
- Future Generations Commissioner for Wales: Inequality in a Future Wales.
- Public Health Wales: Rising to the Triple Challenge of Brexit, COVID-19 and Climate Change for health, well-being an equity in Wales.

Design Principles
The Board is asked to note the set of design principles to guide future development. These principles build on the previous objectives while embracing the changing context to ensure that the revised objectives are as effective as possible.

After an assessment of key information, including the Equality and Human Rights Commission's Technical Guidance, the original design principles identified are: -

- The new objectives need to reflect the substantial change in the NHS environment since the last full review of the objectives was carried out in 2020.
- Each equality objective should enable progress to be made across relevant protected characteristics.
- The targets underpinning each equality objective should provide the focus for specific action, including where required for individual protected characteristics.
- Use of targets also meets the requirement in the legislation and the EHRC technical guidance that equality objectives should be specific and measurable.
- Equality objectives should be either patient or workforce-focused unless separation would be impractical or make no sense.
- Equality objectives need to be as specific and measurable as possible.

Using futures and foresight research for the long-term success

Sustained improvement will be central to reviewed SEP and the Health Board will need to adopt implementation approaches that include learning. Progress will be evaluated annually to understand what does and does not work to inform changes to the agreed approach.

Looking at the futures cone (Figure 1), the EDI Workstream will examine trend data to explore projected futures and inform the equality objectives for the next four years, in addition to potential future needs.

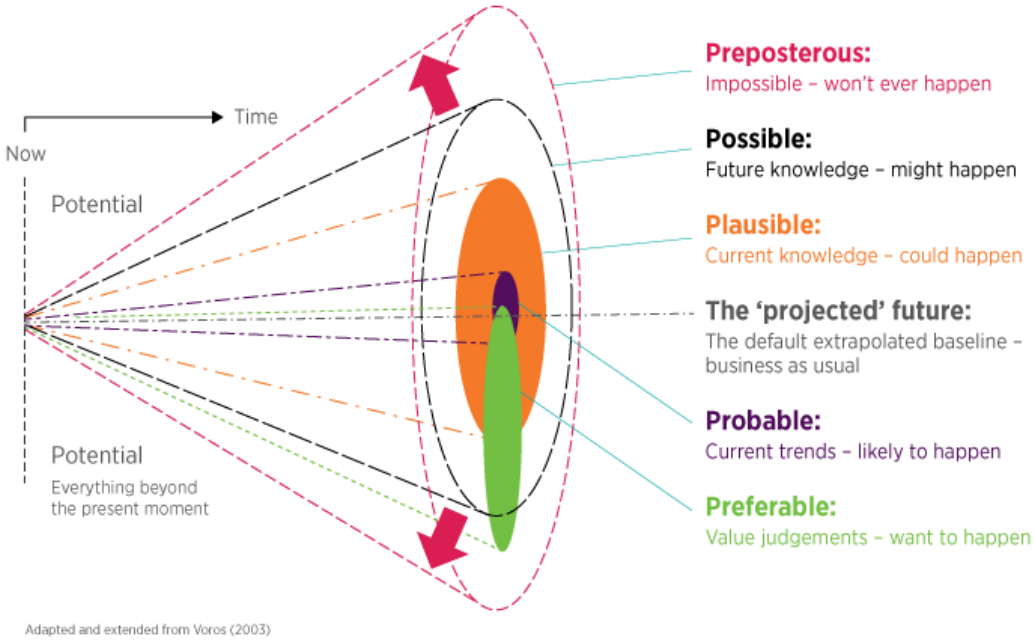


Figure 1: The Futures Cone (Voros, 2003).

An assessment of the context within which the organisation is working, combined with emerging strategic drivers such as Welsh Government's Disability Action Plan and the anticipated Workforce Race Equality Standards (WRES), an initial set of objectives has been established which will be shared with the wider public for their views in a more meaningful way.

Our Approach

The planned approach to consultation and engagement will actively explore if/how best to bring together the separate statutory equalities reporting frameworks and any future health inequalities reporting requirement. Despite the separate legislative frameworks and scope, the importance of aligning action on health inequalities with action on equalities so that the legal obligations are recognised. Work in these two areas can complement and reinforce each other.

An enabling approach to ensure staff and patients are at the heart of our SEP and help shape the organisation and services that they want will be adopted.

The approach will be evidence-based, including the analysis of national EDI trends, and a wide range of data sources to inform our SEP actions, including, but not limited to: -

- Workforce data.
- 'Moving on' data.
- Datix reporting.
- Staff Wellbeing Survey and NHS Staff Survey, 2023.
- Patient Surveys.
- Narrative of our communities.
- Evidence of our response to recommendations made by others concerning inequalities in access, experience, and outcomes.
- Our position on Workplace Equality Indexes (e.g., Disability Confident, Stonewall, etc.).

The process will be transparent with the data and performance being shared externally.

The need for the organisation to be more outward focussed and there is active engagement with partner organisations (e.g., Diverse Cymru, Stonewall, Race Council Wales, NHS Race Observatory, Inclusive Employers, Macmillan Trust, HEIW, etc.) as part of continuous improvement.

EDI will be embedded in the Leadership and Development Programmes to ensure inclusive, compassionate leadership and encourage local ownership of the equality objectives.

Intersectionality will be a key tenet of the emerging SEP, recognising people who share more than one protected characteristic are at risk of multiple disadvantages, inequity, discrimination, harassment, and victimisation. The impact of intersectionality may vary and is difficult to quantify; however, it is important to recognise the concept in terms of developing policy and practice, promoting equality and addressing discrimination, harassment, and victimisation.

The Evaluation and Review Process

The process for evaluating the Health Board's equality objectives for 2020-2024 and updating objectives for 2024-2028 will be carried out using a range of sources, resources, and activities, including:

- Quantitative data and qualitative information we collect and monitor for our patient and workforce.

- Feedback through our engagement, involvement and survey activities with patients, the public and other stakeholders.
- The monitoring and review of our previous objectives.
- Feedback through the 2023 staff wellbeing survey and our local staff engagement activities.
- National drivers, good practice guidance and benchmarking with other NHS organisations.

Engagement and Consultation Project Plan

Before finalising the new equality, objectives and publishing them in a proposed SEP, the views of various stakeholders on the proposed objectives and the potential steps that could be taken to fulfil them will be sought.

The project plan (Appendix 1) sets out a timeline for the scheduled engagement and consultation activities and will be reviewed and updated as the development of the objectives and plan are progressed.

The engagement activities are guided by the National Participation Standards in Wales to make sure that stakeholders are engaged in a meaningful way.

The planned patient, staff and public engagement and consultation activities will give us a strategic direction for the reviewed SEP and the actions within it. Once the revised equality objectives have been developed, the revised SEP will be brought to the Board for discussion and approval.

Staff and Volunteer Pre-Consultation Engagement

The SEP does not just focus on patients and the wider community, but also the equality, diversity and inclusion needs of staff and volunteers in the workplace. It is vital that the organisation also includes them in the engagement and co-production activities.

This will be achieved via our Staff Diversity Networks, as well as going out and talking to our staff on site, with a series of workshops and Equality Chat Cafes (see Figure 2) and engagement opportunities, including joining existing opportunities such as the retention work being undertaken by the Organisational Development Team. In addition, workshops will be held for key stakeholder groups across the workforce, including Trade Union Representatives, the Patient Centred Care and Organisational Development Teams.

A survey has also been circulated across the Staff Diversity Networks, in addition to being shared via the intranet, to get the views of staff on the current position with EDI and what they consider to be the priorities moving forward. The survey is available in other formats upon request to ensure accessibility.

The survey data, alongside the feedback from the workshops, will be triangulated with the data from the Staff Wellbeing Survey, to help inform the strategic direction for the revised equality objectives.

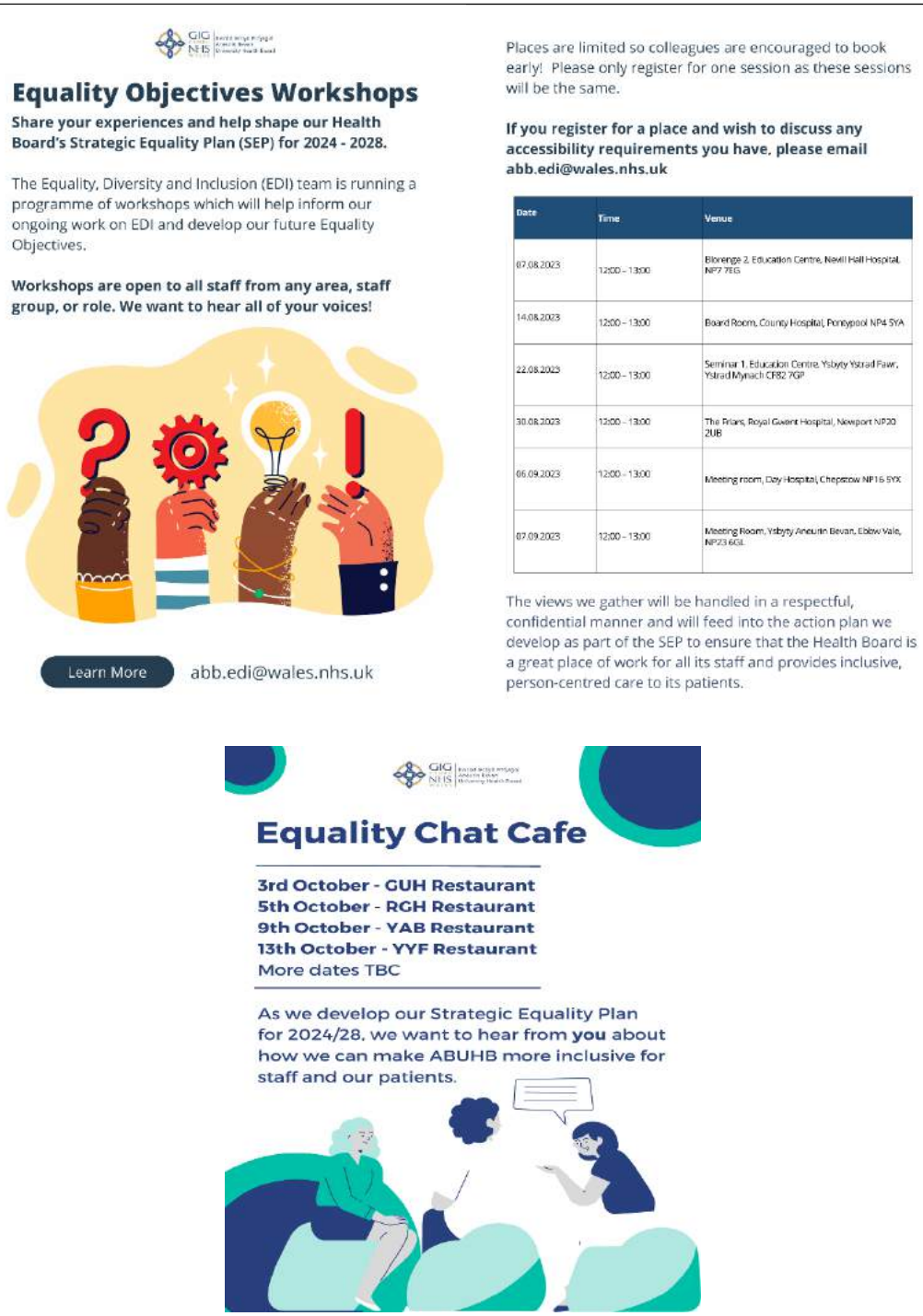


Figure 2: Schedule of Staff Engagement Workshops and Cafes

Stakeholder Pre-Consultation Engagement

External stakeholder workshops will be held throughout the pre-consultation period (dates to be confirmed). These will be thematic with the intention of enhancing understanding of the proposals and increasing engagement.

Workshops are being arranged in collaboration with the citizens voice body, Llais. Llais have an established network of representatives living and working in the communities of Greater Gwent and represent the interests of patients and the public. Working collaboratively with Llais will allow the EDI Workstream to hear people's views, concerns, and real experiences, sharing what works and what does not to help inform the reviewed SEP.

Public Consultation

A twelve-week consultation will be held as required by the Public Sector Equality Duties (2011), that will include a draft of the new SEP based on analysis following the engagement with stakeholders and internal discussions. The consultation will ask respondents to reflect on how the draft SEP will impact the delivery of the obligations of the Health Board under the PSED and whether or not the proposed objectives meet the needs of staff, patients and communities.

A public online survey will be published. This survey will also be sent to key external stakeholders, inviting feedback. Paper-based surveys will also be made available to avoid digital exclusion. The survey will also be made available in Welsh and the frequently spoken languages of local communities.

Specialist online communities will be sourced and contacted to generate more responses, which can be done by liaising with relevant groups and organisations that have close links to relevant audiences. Twitter and Facebook will also be used to source such online groups and specialist online forums.
The survey will be promoted offline as well as online, by contacting relevant groups and organisations on the phone and by e-mail, so that survey links can be circulated further.

The consultation will be conducted in line with the Government's Code of Practice on Consultation.

Equality Considerations

As both a legal requirement, but also a moral requirement, the Health Board will ensure that the consultation process reaches out to all those who have an interest in the proposals and that they are empowered to take part in the consultation. An equality impact assessment has been undertaken to ensure that the process for consultation and decision-making is fully compliant with our legal duties under the Equality Act 2010 and the NHS Act and that we are taking account of people's protected characteristics.
We will also undertake an Equality Risk Assessment to highlight key areas of concern or issues and identify mitigating actions. Consultation information will be made available to all communities in various formats appropriate to the community e.g., Readaloud, Video, BSL, Easy Read.

The organisation will also work closely with voluntary and community sector organisations to raise awareness of the consultation and highlight why people should participate and how they can take part. An offer to meet with specific groups or representatives to seek feedback on proposals will be made.

Costs and Risks
The direct financial implications arising from this consultation will include: -

- Translation of consultation materials into Welsh, BSL and the other frequently spoken minority languages
- Production of easy read consultation materials.

(See Figure 3 for estimated costs)

Activity	Estimated Cost
Welsh Translation of Consultation Document (Maximum 20,000 words)	£1,600
Welsh Translation of Strategic Equality Plan (Maximum 20,000 words)	£1,600
British Sign Language Video Editing and Translation (Half a day)	£250
Easy Read version of Consultation Document (Maximum 4 A4 pages)	£476
Easy Read version of Strategic Equality Plan (Maximum 4 A4 pages)	£476
Estimated Total	**£4,403**

Figure 3: Estimated costs for translation work

It is important to note that given the nature of this consultation and the need to engage across all communities, particularly those that are seldom heard, there may be further translation costs incurred, should there be a request for the documentation in other minority languages. The potential costs for translation would be £70 per 1,000 words.

There will also be ongoing resource implications in terms of developing and implementing an ongoing community engagement exercise around developing equality objectives and prioritised actions and assessing organisational performance against these.

The adoption of new equality objectives will form part of a wider piece of work being undertaken by the Health Board to improve its EDI practices and understanding.

As an organisation much work is required in this area, and the adoption of the new equality objectives is a starting point to ensure compliance with the Equality Act (2010) and meet the requirements of national strategic drivers.

The revised SEP will provide a clear vision of how EDI can positively impact every part of the organisation and how this will benefit staff and the organisation, as well as patients, service users and the communities of Greater Gwent. The focus is to ensure that everyone at ABUHB (Aneurin Bevan University Health Board) feels respected and valued and to build a diverse workforce which mirrors the communities in the area, enabling the organisation to provide communities with a better service.

Ensuring a closer alignment between the steps to deliver both the Health Board's corporate and equality objectives is vital as integration is pursued together with improved employee and patient experience and strive towards becoming a more equitable organisation.

By developing an equality lens for core business and decision making, rather than the development of separate priorities, steps and actions, the Health Board can ensure EDI is at the centre of all action taken.

If the SEP sets out equality objectives that are not achievable or are distanced from overarching corporate objectives, there is a risk that there will be insufficient

prioritisation at all levels of the organisation. It is recommended that the finalised SEP is articulated clearly across the organisation, in order to take this programme of work forward, at which point more detailed divisional action plans will be developed. The Health Board would be at risk of legal challenge if it failed to meet its duties under equality legislation, or if it knowingly or unknowingly allowed discrimination to occur.
Argymhelliad / Recommendation The Board is asked to note the approach to reviewing and revising our equality objectives and the set of design principles to guide future development.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not Applicable
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources 7.1 Workforce 6. Individual care 3.2 Communicating Effectively
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Getting it right for children and young adults Older adults are supported to live well and independently
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Partnership First
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Improve the wellbeing and engagement of our staff Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	British Sign Language (BSL) Equality Human Rights Commission (EHRC) Equality, Diversity, and Inclusion (EDI) Health Education in Wales (HEIW) Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and many other

	terms, such as non-binary and pansexual (LGBTQ+) Public Sector Equality Duty (PSED) Strategic Equality Plan (SEP)
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Progress of the Equality Objectives (2020-2024) has been shared and approved by the People and Culture Committee.

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper
• **Service Activity & Performance**	Not Applicable
• **Financial**	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	**Yes not yet available** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

SIMPLE GANTT CHART by Vertex42.com
https://www.vertex42.com/ExcelTemplates/simple-gantt-chart.html

About This Template

This template provides a simple way to create a Gantt chart to help visualize and track your project. Simply enter your tasks and start and end dates - no formulas required. The bars in the Gantt chart represent the duration of the task and are displayed using conditional formatting. Insert new tasks by inserting new rows.

Guide for Screen Readers

There are 2 worksheets in this workbook.

TimeSheet
About

The instructions for each worksheet are in the A column starting in cell A1 of each worksheet. They are written with hidden text. Each step guides you through the information in that row. Each subsequent step continues in cell A2, A3, and so on, unless otherwise explicitly directed. For example, instruction text might say "continue to cell A6" for the next step.

This hidden text will not print.

To remove these instructions from the worksheet, simply delete column A.

Additional Help

Click on the link below to visit vertex42.com and learn more about how to use this template, such as how to calculate days and work days, create task dependencies, change the colors of the bars, add a scroll bar to make it easier to change the display week, extend the date range displayed in the chart, etc.

How to Use the Simple Gantt Chart

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Project Management Templates

About Vertex42

Vertex42.com provides over 300 professionally designed spreadsheet templates for business, home, and education - most of which are free to download. Their collection includes a variety of calendars, planners, and schedules as well as personal finance spreadsheets for budgeting, debt reduction, and loan amortization.

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	5 October 2023
CYFARFOD O: **MEETING OF:**	Executive Committee
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Aneurin Bevan University Health Board Patient Safety Incident Reporting & Management Policy (Duty of Candour: Moderate/Severe Harm)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Garvin Jones – Head of Legal Services

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

For assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Boards 'Policy & Procedure for the Management of Serious Concerns (Severe or Catastrophic) was issued in 2012 and due for review in 2015. This is now significantly outdated. There have been numerous developments and changes of focus over the intervening period:

- Significant changes in national legislation and policy, including the introduction of Duty of Quality and Duty of Candour.
- Changes to the methodology for National Reportable Incidents (NRI's), moving away from prescriptive 'trigger lists' to 'judgement' and 'analysis'.
- An embracing of new concepts, including 'Safety 11 culture' and 'Just culture'.
- Alongside 'good' incident investigations, ever important need to embed learning & improvement from our investigation findings, to reduce patient safety incidents and prevention of future occurrence.
- 'Rich stream' of learning/improvement/actions now formally submitted and assessed for assurance via the Welsh Risk Pool (WRP).
- Increased recognition of the ever important need to ensure our systems put patients, families, and staff at the heart of our process.

The Health Board's policy has been updated and refreshed to reflect the changing landscape. As a Health Board we must ensure that our processes and approaches to this complex and sensitive area of healthcare are aligned, to ensure the quality of our Patient Safety investigations, that our patients are at the heart of that process, and to maximise learning opportunities for the benefit of patients, service users, their families, our staff and other NHS organisations.

In addition to Patient Safety Incident investigations, focussed on an adverse event causing moderate or severe harm, the Health Board will invoke other types of investigations as determined, including thematic reviews, look back reviews, joint investigations, concise reviews, and rapid learning. These will be discussed and taken forward via the Executive Huddle.

Going forward, the Health Board will look to incorporate patient wishes/ concerns/ expectations from the outset directly into the Terms of Reference for the intended investigation. The Health Board will share the draft TOR with the patient/ representative and look to agree these wherever possible.

Accountability for tracking and implementing learning and actions.

The central Patient Safety Incident Team will monitor, and track identified Divisional actions and learning from incident investigations. Whilst the central team will assist with this quality assurance, ultimately each Division will be responsible and accountable for the delivery of its learning, actions and ongoing monitoring, audits and assurance around compliance. Accountability Agreements will be developed for each Division. An Escalation process will be invoked if required.

Actions arising from moderate/severe investigations to be shared with Executives and Divisional Triumvirate.

The Health Board strives to be an all-encompassing learning organisation where people continually expand their capacity to improve.

Cefndir / Background

On 11th May 2023, the NHS Wales Executive published NHS Wales National Policy on Patient Safety Incident Reporting & Management. The purpose of this Policy is to set out clear expectations and standards for patient safety incident reporting and management across NHS Wales, superseding the previous guidance on Serious Incidents within the 2013 Putting Things right guidance document. The Health Board's policy, and processes going forward, have been updated to reflect the National policy and approach.

For context, this updating of our policy should be seen in the wider landscape of current works underway at the Health Board. Patient Safety Incidents are increasing. We currently have a high number of significant/severe harm investigations underway. We are seeing repeated incidences and themes. Whilst these are being managed and local learning occurs, this does not appear to translate into organisational learning.

With this in mind, a significant piece of work is underway to realign QPS resources in a new central model, to include ABCi improvement colleagues, and so better align our ability to drive and embed learning and improvement. The central Patient Safety Incident team, alongside a new alignment to the legal services team, will see increased specialism, to include dedicated Investigating Officers, ensuring required skills and independency for our most complex/involved/sensitive and reputational patient safety incident investigations.

Through these combined, cost-neutral changes, we hope to make more effective use of our available resources and skilled staff, reduce variation in practices, achieve a more unified consistent approach, being more adaptable and responsive to our most sensitive and complex incidents, promoting the Health Board's reputation as a truly learning organisation.

Asesiad / Assessment

The Health Board's Patient Safety Incident Reporting & Management Policy supports the NHS Wales National Policy which endeavours to empower all NHS organisations in Wales to take more ownership and accountability for incident reporting and management, and thereby learning & improvement from our investigation findings, to reduce patient safety incidents and prevention of future occurrence.

A summary of key changes outlined in the chart below:

2012 Policy	2023 Policy
Referred to as a Serious Incident	Redefined as Patient Safety Incident
Severe and Catastrophic harm considered	Moderate and severe harms considered in addition to thematic reviews of lower harm incidents
Safety I culture	Safety II culture
Focusing on 'What went wrong'	Examining 'what went right' in addition to 'what went wrong'
Focus on incident in isolation	Focus on themes and wider learning from these.
Incidents categorised as Red 1 (Corporate led) and Red 2 (Divisional led) investigations	Incidents categorised as Moderate and Severe investigations.

New components of 2023 policy:

Duty of Candour obligations explicit
Aligns to the All-Wales National policy on patient safety incident reporting and management – previously local arrangement responsibility.
The provision of healthcare was or could have been a factor in that harm occurring.
Just Culture introduction
Outlines National Reporting process
Aligned to new legislation - Health and Social Care (Quality and Engagement) (Wales) Act 2020, The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023, Putting Things Right guidance document (v3, 2013), The Duty of Candour Procedure (Wales) Regulations 2023 and The Duty of Candour Statutory Guidance 2023.
Inclusion of definitions of terms
Removal of H+S and child protection sections (links to supporting policies)
Removal of Coronial reporting categories
Importance of timely patient and family engagement in setting and agreeing Terms of Reference
Clarity of Executive sign off process.
Clarity upon lead divisional/organisational responsibility for action plan production and dissemination of organisational learning.
Introduction of incident review by Division within 2 working days.
Presentation of incident to weekly pre- executive huddle.
Recognised importance of securing CCTV / other evidence where relevant

Argymhelliad / Recommendation

To agree adoption of the updated Health Board Patient Safety Incident Reporting & Management Policy 2023 (Duty of Candour: Moderate/Severe Harm)

The Executive Committee is asked to recommend approval to PQSOC.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 6.3 Listening and Learning from Feedback 6. Individual care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	NHS Wales National Policy on Patient Safety Incident Reporting & Management.
Rhestr Termau: Glossary of Terms:	Within Policy
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb **Equality Impact Assessment** (EIA) completed	No, not needed

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Choose an item.

Aneurin Bevan University Health Board

Patient Safety Incident Reporting & Management Policy

(Duty of Candour: Moderate/Severe Harm)

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue 2 | Issue date: 07/11/2023
Approved by: Patient Quality Safety Outcome Committee | Review by date: 07/11/2026
Owner: Head of Legal & PSI | Policy Number: ABUHB/Corporate/Number

Contents

1 Introduction and Background

Patient Safety Incidents have the potential to cause harm to those in receipt of healthcare. It is inevitable that healthcare systems and processes will have weaknesses and that sometimes, these may result in errors or near misses. Patient Safety Incidents not only impact upon patients, services users, their families, and Health Board staff but can affect the reputation of the organisation, eroding public trust. Therefore, being able to respond effectively and appropriately when things go wrong is fundamental to improving patient safety and the quality-of-service provision. In an increasingly complex health care system, it is impossible to prevent all risks associated with healthcare. Aneurin Bevan University Health Board (ABUHB) is committed to the health and safety of its patients, service users, staff, visitors, and contractors by promoting a culture of openness and honesty, focusing on improving practice and creating a safer environment. It thereby aims to proactively report and manage all patient safety incidents to reduce future risks and mitigate further recurrence.

This Patient Safety Incident Reporting & Management Policy forms part of the Health Board's governance and risk management process for managing, reporting, analysing, and learning from patient safety incidents.

Historically, incident reporting has been used as a key safety indicator in healthcare to attempt to understand where things go wrong to learn and improve safety, experience and outcomes for future patients and service users. Incident reports can be a valuable source of data about where to focus resource and attention to improve patient safety. However, they are only one part of the puzzle and should be examined in the wider context of other sources of safety intelligence. Patient safety incident reporting has changed across NHS Wales as our understanding of how to best use intelligence from incident data continues to evolve. This includes triangulation with other data sources (for example, patient experience and compliance data) and moving from a Safety I to a Safety-II approach will help organisations to shift the narrative from focusing purely on "what went wrong?" and balance this with learning from "what goes right".

Applying these new approaches will enable the Health Board to think differently about this complex and sensitive area of healthcare and ensure that these maximise learning opportunities for the benefit of patients, service users, their families, carers and loved ones, and ABUHB staff. Incident reporting and management can highlight specific weaknesses in our healthcare system or processes that need to be addressed to prevent future incidents leading to avoidable death or serious harm.

The Patient Safety Incident Reporting & Management Policy seeks to promote an open reporting culture which encourages staff to look critically at their own actions and those of their teams, with an emphasis on learning and not blame, and where Health Board staff feel supported to identify, report, manage and learn from patient safety incidents, without the fear of punitive response or action. The Health Board are fully committed to embedding Speaking Up Safely as part of our culture. Speaking up Safely: A Framework for the NHS in Wales (gov.wales)

ABUHB's Patient Safety Incident Reporting & Management Policy supports the NHS Wales National Policy (effective from 11 May 2023) which endeavours to empower all NHS organisations in Wales to take more ownership and accountability for incident reporting and management.

2 Policy Statement

This Patient Safety Incident Reporting & Management Policy covers the reporting, management, and investigation of patient safety incidents. These will be facilitated by the Patient Safety Incidents Team, in conjunction with and support from, the Executive team, Divisions and Directorates, the Health & Safety Team, and Health Board staff.

While many patient safety incidents will not result in significant harm to an individual, the exploration of incident reports can help provide a source of intelligence which can be used by healthcare providers for a variety of purposes, including:

- Highlighting existing risks so that early safety actions can be implemented to reduce the likelihood of recurrence.
- Reviewing of current measures, the Health Board has in place to prevent incidents.
- Fulfilling the Health Board's legal and statutory obligations to record and report certain defined incidents as set forth by NHS Wales Executive.
- Acting as a mechanism for oversight and assurance particularly where significant harm has occurred in the delivery of healthcare, in line with The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 - also known as 'Putting Things Right' (referred to forthwith as 'the Regulations').
- Enabling the monitoring of trends, themes, and patterns of incident types or in certain areas, departments or hospital sites and helps to facilitate thematic review for wider learning.

- Learning from what has gone wrong and what could have been done differently, ensuring the sharing of lessons learnt from appropriate levels of investigation and providing a springboard for onward system improvements for the safety of patients.
- Ensuring that all learning is disseminated among key members of the Health Board to inform and improve future practice.
- Providing assurance to patients, service users, their families that lessons have been learned.

There are several routes within the Health Board for learning opportunities to ensure an open and positive learning culture. These include, but are not limited to, patient safety incident investigations, patient experience and complaints alongside established Health Board panels such as Medical Examiner, Falls Review, and Redress. These should be managed collaboratively and thoroughly to determine root causes, contributory factors, and actions where appropriate to improve services. ABUHB is committed to ensuring that all actions for learning and improvement from patient safety incidents should be disseminated across the whole organisation to ensure the safety of patients, service users and staff.

3 Aims

ABUHB aims to ensure that all staff can identify Patient Safety Incidents, take appropriate actions, and mitigate risks of avoidable harm to patients, staff, and service users. Integral to this is the development of an organisational culture which supports incident reporting in an open and fair environment in line with a 'just culture.' Efforts to resolve system failures to support staff in delivering a quality service will be prioritised to improve service delivery. Analysis and learning from incidents are a critical part of patient safety including learning from when things go well. ABUHB is committed to the development of a positive learning culture throughout the organisation.

4 Objectives

- Ensure a clear and consistent Health Board approach to incident reporting, management and investigation aligned to the All-Wales National Policy.
- Provide support and guidance regarding the reporting and investigation of patient safety incidents within ABUHB.
- Provide clear guidance on what types of incidents should be nationally reported to the NHS Executive, and how this should occur.

- To ensure that all incidents (including incidents of near miss) are appropriately reported, and recorded, and an appropriate and proportionate level of investigation is undertaken.

5 Scope

This policy replaces the ABUHB Serious Incident Policy (2012). This policy applies to all permanent and temporary employed staff working within ABUHB, including primary care contractors, who have a responsibility to report and/or investigate and co-operate with Patient Safety Incidents. This policy only applies to patient safety incidents which are to be reported, managed, and investigated by ABUHB.

The Policy links and may also need to be considered in conjunction with the following documents:

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023
- Putting Things Right guidance document (v3, 2013)
- The Duty of Candour Procedure (Wales) Regulations 2023
- The Duty of Candour Statutory Guidance 2023

6 Definitions

6.1 Patient Safety Incident

A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare.

This also extends to;

"A situation in which one or more patients or staff are involved, has or could result in significant harm or death; is likely to produce significant legal, or media interest; could damage the Health Board's (HB) reputation or assets and may have significant HB wide implications for practice and delivery of care"."

Policy Term	Applicable Definition
Concern	As defined in the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011,* a concern is any complaint, claim or reported patient safety incident.
Patient Safety Incident	Refers to an incident occurring during the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient.
Patient or Service user	A person to whom healthcare is or has been provided. Healthcare includes services for the prevention, diagnosis, or treatment of illness as well as the promotion and protection of public health. It also includes NHS staff accessing treatment and care through wellbeing/ occupational health services.
Action	Something done intentionally or unintentionally.
Inaction	Something **not** done intentionally or unintentionally including because of indecision, unnecessary delay, failure to act.
Nationally Reported Incident (NRI)	A patient safety incident which is nationally reportable in line with this policy.
"Must report"	A sub-set of Nationally Reportable Incidents where national reporting is mandated through this Policy.

6.2 Harm definitions

The following definitions align with the definitions set out in the Duty of Candour Statutory Guidance.

No harm	Any patient safety incident that had the potential to cause harm, but impact resulted in no harm having arisen.
Low harm	Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care.
Moderate harm	Any significant but not permanent harm, or harm that requires a 'moderate increase in treatment' relating to the incident. A 'moderate increase in treatment' is further defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care.
Severe Harm	The permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition.
Death	A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient or service user's illness or underlying condition.

A near miss is an incident that did not result in harm, loss, or damage, but could have.

7 Roles and Responsibilities

7.1 Chief Executive

The Chief Executive has overall responsibility and accountability to ensure that effective reporting and management of the risks associated with Patient Safety Incidents within ABUHB and is consistent with good practice throughout the Health Board.

The Chief Executive is responsible for ensuring that ABUHB meets its mandatory reporting obligations to external bodies including the NHS

Executive, Wales and Health and Safety Executive (HSE). This is achieved through the development of robust incident reporting and investigation mechanisms. The Chief Executive and the Executive Team are committed to improving patient outcomes and patient safety and increasing patient satisfaction as well as workplace health and safety of staff. Timely and effective reporting, investigation and analysis of incidents are important constituent parts in achieving this commitment.

7.2 Responsible Officer

The Executive Director of Nursing has day to day responsibility for quality and patient safety. They are responsible for and overseeing the day-to-day management of these arrangements and will provide leadership and support in achieving the aims of this policy and procedures.

The Responsible Officer ensures arrangements are in place to:

- Ensure that concerns (patient safety incidents, complaints, and claims) are dealt with under a single arrangement.
- Manage concerns in line with the Putting Things Right (PTR) Regulations (2013).

The responsibilities of the Executive Director of Nursing are delegated to the Head of Patient Safety Incidents but remain under the direct control and supervision of the Executive Lead.

7.3 Head of Patient Safety Incidents

The Head of Patient Safety Incidents, with the support of the central Patient Safety Incident team, is responsible for the handling and consideration of patient safety incident investigations (Duty of Candour: Moderate/ Severe/ Death) and their role requires them to undertake other functions in relation to dealing and cooperating with other persons or organisations, e.g., primary care providers. The Head of Patient Safety Incidents provides leadership and advice to the Executive Board, clinicians and managers on the handling and management of Patient Safety Incident investigations. This includes implementing a system across the Health Board to ensure the remedial actions of Divisions and Directorates are tracked and implemented, with escalation if required, to avoid recurrence of incidents and the sharing of lessons learnt across the organisation and beyond.

All Patient Safety Incidents raised will be discussed via the weekly Executive Safety Huddle. Details of the subject and nature of the incident together with the outcome of the investigation must be recorded. Compliance with

the stated time periods for response are monitored and reported. The Board are made aware of Patient Safety Incidents which may adversely affect the reputation of Board.

7.4 Patient Safety Incidents Team

The central Patient Safety Incident team will provide an Annual Report to the Board. This report will include the number of Patient Safety Incidents. The report will focus on providing assurance to the Board that lessons identified during the investigation of an incident are actioned and that appropriate remedial action is implemented, monitored, and evaluated for effectiveness.

7.5 Divisional Directors

Are responsible for establishing structures to ensure that Patient Safety Incidents are reported in a timely manner and appropriately investigated within their division. This includes establishing reporting and monitoring arrangements within the Division with a focus on lessons learnt.

7.6 Divisions

Each Division will establish a Quality and Patient Safety forum which includes in its terms of reference the need to review monitor and audit its management of Patient Safety Incidents.

7.7 Redress

If the investigation identifies that there is a possibility that the Health Board may have breached its duty of care to the patient, and that as a result this has caused harm to the patient, and assessed to be within the financial threshold for Redress, the division/locality will need to submit their investigation findings to the Health Board's Redress Panel. In addition to the investigation papers, clinical opinions on harm, and a draft CEO response, the Division will need to complete an LFER to summarise the case and submit to the Redress Panel – Learning from Events Report.

Further information on the required process can be obtained from the Legal Intranet pages: Legal Services - Home (sharepoint.com)

The Redress Panel will formally review the information provided and make a determination as to whether a breach of duty and harm has occurred – a 'Qualifying Liability'.

It is possible that the Panel will require further information before a determination can be made. Once the further information has been gathered the case will be represented to the Panel.

The findings of the Redress Panel will be layered into the draft CEO response and send to the CEO for final approval and sign off.

Each division will produce a robust and measurable action plan related to Patient Safety Investigations that occur within their division.

7.8 Investigating Officers

Investigating officers are required to:

- Undertake all patient safety incident investigations and produce written reports in accordance with this policy when appointed by the Divisional Management/QPS team or on occasions the corporate team to do so.
- Seek and undertake the Health Board Investigating Officer training to perform this role.
- Communicate with other key staff involved in the investigation and ensure confidentiality, integrity, sensitivity, courtesy, and professionalism throughout their investigation.
- Act in the best interests of patients and their families in the course of their patient safety incident investigation. Seek advice from specialist departments where necessary.
- In cases where information is provided by a member of staff or employee (e.g., from their statement) is referenced in the report, the member of staff or employee must be shown a copy of the report before it is approved.

7.9 Responsibility of All Staff

- Work to the principles and aims outlined in this policy and the All-Wales National Policy.
- To identify, report and review all patient safety incidents (regardless of harm).
- To learn from Patient Safety Incidents and use opportunities to share learning among colleagues.
- To fully co-operate in an investigation to ensure that there is no unreasonable delay in providing information to the investigating officer. Where appropriate to provide statements and attend meetings to give information. Employees are encouraged to seek assistance or advice from their employee's representative. Staff with

any literacy issues, must be supported to complete statements from their line manager.

7.10 Responsibility of the Patient Quality Safety Outcome Committee

- PQSOC to receive assurance of data, learning and actions.
- PQSOC to provide assurance to the Board.

7.11 Primary Care (General Medical Services) contractors in NHS Wales

- Accountable for the quality and safety of care and services provided to their respective populations.
- Required to locally report incidents that have occurred within their organisations using the Datix Cymru system. (The health Body whose system they report into is responsible for assessing whether incidents have met the NRI threshold and undertaking any subsequent reporting).
- Primary Care Contractors must notify the relevant Health Board of occurrences where the Duty of Candour is triggered in respect of the health care they provide under a contract or other arrangement.
- Establishing mechanisms to extract and share learning from incidents and taking action to reduce the risk of recurrence and improve patient and service user safety, experience, and outcomes.

8 Nationally Reportable Incidents

8.1 Governance and Assurance Requirements

Aneurin Bevan University Health Board must ensure that it has robust systems and processes in place in relation to local and national incident reporting, including:

- Systems and processes to enact this policy in all areas of the organisation.

- All incidents should be reviewed within an appropriate governance framework to determine required risk management activities as well as any national reporting requirements.
- Being responsible and accountable for their judgements and decisions in line with the policy.
- Integration with other relevant clinical and corporate governance processes e.g., management of complaints and claims, mortality review processes etc.
- Internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off on national incident notification and investigation outcome forms.
- Clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board.
- Mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate.
- Systems for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. Organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes.
- Capturing and demonstrating shared learning.
- Ensuring engagement with any affected patient or service user or anyone acting on their behalf, in line with the legal Duty of Candour.

8.2 Types of Incidents

Patient safety incidents can be single isolated events, or multiple recurring events which can signal more systemic failures in care or demonstrate system weaknesses. They can also include events which indirectly impact patient safety or an organisation's ability to deliver a service, such as a failure of an IT system. Consequently, there is no definitive list of what constitutes a patient safety incident, and the Health Board will need to apply judgment when considering what should be reported, both at a local and a national level.

Examples of incidents which must be reported include but not limited to:

- Unexpected death
- Clinical error
- Equipment failure
- Unexpected outcome of clinical intervention
- Absence of records
- Self-harm/suicide/overdose
- Delays in diagnosis or treatment

- Slips, trips, and falls (patients, public & Staff)
- Information Governance issues
- Staffing/resource related.
- Medication errors (prescribing, administration, anaphylaxis)
- Never Events (see Appendix for further guidance)

Incident Reporting should not be used as a means for staff to register a point of view, highlight a situation they were unhappy with or raise a 'political' issue. There are other, more appropriate, means of raising and dealing these within ABUHB. The Health Board also has other policies that may be the more appropriate avenue for raising a concern.

8.3 Complaints as Patient Safety Incidents

The Health Board may be alerted to a Patient Safety Incident raised via the Complaints process. On receipt of a concern raised by a patient, their carer or representative, the Complaints Manager will conduct an initial review and grade the incident in terms of level of harm to the patient. It is acknowledged that the complaint letter is based on the perspective of the patient/family and facts will need to be verified. Therefore, for concerns graded as serious (severe or catastrophic) the complaints manager will check whether there is a serious incident investigation underway and send the concern to the Locality/Divisional Director to arrange for a rapid review (within 3 working days) to verify the grading. If grading is verified the complaint will be managed via the serious concerns process.

8.4 Datix Cymru

All patient safety incidents should be reported through Datix Cymru (part of the Once for Wales Concerns Management System) in line with the applicable User Guide operational at the date of reporting.

Employees should have access to report directly into the system. Relevant clinicians should register on the Datix Cymru system to access and review incidents within it also assign and be assigned actions as well as being able to send and receive e-mails out of Datix Cymru thereby creating an audit trail.

The use of Datix Cymru ensures a consistent approach to data collection and analysis. This should be sufficient to capture and analyse data from across all parts of the patient or service user pathway, including (but not limited to):

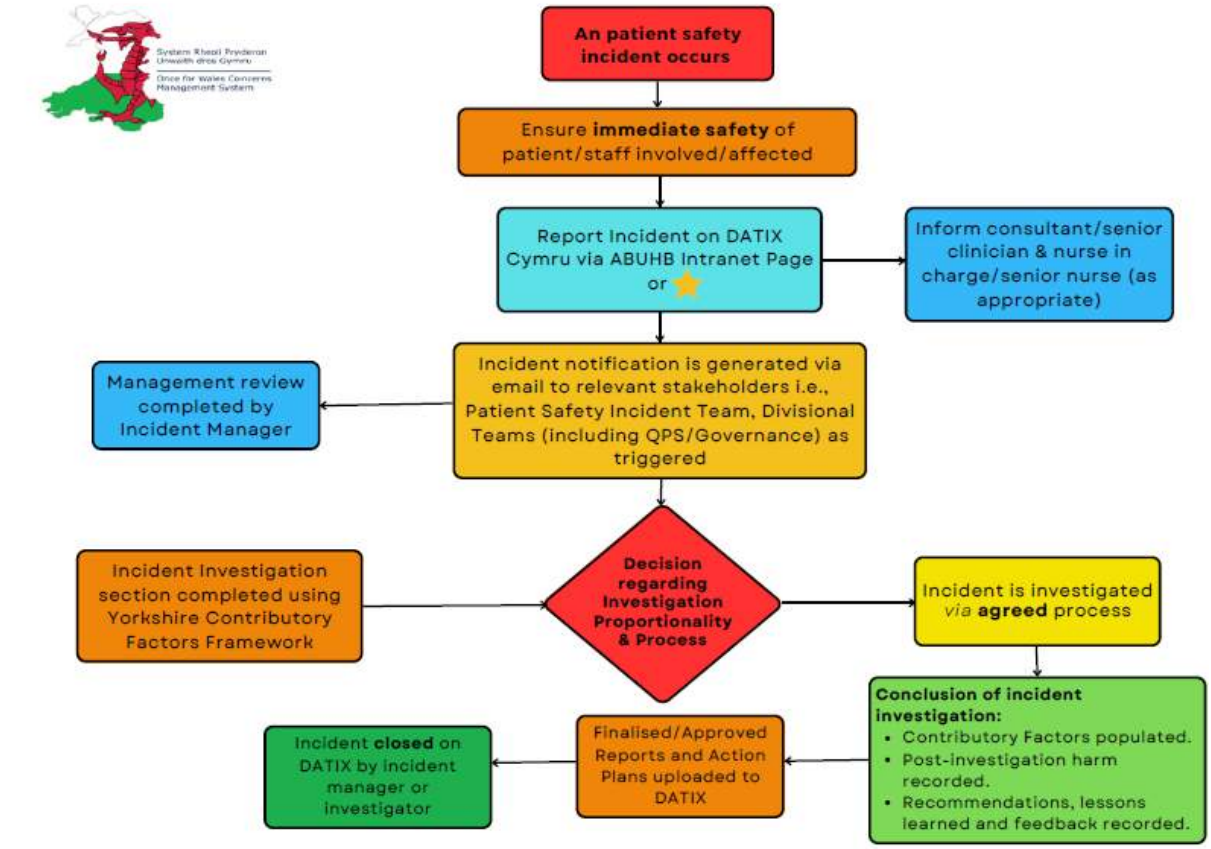
- Secondary and acute care settings
- Primary and community care, including community pharmacy, optometry, dentistry services urgent and emergency services including emergency departments & ambulance services.
- Out of hours' services
- Public health services
- Relevant IT services
- Prisons
- Commissioned services, and
- Incidents identified through the course of other clinical and corporate governance processes, for example Medical Examiner and Mortality Reviews.

The systems and processes must fully align with the Health Boards' governance and assurance mechanisms, ensuring clear reporting of relevant information.

The Health Board will ensure that local processes are reviewed, amended and/or adapted to incorporate the requirements of this Policy.

Guidance for Reporting an Incident can be found in the Appendices.

Figure 1: Process for reporting and investigation of a Patient Safety Incident within ABUHB



9 Review of Patient Safety Incidents to ascertain if they are Nationally Reportable Incidents (NRIs)

As part of the initial assessment process the Health Board will need to consider whether an incident requires reporting nationally, taking the following principles into account:

Principle 1 - 'Must reports'

Incidents related to the following are always nationally reportable:

- Never Events, as specified within this Policy, even where no harm has occurred. (The current NHS Wales Never Event list can be found in Supporting Section 1 of this Policy);
- Suspected mental health homicides;
- Suspected suicide or self-inflicted death
    - in any clinical setting; or

    - during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge
- maternal, perinatal, and infant deaths.

Principle 2 - outcome/harm

A safety incident should be nationally reported if it is **assessed or suspected** an **action or inaction** during a patient or service user's treatment or care, in any healthcare setting, **has**, or **could have caused or contributed** to their **severe harm** or **death**.

It will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, organisations should nationally report the incident, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded later.

Acts and inactions can relate equally to human interactions, technical failures and/or delays in systems and processes.

Principle 3 - number of patients or service users involved.

Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- Screening services
- IT failures
- Data breaches
- National system failures, and/or
- Service disruptions

Principle 4 - learning opportunities

Incidents should be nationally reported where they present new learning opportunities, particularly where a similar risk may be present in other NHS organisations. This may include:

- Near misses and/or no or low harm incidents where the learning would be beneficial to be shared nationally with other organisations to help raise awareness and mitigate risks for other patients or service users; and/or

- Incidents may present which are unusual, unexpected, or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial for others.

Principle 5 - joint decision making around reporting and investigation.

Some patient safety incidents will require joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially requiring joint investigation, to ensure relevant information is obtained from all sources to inform the discussion.

9.1 Reporting Process for Patient Safety Incidents as NRIs

A patient safety incident will be nationally reported to the NHS Wales Executive within seven working days from the date of knowledge of the incident.

The reporting process is set out in **Appendices**.

9.1.1 Welsh Government Early Warning Notifications (EWN)

Early Warning Notifications (EWN) (previously No Surprise Reporting) is a communication function to provide rapid information to Welsh Government on a range of issues, which may or may not relate to patient safety incidents.

The EWN process is independent of the incident reporting systems which are overseen and managed by the NHS Wales Executive.

AN EWN should be considered with regards to incidents which may or may not have resulted in direct harm to patients, but may have an impact on service provision, organisational reputation, adverse media coverage or political embarrassment.

An EWN will be submitted to Welsh government via PTR only and requires Executive sign off prior to submission.

For clarity, where a patient safety incident meets both the requirements of a EWN and a NRI, both processes must be followed.

9.2 Initial assessment to determine risk management and next steps.

All patient safety incidents will require an initial assessment to assess the circumstances, identify the relevant make safe actions required, and determine the next steps to manage the incident. This initial assessment should take place as soon as practicable after the incident (within first 72 hours) has occurred or otherwise been identified by the Health Board.

This initial assessment must include:

- Review of known information about the incident and consideration of further information to be obtained to inform the next steps.
- Assessment of risk and determination of make safe actions in relation to:
  - All patient(s) or service user(s) affected by the incident; and
  - The organisation, or other safety systems, to prevent recurrence in similar circumstances;
  - Consideration of engagement with the patient or service user and anyone acting on their behalf as appropriate. This assessment will need to balance the desire to engage transparently and compassionately with all affected by the incident whilst having due regard for legal matters of consent and capacity.

The initial assessment must be undertaken by a member of staff of sufficient seniority and experience in incident management proportionate to the circumstances of the incident, and in many cases will require a multi-disciplinary approach. This should ideally be undertaken by the incident manager or an ABUHB appointed member of staff identified to complete an incident investigation.

The incident will be presented to a pre-executive huddle panel made up of Assistant Director level representatives form Nursing, Medicine and Therapies and Health Sciences.

9.3 Just Culture and Staff Wellbeing

Staff who have been involved in a patient safety incident should be treated in a consistent, constructive, and fair way. ABUHB in conjunction with NHS Wales endorses the use of the NHS England Just Culture guide as a tool to support the fair treatment of staff who have been involved in an incident.

It supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

The just culture guide should not be used as a routine or integral part of a patient safety investigation – it should only be used when consideration needs to be given to whether an individual member of staff requires support or management to work safely.

The Just Culture guide, along with supporting reference materials, can be found on the NHS England website - www.england.nhs.uk/patient-safety/a-just-culture-guide/.

If staff are involved in an incident, the investigating officer assigned to undertake an investigation might want to talk to all staff involved about what happened. Staff may be asked to provide a formal statement of their involvement or what they witnessed. This helps to understand the events leading to and during the incident. Staff who are asked for this type of information should receive support from their clinical supervisor/line manager and should be kept informed of what is happening with any investigation.

Being involved in a patient safety incident can be upsetting for any member of staff.

Staff who are worried or distressed by what has happened or need someone to talk to can access support via their clinical supervisor, or local education centre. They can also self-refer to Employee Wellbeing Service.

9.4 Corporate Responsibilities

The ABUHB Patient Safety Incidents Team will escalate patient safety incidents of potential concern, and which meet the criteria of national reportable incidents to the Executive team via the weekly Executive Safety huddle to:

- Determine the depth and parameters of an appropriate investigation;
- Consider, where required, escalation e.g.:
  as a Nationally Reported Incident (NRI) or
  Early Warning Notification

- Determine reporting to relevant national frameworks (e.g., multiagency safeguarding processes); Reporting to relevant external bodies (MBRACE/HSE/RIDDOR/SHOT);
- Any relevant communications handling required;
- Next steps in terms of incident management.

10 Duty of Candour

The provisions of the statutory Duty of Candour, as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect on 1 April 2023. This is an organisational duty on all NHS bodies and primary care providers. More information on the Duty of Candour, including the statutory guidance, can be found on the Welsh Government website.

Incident reporting, management and investigation is intertwined with the principles of Being open: communicating patient safety incidents with patients and their carers and must adhere to the Duty of Candour, so in practice these activities should be fully integrated. In preparation for the Duty of Candour, NHS organisations have been reviewing their systems and processes in relation to concerns and incident reporting, investigation, and management to ensure that they are aligned as far as possible, to provide a seamless patient or service user experience.

The Duty of Candour is triggered when:

- An adverse patient safety event (usually an incident) occurs, and the service user sustains or could sustain harm which is:

  - Unintended or unexpected, and
  - More than minimal e.g., moderate, severe or death, and
  - The provision of healthcare was or could have been a factor in that harm occurring.

At the point, the incident is reviewed, and it is recognised that the above triggers for the Duty of Candour have been met, the organisation becomes 'aware'. It is at this point that the Duty of Candour procedure should be initiated.

The Duty of Candour is not intended to operate retrospectively and therefore will only apply where the conditions triggering the Duty of Candour as set out in Section 3 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 occur after the date on which Section 3 was brought into force (i.e., 1 April 2023). In practical terms, this means that

the provision of health care and the harm which ensued, must have taken place after 1 April 2023.

For the avoidance of doubt, the Duty of Candour may be triggered following a retrospective case review but that the conditions which gave rise to the notifiable adverse outcome must have occurred after Section 3 was brought into force.

- The Duty of Candour Statutory Guidance 2023 – see **Appendices**
- Duty of Candour Datix Process – see **Appendices**

11 Investigation

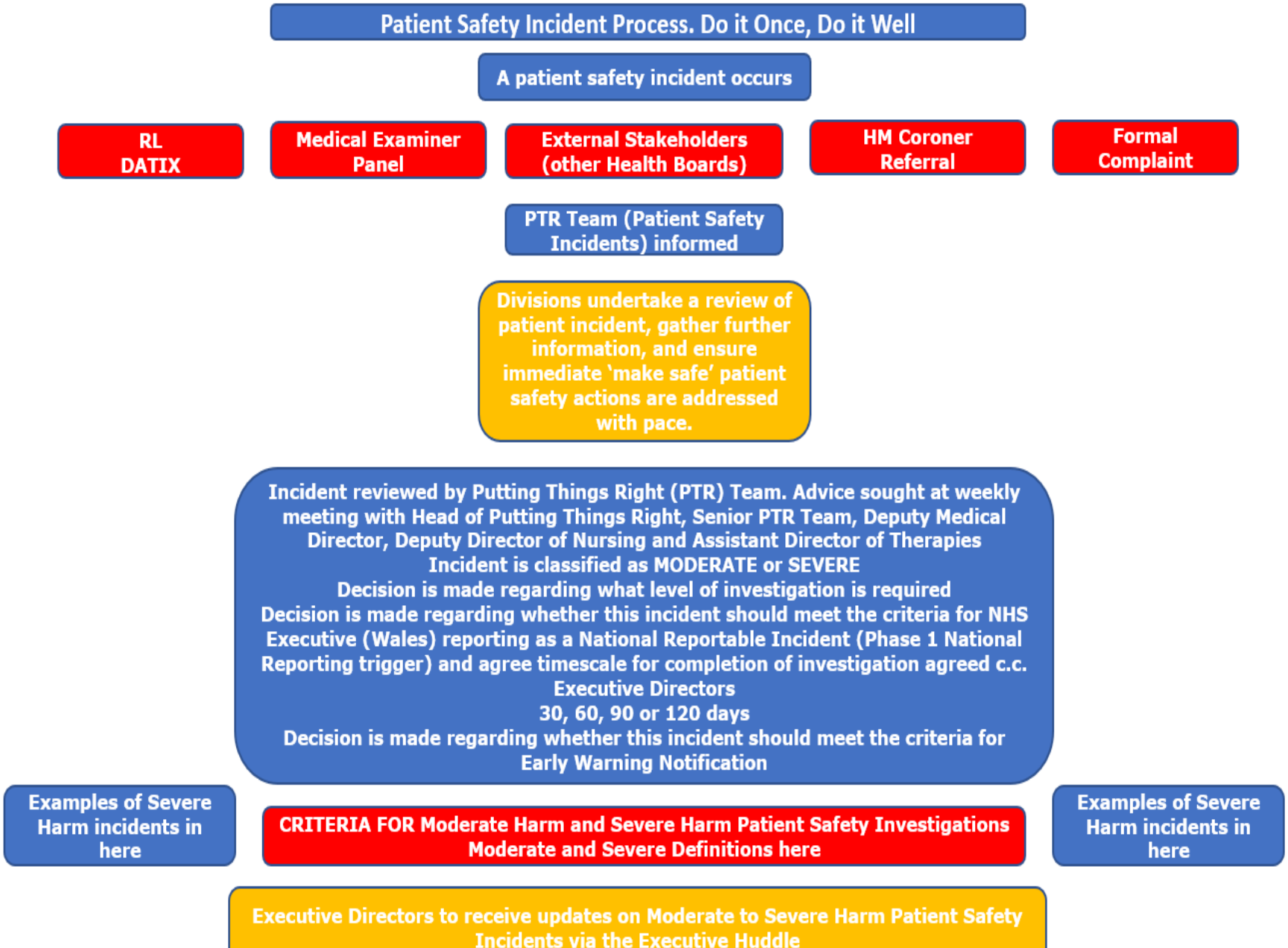
All concerns reported in NHS Wales, including patient safety incidents, must be subject to an appropriate and proportionate investigation in line with the NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2023.

Regulation 23 outlines the requirements of the investigation to be undertaken and requires the organisation to undertake the investigation in the manner that appears, to that organisation, to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily, and efficiently.

In addition to Patient Safety Incident investigations, focussed on an adverse event causing moderate or severe harm, the Health Board will invoke other types of investigations as determined, including thematic reviews, look back reviews, joint investigations, concise reviews, and rapid learning. These will be discussed and taken forward via the Executive Huddle.

Patients and/or their representatives/family will be engaged from the beginning of the investigation. If the Duty of Candour has been triggered this will commence at that point. Patients must be contacted to ascertain any concerns, explain the intended investigation and its purpose, to ascertain the patient's wishes and expectations. The Health Board will incorporate this input from the patient directly into the Terms of Reference (TOR) for the intended investigation. The Health Board will share the draft TOR with the patient/representative and look to agree these wherever possible. The ultimate determination of the TOR will rest with the Health Board to ensure investigations progress and wider opportunities for learning/prevention of future harm are not lost through delay.

Appendix 1


Patient Safety Incident Process. Do it Once, Do it Well
A patient safety incident occurs
RL DATIX
Medical Examiner Panel
External Stakeholders (other Health Boards)
HM Coroner Referral
Formal Complaint
PTR Team (Patient Safety Incidents) informed
Divisions undertake a review of patient incident, gather further information, and ensure immediate 'make safe' patient safety actions are addressed with pace.
Incident reviewed by Putting Things Right (PTR) Team. Advice sought at weekly meeting with Head of Putting Things Right, Senior PTR Team, Deputy Medical Director, Deputy Director of Nursing and Assistant Director of Therapies
Incident is classified as MODERATE or SEVERE
Decision is made regarding what level of investigation is required
Decision is made regarding whether this incident should meet the criteria for NHS Executive (Wales) reporting as a National Reportable Incident (Phase 1 National Reporting trigger) and agree timescale for completion of investigation agreed c.c. Executive Directors
30, 60, 90 or 120 days
Decision is made regarding whether this incident should meet the criteria for Early Warning Notification
Examples of Severe Harm incidents in here
CRITERIA FOR Moderate Harm and Severe Harm Patient Safety Investigations Moderate and Severe Definitions here
Examples of Severe Harm incidents in here
Executive Directors to receive updates on Moderate to Severe Harm Patient Safety Incidents via the Executive Huddle

Appendix 2

Moderate to Severe Harm Patient Safety Incident Process

- **Appointment of Chair** of Investigation process **(list as appendix)**
- A **trained** Investigating Officer (IO) is appointed by the Division in advance of the **initial** meeting (consideration of multiple IOs if cross-divisional)
- Timeline of events completed by the Division **and clinical notes secured**.
- List of key stakeholders to attend is agreed (including any external).
- **Dates for initial and outcome meetings are arranged**.
- Standard PTR Incident Agendas are used.

Initial Meeting
1 week

Purpose of meeting (Initial meeting agenda used):

- Division present overview/timeline of patient safety incident.
- Agree Terms of Reference and Scope of Investigation.
- Nominate a Patient/Family Liaison Officer for Patient/family. ***Need discussion about minutes***
- Appoint an Action Plan Lead.
- Consider if incident meets the criteria for National Reporting.
- Gain assurance that immediate patient safety actions undertaken.
- Identify support for staff.
- Assurance of immediate Patient Safety actions undertaken **and added to Action Plan**
- **Any early learning for sharing to be presented.**

Family Liaison Officer Contacts Patient/Family and asks if they have any questions/concerns to be investigated as part of the process.

Investigation Period
6 weeks

- Investigating Officer undertakes investigation based on Terms of Reference and Scope, including any additional Patient/Family questions and drafts investigation report (+/- Fishbone Diagram)
- Investigating Officer meets with PTR Incidents Team and the draft investigation report is reviewed against Terms of Reference. Consider if any other areas of investigation need to be explored.
- The Investigating Officer meets with Action Plan Lead, shared key areas of learning and improvement and the draft action plan is developed.
- The Investigating Officer considers any Breach of Duty and if Learning from Events (LFER)/Redress required.

Investigating Officer shares Investigation Report and Action Plan (+/- Fishbone Diagram) and sends to Divisional Management for Divisional Approval.

Outcome Investigation Meeting
10 weeks

- Divisionally Approved Investigation Report and Action Plan is presented and Chair Approval is completed.
- Agree monitoring of Actions and ABUHB learning.
- Consider if Incident meets the criteria for National Reporting (if reported, an NHS Executive Outcomes Form is completed by PTR (Incidents) Team.
- Confirm arrangements for sharing report with relevant staff and family/patient.
- Confirm arrangements for sharing report and action plan with Legal Services (for HM Coroner)

Approved Investigation Report and Action Plan (+/- Fishbone Diagram) are formatted and saved in Word and PDF. PDF copies are uploaded to RL DATIX as Approved and PTR (Incidents) Team will email Divisional QPS out of RL DATIX to request closure of the incident.
Investigating Officer emailed final Exec Approved Report as copy.

Sharing of Approved Reports with Patient/Family

11.1 Guidance for Investigating a Concern

The investigating officer will undertake several steps in the thorough investigation of a Patient safety Incident.

Purpose of the Investigation

1. **To find out the full facts** with respect to sequence of events that led to concern
2. To determine **what, if anything, went *wrong*** – and what went well
3. To find out **why it went wrong**
4. To Identify what actions are required to **prevent it happening again**

Planning the Investigation

Take time to plan your investigation

- Be clear of the issues
- Make a list of the people you will need to speak to/contact and what information you need from them
- Remember other people may emerge as you gather information
- Identify the documentation you will need to look at, e.g.
    - Medical and nursing records
    - Incident form
    - CWS / Myrddyn
    - Staff rotas, etc
- Remember time scales
- Factor in:
    - Availability of medical records
    - Availability of key staff
    - Time to draft the report
    - Time for the corporate review

Finding out the Facts

Gather the information - this is the lifeblood of any investigation and will take 60% of your time. Facts will be obtained from:

- Documentation
- Interviews/or information gained from the staff involved in the concern/witnesses
- Examination of equipment records, where necessary
- Examination of the location of the incident may relevant
- A review of appropriate policies and procedures
- **Consider whether CCTV exists and if it aids the investigation N.B. it will require securing within 28 days**

Determine what, if anything, went wrong

- What service/care should have been provided?
- What was provided and what happened?
- Map and analyse the information gathered by using relevant tools (e.g., timeline, tabular timeline, narrative chronology, time person grid)
- Compare sequence of events with relevant standards, protocols, and guidelines

Determining why it went wrong

- Were suitable standards in place to control what went wrong?
- If standards in place, were they appropriate or sufficient?
- If standards were good enough, were they applied in practice?
- Look at the influencing factors, such as:

    - Staff factors
    - Patient factors
    - Environmental factors
    - Task factors
    - Equipment factors
    - Team factors
    - Organisational and Management factors

Use appropriate tools dependent on severity and complexity of concern. Remember, some tools help gather information, some help to analyse information and some help to draw conclusion. (ABUHB Patient Safety Incident Toolkit).

More information on the ABHB Toolkit can be found on: Putting Things Right - Web Page Tool Kit.pdf - All Documents (sharepoint.com) and within the Appendices.

Preventing it happening again

- What lessons can be learnt?
- Are there any recommendations?
- Think about failures that have led to concern, e.g.

    - Human error or inappropriate behaviour by staff
    - Procedural or administration problems
    - Communication problems
    - Recommendations to be practical, proportionate and constructive

Involving patients, families, service users and carers

Involvement begins with a genuine apology. The principles of honesty, openness, and transparency (Being Open) must be used. All ABUHB staff involved in liaising with patients, families, service users and carers must have the necessary skills, expertise, and knowledge to explain what occurred comprehensively and compassionately. The appropriate person must be identified for each incident in accordance with the Duty of Candour.

- Patients and/or their representatives will be engaged from the beginning of the investigation. They must be contacted to ascertain any concerns and to help inform the Terms of Reference for the investigation.
- Patients and their families will know what they can expect from the investigation. They will be informed of realistic and achievable timescales and outcomes, including predicted timescales for investigation.
- Patients and their families will be made aware of the rationale and purpose of the investigation.
- Patients and their families will be provided with the opportunity to express any concerns and questions
- Patients and their families will be provided with a draft final patient safety incident report inclusive of the findings. The Health Board will consider any further comments or questions before finalisation of the report.
- Patients and their families will be signposted to any identified appropriate support services.

- Patients and their families will be provided with the opportunity to meet with representatives from the Health Board to discuss the findings and explore any further concerns.

11.2 Methodologies

Methodologies used should ensure the involvement throughout the investigation of appropriate staff and patient, service user or a person acting on their behalf.

For certain incident types, to support a consistent national approach there are several focussed review tools built into Datix Cymru which should be used where they are available. This includes safety incidents relating to:

- Falls
- Pressure damage (All Wales Pressure Ulcer/PU tool)
- Extravasation

Use of Yorkshire Contributory Factors Framework

The Yorkshire Contributory Factors Framework (YCFF) has been built into Datix Cymru to support a consistent approach to the analysis of incidents, including the identification of cross-cutting themes to enable targeting of improvement activities.

Accordingly, the use of the YCFF is required for NRIs and encouraged for other patient safety incidents (see Appendices).

11.3 Joint investigations

Some safety incidents will require joint investigations, including between:

- different departments within the same organisation;
- where patients have been moved between organisations, including patient handovers at emergency departments; and
- where services have been commissioned, including relating to social care.

For joint investigations involving multiple organisations, please refer to the joint investigation process in Appendices.

The Health Board currently holds weekly joint investigation meetings with Welsh Ambulance Service Trust (WAST) to review collaboratively cross organisational incidences.

Commissioned Services

When healthcare is funded by another Welsh NHS body (Health Board or Trust), the Regulations require a full investigation up to and including consideration of qualifying liability (QL). Organisations are required to undertake a joint investigation with a lead organisation agreed.

There are however distinct differences in how the Regulations are applied when healthcare provision has not been provided by a 'Welsh NHS body' (Health Board or Trust) through NHS funding arrangements. The degree in variation is predicated on which other type of 'responsible body' provided the healthcare, and particularly when the healthcare has been provided outside of Wales.

The way in which the Regulations vary can be divided into two categories;

1. NHS Wales funded healthcare provided by another UK NHS provider, i.e.:
   - NHS England; or
   - NHS Scotland; or
   - NHS Northern Ireland; and

2. NHS Wales funded healthcare provided by an 'independent provider', either:
   - Provided in Wales under arrangements made with a Welsh NHS body and is not an NHS body or a primary care provider; or
   - Provided outside of Wales.

NHS Wales funded healthcare provided by another UK NHS provider

When the Regulatory duty is applied to other UK NHS organisations through cross-border and other commissioning arrangements, it is anticipated that local procedures for managing concerns and investigations will be of a sufficient standard to support investigations in keeping with the Regulations. The Regulations require other UK nations to consider a qualifying liability (QL) and refer the matter back to the NHS Wales commissioning organisation where they consider a QL **does or may** exist. However, there is no requirement on other UK NHS organisations to inform

an NHS Wales commissioning organisation where they **do not** consider a QL exists.

NHS Wales funded healthcare provided by an 'independent provider'

The Regulations state any responsible body, who provides healthcare **in Wales** under arrangements made with a Welsh NHS organisation, and who is not an NHS Wales Health Board or Trust, must have arrangements in place to manage and undertake investigations when a concern, including a patient safety incident, is raised.

The first element to highlight is that the Regulations do not apply to private provision of healthcare *outside* of Wales.

The second element relates to private provision *within* Wales. In this regard, this will include healthcare provision in care and residential home settings through continuing healthcare (CHC) and funded nursing care (FNC) arrangements, including local authority managed, third sector/charitable/not for profit sector, and private business. This also extends to any other privately provided healthcare which is NHS funded.

Responsibility to Investigate

Whilst the Regulations require an investigation to be undertaken when a patient or service user is subject of a concern during funded provision of healthcare, there are two key differences when a concern is raised in this regard:

- The investigation is to be **undertaken by the provider** and not the NHS commissioning organisation, in keeping with the requirement on them to have arrangements in place to do so; and
- There is no requirement on the provider to consider a QL as part of the investigation process.

Joint investigations in relation to commissioned services

Although the Regulations require the provider to undertake investigations when a concern is raised (including a patient safety incident), it is envisaged that when a concern is raised both in respect of the commissioned healthcare provider, and the commissioning organisation, it

will be for the NHS Wales organisation to lead a joint investigation. The Regulations still however limit the independent provider element of the investigation to a factual response and not as far as considering QL, but the NHS element of the investigation is required to consider QL.

Post discharge

Concerns which occur during healthcare provision by an NHS Wales body prior to, or during a transfer of care to an independent provider through NHS funding arrangements, will remain the responsibility of NHS commissioning organisation to manage and investigate, fully in keeping with the Regulations up to and including consideration or QL.

11.4 Investigation outcomes

Learning from incident investigations

A fundamental part of undertaking incident investigations is to learn from previous experience to identify areas for improvement to reduce the risk of similar incidents occurring in the future.

Completing an incident investigation

The accountability for supporting and engaging with an incident investigation sits within the Division who undertook the investigation.

To allow the Executive Board to be assured that incidents within the organisation have been dealt with appropriately, the Health Board must ensure robust processes are in place to inform and assure their Boards that:

- The quality of their investigation processes is of a high standard;
- Investigations are being undertaken and completed in a timely manner;
- Patients or service users or anyone acting on their behalf are being engaged and supported during the investigation process and the findings and outcomes of the investigation are shared with them; and
- Appropriate actions are being taken and learning is being shared across the organisation.

All Patient Safety incident investigations and their accompanying action plan, resulting in Moderate and above harm, in addition to all Never Events will receive Senior Executive sign off.

Learning, and ongoing monitoring and assurance of actions, will be presented at the Quality and Patient Safety Operational Group by Divisions and Directorates through to Patient Quality Safety Outcome Committee.

Accountability for tracking and implementing learning and actions

The central Patient Safety Incident Team will monitor, and track identified Divisional actions and learning from incident investigations. Whilst the central team will assist with this quality assurance, ultimately each Division will be responsible and accountable for the delivery of its learning, actions and ongoing monitoring, audits, and assurance around compliance. Accountability Agreements will be developed for each Division. An Escalation process will be invoked if required.

Actions arising from moderate/severe investigations to be shared with Executives and Divisional Triumvirate.

The Health Board strives to be an all-encompassing learning organisation where people continually expand their capacity to improve.

12 Process for reporting outcomes of a National Reportable Incident investigation

Detailed guidance on the process for reporting NRI investigation outcomes to the NHS Wales Executive is in Appendices.

This function will be undertaken by the Patient Safety Incident SI team.

13 Training

Staff undertaking the Investigating Officer Role Should attend the Putting Things Right Serious Incident Investigation and Complaints Training. This workshop is held over a full day and should be attended by Senior Health Board staff involved in the handling and response to Complaints and Serious Incidents received within the Health Board.

The workshop focuses upon developing an understanding of Serious Incident and Complaints investigation and response in line with the Putting Things Right regulations and provides:

- An understanding of the PTR process and the framework for investigating concerns.
- Roles and responsibilities of the IO.
- An overview of the necessary tools and knowledge required in the execution of an investigation.
- Signposts to the resources used to support investigations.

14 Review

This Policy will be reviewed every 3 years or in line with any National or Local Policy change.

15 References

Health and Social Care (Quality and Engagement) (Wales) Act 2020

The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023

Putting Things Right guidance document (v3, 2013)

The Duty of Candour Procedure (Wales) Regulations 2023

The Duty of Candour Statutory Guidance 2023

16 Appendices/Supporting information.

1. NHS Wales Never Events list
2. Nationally Reportable Incident (NRI) reporting processes & flow chart
3. Guidance on nationally reporting specific incident types
4. Joint investigation process
5. Guidance on Safety-II principles
6. Commissioned Services flowchart

7. Cause and effect diagram (fishbone diagram)
8. Yorkshire Contributory Factors Framework - Improvement Academy
9. Systems Engineering Initiative for Patient Safety (SEIPS)
10. Guidance for Reporting an Incident
11. Datix Cymru Incidents Module User Guide
12. Health and Safety Intranet pages
13. Safeguarding Intranet pages
14. Putting Things Right Intranet pages
15. Duty of Candour Datix Process
16. The Duty of Candour Statutory Guidance 2023

Agenda Item: 3.7

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Long-Term Strategy: Governance, Principles and Timeline.
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans, Director of Strategy, Planning & Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Chris Dawson-Morris, Deputy Director of Strategy, Planning & Partnerships

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

Ar Gyfer Penderfyniad/For Decision

- To discuss and approve the approach to developing the Long-Term Strategy including the governance, principles, and timeline.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper follows the dedicated Board Briefing session on 20th September to shape a proposal to develop a new long-term strategy for the organisation that builds upon Clinical Futures. The feedback from that session has been included and further refined through consideration at Executive Committee and Partnerships, Population Health, and Planning Committee.

An engagement pack is in development and following initial testing at the Senior Leadership Group on 10th November is undergoing further refinement to pick up the feedback.

Cefndir / Background

The Health Board's extant strategy is the Clinical Futures strategy which was the driving force for the service reconfiguration realised through the Grange University Hospital opening, the Enhanced Local General Hospitals network and developments in community services. The premise of Clinical Futures was to redesign the system of care so that people could be supported to better manage their own health and wellbeing. When a citizen needs to access care and support, they might do so as locally as is safe and appropriate with a focus on out of hospital settings.

Alongside the Clinical Futures strategy a number of other arrangements contribute to setting strategic direction of the organisation. Through partnership, the Health

Board is instrumental in the delivery of several strategic work programmes such as Building a Fairer Gwent, the Area Plan for Gwent, and the Gwent Well-Being Plan. The medium-term vision for the Health Board is articulated through its Integrated Medium-Term Plan and the life course approach within this. All of these approaches are framed around the ambition to reduce health inequalities and improve population health for our communities.

The changing demographics of the population, renewed hospital configuration, partnership landscape and pandemic learning suggest that it is an appropriate time to consider a new long-term strategy that articulates joint commitments with our population through to 2035.

Asesiad / Assessment

The strategy will articulate the organisation's role in the wider Gwent health economy, recognising that the Health Board is more than just a provider of services. The strategy will seek to align the vision, ambition, and commitments of the Public Service Board (PSB) for Gwent and those of the Regional Partnership Board (RPB)

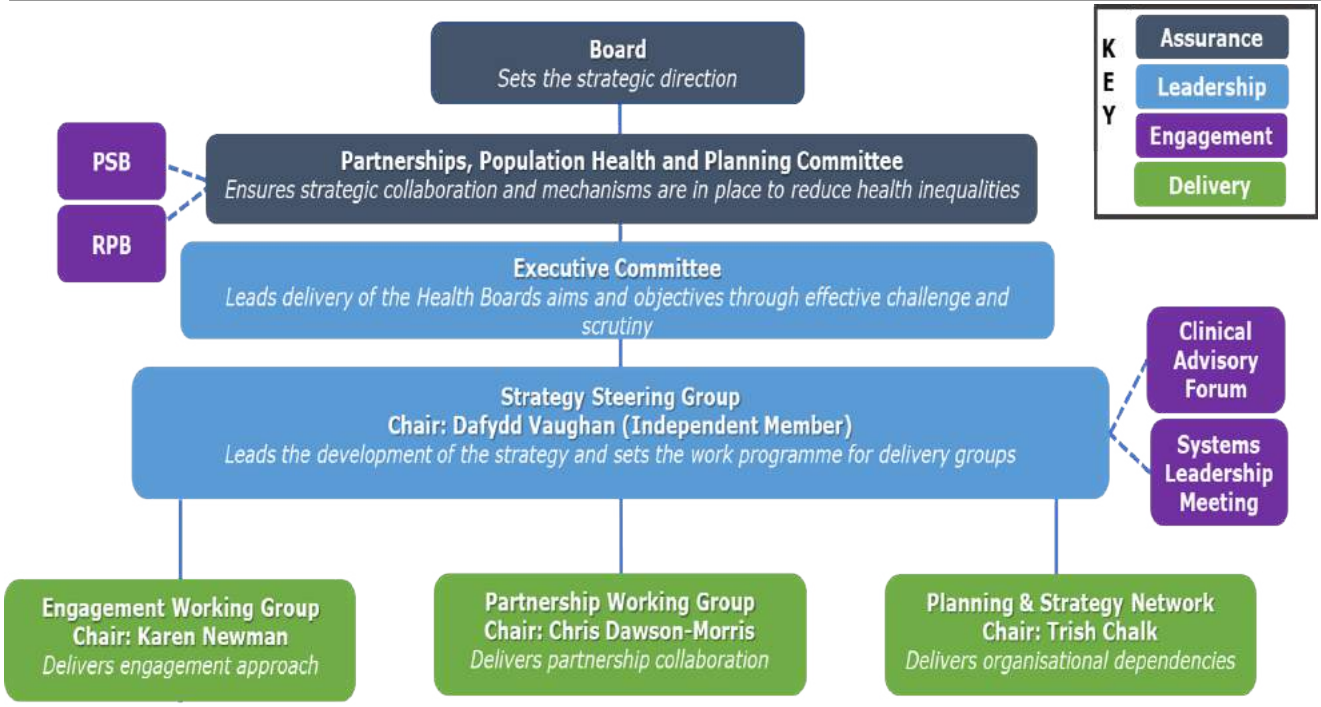
The strategy will be the guiding light that describes the organisational commitments with the people of Gwent, taking learning from areas such as Wigan who established the Wigan Deal in partnership for the county. The intended approach, following the Board session, is development of the strategy with reference to available insight, data and intelligence, an appreciation of best practice, innovation, and evidence and through meaningful engagement based on the needs of the communities and individuals.

The development of the long-term strategy will act as a tool to facilitate the Board setting a new strategic framework for the organisation. A draft proposal to support discussion is provided below and the details of each element will be developed through engagement:

To develop effectively a meaningful long-term strategy a clear governance structure will need to be in place. The governance has been designed to include the leadership and assurance roles of the Executive Committee, Partnerships, Population Health and Planning Committee and Board. The Strategy Steering group will oversee the strategy development and the implementation framework for delivery. To recognise the complexity of the Strategy development there will be three working groups each with the responsibility of managing a key dependency.

Working Group	Dependencies
Engagement	• Relationship with Llais and other bodies • Staff engagement events • Population engagement events, existing engagement calendar

Partnerships	• Regional Partnership Board • Public Service Board including Building a Fairer Gwent • Existing Partner(ship) strategies and plans
Planning & Strategy Network	• IMTP 24/25 • Quality Strategy & Assurance Framework • Financial Recovery Plans & Bed Plan • Outcomes Framework • Workforce & Financial Plan



Following the Board session and discussion at Partnerships, Planning and Population Health Committee and Executive Committee the following assumptions are proposed recognising they will continue to be refined through further engagement:

<u>Assumptions</u>

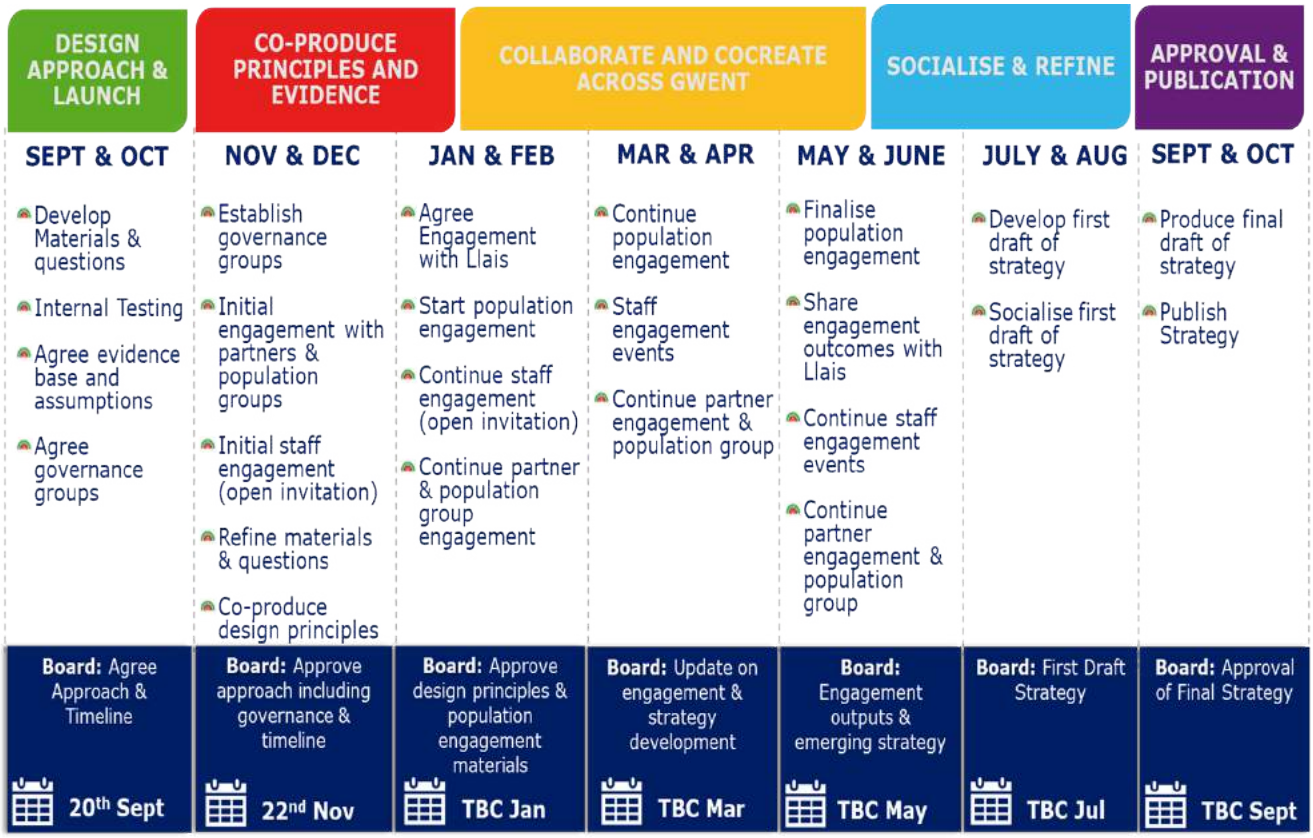
- A strategy for improving the health of Gwent.
- Proportionate Universalism will be its bedrock.
- It will be developed in partnership and articulate the Health Board's unique added value.
- It will establish the Health Board's role as an anchor institution.
- It will form the basis of the values and behaviours framework of the organisation.

The initial engagement approach is proposed with the following principles:

- Big Public Conversation through a varied methodology involving individuals and population groups,
- Take learning from digital engagement on capturing individual stories and experiences,
- Drawing on known themes and trends (through complaints, feedback, and concerns),
- Maximise existing channels,
- Incorporate "Building a Fairer Gwent" engagement.
- Reflecting any engagement done through the RPB
- Collaborate with Partners Organisations

- Tailored by life course and community.
- Incorporate the Arts as outlined in our Arts in Health Strategy
- Incorporate Digital Media

An initial engagement pack has been developed and will be refined over the next month incorporating feedback from Senior Leadership Group and other for a. The proposed timeline to have a new strategy in place for September 2024 to inform the Integrated Medium-Term Plan 2025-28 is below:



Aligned to the timeline the key next steps and actions completed are;

Sept:	✓ Board briefing session
Oct:	✓ Agreed chairs of governance groups
Nov:	▪ Partnerships, Planning and Population Health Committee and Executive Committee shaped approach ▪ Initial engagement pack shared for internal testing
Dec:	▪ First meeting of Strategy Steering Group ▪ Initial engagement with population groups and partners ▪ System Leadership Group session ▪ Established staff intranet page on strategy development and cascade offer to attend divisional meetings for engagement

Argymhelliad / Recommendation

The Board is asked to approve the approach to developing the Long-Term Strategy.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol:	None

Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. All IMTP Priorities Apply
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the wellbeing and engagement of our staff Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	A Horizon Scanning Pack has been developed which outlines the evidence base.
Rhestr Termau: Glossary of Terms:	Proportionate Universalism: Actions are universal but with an intensity that is proportionate to level of social disadvantage
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Board Briefing Session (20th September) Partnerships, Planning and Population Health Committee (2nd November)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Not Applicable
• **Financial**	Not Applicable

Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**Yes not yet available** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Involvement - The importance of involving people with an interest in achieving the well-being goals, and ensuring that those people reflect the diversity of the area which the body serves

Agenda Item: 4.1

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Stroke Service Reconfiguration Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Leanne Watkins, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Tracy Morgan, General Manager, Medicine Kate Fitzgerald, CF Assistant Programme Director

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

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this SBAR is to provide an update on the temporary consolidation of the Stroke service across the Hyper Acute Stroke Unit (HASU) at the Grange University Hospital (GUH) and one stroke rehabilitation site at Ysbyty Ystrad Fawr (YYF).

The Stroke service has experienced significant workforce challenges for a prolonged period of time. This position has further deteriorated with increased workforce challenges across a range of disciplines resulting in a lack of stability in the core clinical provision for the Stroke pathway. In the long term a sustainable workforce model is key to ensure the delivery of optimal patient outcomes and safe, quality patient care.

This proposal was approved temporarily by the Board is aligned with the recommendations outlined in the Getting It Right First Time (GIRFT) review which was undertaken in September 2022 through best practice guidance to improve the

quality of care delivered for stroke patients. The stroke service is currently delivered across all three enhanced local general hospitals (eLGH) sites with a specialist hyper acute stroke unit at the Grange University Hospital (GUH), in line with the Clinical Futures Model.

Cefndir / Background

In order to support the delivery of the new clinical model and the reconfiguration of services following the opening of the Grange University Hospital in November 2020, the Stroke service redesigned its clinical model and introduced new patient pathways.

This included the relocation of the specialist hyper-acute stroke unit (HASU) from RGH (Royal Gwent Hospital) to GUH and the consolidation of Stroke rehabilitation across the three eLGH sites. In turn, under the new model of care, all three of the eLGH sites provide sub-acute care, therapy, and rehabilitation services for stroke patients.

Over the last few months, the Stroke service has experienced considerable workforce challenges, these challenges were escalated through to the eLGH Reconfiguration Programme Board, chaired by the Chief Operating Officer. The Programme Board recommended establishing a Stroke Task and Finish Group due to the urgent service risk to review and analyse the long-term optimal Stroke service configuration.

As part of the analysis the Stroke Task and Finish Group undertook an options appraisal to review the optimal service model with representatives from medical/nursing/therapy disciplines and clinical leads from the across the eLGH sites. The highest scoring and therefore the preferred option was one acute site at GUH and one rehabilitation site at YYF, with a proposed reduction of 8 beds from the current core base due to the benefit of the centralised model.

Asesiad / Assessment

The temporary reconfiguration of the Stroke service was approved by the Public Board on 17th July 2023 with a request for a further update in relation to a number of key areas which will be covered in this paper.

Implementation Phase

The Stroke reconfiguration is now in the implementation phase, which involves operationalising the agreed proposal as outlined during the planning phase with a delivery timeline of the end of November 2023. The General Manager, Medicine is chairing a weekly Stroke Operational Group with representation from across the service workforce disciplines. There are dedicated working groups focussing on the following areas:

- Transfer of Patients/Flow
- Patient Pathways – Medical/Nursing/Therapies
- Estates/Facilities/Equipment
- Workforce Model
- Communication and Engagement

Organisational Change Policy (OCP)
The Stroke and COTE OCP consultation formally commenced on Monday 31st July 2023. The consultation period lasted 4 weeks, closing on Sunday 27th August 2023. The responses received from the three eLGH sites were positive overall; staff appreciated the current workforce challenges experienced and that consolidating the rehabilitation service for Stroke patients would enhance the provision of safe patient care.

The changes detailed within the OCP documentation do not alter the remit of staff roles and responsibilities. It is however accepted that as a result of this change there may be a temporary requirement for staff to work from an alternative ward within the existing site or alternative sites and change their contractual base. As outlined through the process, where possible individual staff preferences have been accommodated in terms of work location and speciality, ensuring alignment with the service and staff requirements.

COTE/Stroke Reconfiguration
The Stroke reconfiguration is intrinsically linked with the COTE service in terms of the staffing model, bed capacity and site management. In essence it is difficult to reconfigure one service without impacting on the other. As part of this approved proposal, up to 40 COTE patients at YYF may need to be displaced to RGH and NHH to provide the required capacity for the increased stroke demand at YYF. From the middle of November (date to be agreed by the Stroke Task and Finish Group) all Stroke patients at GUH will be stepped down directly to YYF to enable a gradual redirection of patients as clinically appropriate to YYF which will reduce the number of patients requiring displacement.

The revised Stroke bed base is as follows:

Site	Current Bed Base	Revised Bed Base
GUH (no change)	15	15
RGH	24	0
NHH	24	0
YYF	15	55
Total	78	70

The reconfigured Stroke bed base at YYF:
- 28 beds on Bargoed ward (plus two rehabilitation rooms)
- 27 beds on Oakdale ward (plus three rehabilitation rooms)

The reconfigured COTE bed base at RGH and NHH:
- 20 beds with ability to surge to 23 on C5W at RGH, current Stroke ward.
- 20 beds with the ability to surge to 22 on 3.4 NHH, current Stroke ward.

It is noted that the Health Board has the ability to meet the demand for COTE beds within locality areas aligned to care closer to home principles. However due to wider system pressures this position is often compromised and patients are treated out of

area. The Health Board is also currently operating above the Clinical Futures bed base.
The current COTE capacity at YYF will reduce as a result of this proposal which due to the challenges identified above further increases the risk of patients being treated 'out of area'. To reduce and mitigate this risk considerable work is ongoing across the Health Board through the Patient Safety Events with the aim of reducing the number of medically fit patients in acute beds to support the provision of adequate core capacity to continue to support patients within their local hospital.

Three Patient Safety Team interventions have been held across RGH and YYF focusing on rapidly improving timely hospital discharge working with the full multi-disciplinary teams including Local Authority and community partners. These interventions aim to right size hospital capacity, align patients to the most appropriate care setting to meet their needs, acknowledging that home is the best place for people to recover.

The event at RGH at the end of September delivered a sustained 16 bed reduction in the bed base with further interventions planned at RGH, YYF and SWH in November 2023. These ongoing targeted interventions will continue to support the reconfiguration of the COTE and Stroke services by aligning capacity with demand, reducing the bed base, and achieving the best results for patients in a timely manner whilst maintaining quality and safety.

The table below sets out the current and future bed plan for the COTE and Stroke, services following the Stroke consolidation:

	Pre-Consolidation			Post-Consolidation			Variance	
	Stroke	COTE	Total	Stroke	COTE	Total	Stroke	COTE
GUH/HASU	15	0	15	15	0	15	0	0
RGH	24	128	152	0	151	151	-24	23
YYF	15	131	146	55	86	141	40	-45
NHH	24	140	164	0	162	162	-24	22
Total	78	399	477	70	399	469	-8	0

The above table demonstrates the net reduction of 8 beds within the Stroke service.

Further Patient Safety Team events are planned across both the acute and community settings, the changes these events are intended to create will form a further update to board in the coming months.

Therapy/Rehabilitation
Over the last few weeks, therapy teams from across the three eLGH sites have been working together to review existing facilities/equipment and plan for the move to one rehabilitation site at YYF. The planning has included maximising and enhancing the existing environment at YYF working with the site operational team. It is noted that due to the single room layout, five single rooms aligned to the two stroke wards will be utilised for Stroke rehabilitation, as there is a lack of suitable ward therapy

space in the current configuration. As part of the permanent long-term service plan the lack of appropriate rehabilitation space at YYF will be highlighted and reviewed accordingly.

In addition, the therapy and operational teams on each of the eLGH sites are currently reviewing equipment and assessing what specialist stroke equipment needs to move to YYF and what general therapy equipment will remain at RGH and NHH, noting that patients will continue to step down to RGH or NHH to continue with their ongoing rehabilitation if required and will benefit from access to the equipment.

As three rehabilitation sites will be consolidating into one site, additional storage space will be required at YYF to accommodate extra equipment. In recognition of the urgent service risk around this reconfiguration, a temporary break out space used during COVID has been identified on the 3rd floor at YYF for conversion into a storage area. A capital bid proforma has been submitted and agreed, the works are progressing with the aim of being completed ahead of the move. It is noted that no additional equipment has been purchased.

CNRS/Community Services

The Community Neuro Rehabilitation Service (CNRS) is not directly affected by the reconfiguration of inpatient wards, the service has confirmed that an in-reach model will operate at YYF to support the timely discharge of Stroke patients' home from hospital to continue rehabilitation at or closer to home.

The therapy led Community Neuro Rehabilitation Service (CNRS) and Community Hospitals will continue to support the Stroke service. The change does not impact on the service provision or staffing across these areas.

The focus as always is to support patients to be discharged home. However, in the event that patients require ongoing support following their Stroke or if there are complexities within discharge planning, in order to continue to work within the principles of care closer to home, out of area Stroke patients receiving their care within YYF will be transferred to the appropriate facility to meet their needs within their local area. This maybe within an eLGH, Community Hospital or Step Closer to Home environment to ensure patients are supported locally and flow is maintained across the stroke pathway. In addition, the Health Board continues to work closely with Local Authority partners, noting that Caerphilly Local Authority have agreed to act as a Trusted Assessor for out of area Stroke patients and there are ongoing discussions in relation to the implementation of the Trusted Assessor model across all Local Authorities to ensure patients are discharged in a timely manner.

Financial Update

The Stroke reconfiguration will deliver a reduction of 8 beds with an associated opportunity of a reduction in spend of £626k pa. This is made up of £400k nurse establishment reduction, £160k medical staff and £80k ward assistants. However, this is predicated on the spare capacity not being utilised to support the wider system. In the event that capacity is required to support the wider system the cash releasing opportunity would reduce to £400k. The medical workforce will continue

to be used to support the wider system bed plan. This figure is based on all nursing vacancies being filled.

It is important to note that without a significant reduction in the number of medically optimised patients, the total savings will not be realised.

A more cost efficient and effective model will be explored for the cohort of medically optimised patients aligned to the Discharge Improvement Programme this will include the establishment of a 'Ready to Go' ward. This model will take into account the learning from the introduction of the 'Home Ward Bound' wards last year and will focus on expediting discharges and providing on-going care with a reablement focus to prevent deconditioning and improving patient outcomes. This will be progressed via the wider eLGH Reconfiguration working group.

Communication and Engagement

A Communication and Engagement Working Group has been established with representation from the Corporate Communication/Engagement and Planning teams. The following areas have been progressed:

- Communication schedule for the temporary service change.
- Information leaflet and letter to inform patients of the temporary service change.
- Letters to stakeholders to inform them of the temporary service change, including WAST, Local Authority, Primary Care and Powys Teaching Health Board.
- Wider staff communication via the intranet, focused communication with staff through team meetings, 1-1s and Divisional communication through the dedicated working group.

As described in the previous Public Board paper, this change will be subject to public engagement and consultation. In agreement with Llais, this will commence when the temporary change is implemented. This will be in accordance with the Welsh Government guidance and will require an 8-week public engagement followed by a further 12-week consultation period.

Risk Assessment

Issue	Risk	Mitigation
Interdependences with other services at eLGH sites, in particular COTE	Destabilisation of medical, nursing workforce across eLGH sites, COTE patients displaced to RGH/NHH to provide capacity for increased stroke demand at YYF	Strategic oversight through the eLGH Reconfiguration Programme Board, recognising the interdependencies between workstreams and consolidation of other clinical models, appropriate capacity identified for

		displacement of COTE patients
Alignment with Clinical Futures Strategy, care close to home delivery model	Stroke patients travelling further distance to receive care, therapy, and rehabilitation services	Consolidation of the services, sustained staffing, centre of excellence, patients received better quality care, start rehab at home sooner
Relocation of staff from RGH and NHH to other sites as per the proposed consolidated model	Loss of specialist stroke staff	Through OCP staff offered opportunity to work at YYF on a stroke rehabilitation ward or to remain at their current work base working within a different specialty which may be within a different ward, or relocate to another e-LGH site
Public opinion and interest in the proposed reconfiguration	Health Board reputation, poor public profile	Promote key messaging, care close to home where possible, delivery of quality services, service reconfiguration recommendation from external review
Low staff morale at the eLGH sites due to service consolidation, loss of identity at NHH site	Loss of specialist stroke staff	Reinforce opportunities as a result of the consolidation, aligned to wider eLGH reconfiguration
Community hospital pull model at YYF following completion of stroke pathway for appropriate patients	Rehab support delivered out of area, not aligned to care close to home model	Implement step down model for out of area patients at YYF for those requiring further support/care following completion of stroke pathway
Wider implications for stakeholders such as Welsh Ambulance Services Trust/Local Authorities due to the consolidation i.e., travel distance	Increased conveyance times, delays in discharge	Stakeholder engagement on the long-term case for change, trusted assessor model to be implemented as per discharge work programme

Argymhelliad / Recommendation

The Board is asked to: -

- Note the update on the Stroke reconfiguration and the consolidation of services across the Hyper Acute Stroke Unit (HASU) at the Grange University Hospital and one stroke rehabilitation site at Ysbyty Ystrad Fawr (YYF) by the end of November 2023.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 3.2 Communicating Effectively 6.3 Listening and Learning from Feedback 7.1 Workforce
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Older adults are supported to live well and independently Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	CF – Clinical Futures HASU – Hyper Acute Stroke Unit YYF - Ysbyty Ystrad Fawr GIRFT – Getting It Right First Time eLGH – Enhanced Local General Hospital GUH – Grange University Hospital RGH – Royal Gwent Hospital OCP – Organisational Change Process CNRS - Community Neuro Rehabilitation Service

	COTE – Care of the Elderly YYF – Ysbyty Ystrad Fawr SWH – St Woolos Hospital
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Yes, outlined within the paper
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Yes, outlined within the paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**Yes not yet available** **EIA** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Annual Presentation of Nurse Staffing Levels to the Board
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Linda Alexander, Deputy Director of Nursing

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

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to assure the Board of the nurse staffing levels for all wards included under Section 25B of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA) within the review period October 2022 to September 2023 and that ABUHB are meeting its statutory requirements.

Cefndir / Background

The attached annual presentation report (Appendix 1) details the method, output, conclusions, and actions arising from the (Spring & Autumn 2023) nurse staffing recalculation cycles. In line with the requirements of the NSLWA, the triangulated methodology for calculating the nurse staffing levels for adult medical, surgical, and paediatric in-patient wards has been carefully applied to determine the required nursing establishments for all 25B wards and have been presented to the designated person (Director of Nursing) in the challenge and support meetings.

Asesiad / Assessment

Spring recalculations (March/April 2023).

On completion of the Spring recalculations, six wards in total were identified as requiring amendments to previously agreed rosters. These recalculations were presented to the Executive Committee in August 2023. The Spring recalculations were undertaken prior to the decision to re-configure stroke services. It was therefore recommended that any alterations to staffing rosters on affected wards be put on hold. The requirement to continue to staff these wards with temporary staffing in the interim was recognised. Additional recalculation meetings will be required once the reconfiguration is complete to reflect this change.

In August, the Executive Committee approved the proposed planned roster amendments for D2W Royal Gwent Hospital and Bedwas ward Ysbyty Ystrad Fawr.

D2W RGH: 16 bedded elective surgical wards with 2 flex beds.

Professional discussions and review of the acuity confirmed that the ward did not require a HCSW by night. **Cost Saving: £102, 695**

Bedwas Ward YYF: 28 bedded Endocrine/COTE ward.

The budget and roster template has been amended to align and reflect the required 1WTE supernumerary ward manager (previously only budgeted for 0.5 WTE WM following split from AMU). **Cost: £29, 801.36**

The remaining 4 wards, all of which are aligned with the stroke reconfiguration proposals demonstrate a requirement to alter the current establishment following the spring recalculations. Permanent alterations to rosters were put on hold until the reconfiguration process is complete. The wards affected are:

- B4 GUH, C5E RGH, 3/4 NHH, 3/2 NHH

Details of all proposed changes are set out in appendix 1.

Autumn Calculations

Following the recalculation processes, the planned rosters to most wards were deemed appropriate to meet the needs of patients. As a result, no alterations were required to rosters on the medical wards apart from those awaiting the outcome of the stroke reconfiguration service. The Scheduled Care division has made cost neutral adjustments to rosters by reallocating the nurse pool resource to the wards.

Cost savings have been achieved on one elective surgical ward in RGH. RGH D2W establishment review demonstrated a reduction in 1.42WTE RN's which equates to a cost saving of **£52,871.**

Details of all proposed changes are set out in appendix 1.

There have been no required changes to the paediatric ward or the gynaecological ward at the Grange University Hospital.

Argymhelliad / Recommendation

The Health Board has a duty to implement the statutory guidance and ensure compliance with the requirement of the Nurse Staffing Levels (Wales) Act.

The Board is asked to: -

- Receive ASSURANCE that the Health Board is meeting its statutory requirement to calculate the nurse staffing levels for all wards that fall under Section 25B of the NSLWA; and that
- The Health Board is meeting its statutory duty to provide an annual presentation to the Board of the nurse staffing levels on 25B wards.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.1 Safe and Clinically Effective Care 5. Timely Care 7.1 Workforce 3.1 Safe and Clinically Effective Care
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Not Applicable Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prrioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	

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

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

Annual Presentation of Nurse Staffing Levels to the Board	
Health Board	Aneurin Bevan University Health Board (ABUHB)
Date of annual presentation of Nurse Staffing Levels to Board	22 November 2023
Period covered	This report encompasses amendments to ward nursing establishments covered by 25B of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA) from October 2022 to September 2023.
Number and identity of section 25B wards during the reporting period. • **Adult acute <u>medical</u> inpatient wards** • **Adult acute <u>surgical</u> inpatient wards**	The board is required to consider and have due regard to the duty on them under Section 25A of the Act to have sufficient nurses to allow time to care for patients sensitively wherever they are receiving nursing services. There is a requirement to constantly review and carry out comprehensive and systematic reviews of all nurse staffing levels. The Act requires Health Boards and Trusts to report on the calculation process and outcomes for all wards that fall under 25B of the Act, these include all acute medical, surgical and paediatric wards. Within the reporting period 34 acute adult in-patient wards and 1 paediatric ward fulfil the reporting criteria of Section 25B of the NSLWA. The 25B wards include: 21 Adult Acute Medical Wards 13 Adult Acute Surgical Wards 01 Paediatric Ward (50 Beds)

	Calculated and Funded establishments from October 2022 to September 2023					
	Adult acute medical inpatient wards		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (October 2022)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	366.8	473	228.87	229.64	70.22	17.06
WTE of required establishment funded (October 2022)	366.8	473	228.87	229.64	70.22	17.06
Staffing requirements following Spring Cycle (May 2023)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (May 2023)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	372.46	487	228.87	226.9	70.22	17.06
WTE of required establishment funded (May 2023)	366.8	473	228.87	226.9	70.22	17.06
Staffing requirements at end of reporting period (September 2023)	**Adult acute medical inpatient wards**		**Adult acute surgical inpatient wards**		**Paediatric inpatient wards**	
Required establishment (WTE) calculated (September 2023)	**RN**	**HCSW**	**RN**	**HCSW**	**RN**	**HCSW**
	372.47	487	227.21	233.22	70.22	17.06
WTE of required establishment funded (September 2023)	372.47	473	227.21	233.22	70.22	17.06
WTE Supernumerary band 7 sister/charge nurse at end of reporting period (funded but excluded from planned roster)	21		13		1	

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

Act Programme Lead by way of challenge and support meetings which were held in June and October respectively.

In line with the requirements of the Act assurance is sought that:

- All Section 25B wards have a 26.9% uplift applied to the Registered Nurse workforce within their calculated establishments to allow for annual, sick and study leave.

- Ward Managers are supernumerary to the planned rosters. The 26.9% uplift has also been applied to the Ward Manager establishment to cover sick leave, study leave and to enable the continuing provision of the supervisory role in the ward manager's absence.

After several years of reviewing and refining the planned staff rosters and establishments, the Autumn recalculation confirmed most 25B wards have in place the appropriate establishments. All ward managers are supernumerary to the establishment in all 25B wards.

Paediatrics

C1 is an acute 50 bedded paediatric inpatient area inclusive of 2 funded HDU beds. The average occupancy throughout June was 34, very slightly higher than in January. The acuity audit demonstrated a high level of acuity and turnover and an increased length of stay. Reference was made to increased vacancies and a junior staff nursing workforce. However, junior staff are supported with a robust induction programme. Bank usage has increased from 6.63% of the deployed staff to 13.01% this can be explained by the increase in the number of vacancies which were 19.48 WTE in June. Bank staff continue to be mainly substantive staff.

Acute Medical and Surgical Wards

High acuity and the continued need for enhanced care to patients on the Care of the Elderly (COTE) wards was again identified as a theme during the recalculations. The divisions have been proactive in finding innovative ways of working to improve the patient experience and reduce pressures on ward staff. A proof of concept is being piloted in YYF and at RGH considering new and initiative ways of caring for patients requiring an increased level of observation. Both pilots are demonstrating positive results which includes the appointment of activity coordinators to ensure patients receive physical and mental stimulation, using less restrictive practise, keeping them mobile and preventing deconditioning. This not only improves the patient experience but financial

	benefits are also being realised by way of a reduction on the reliance on temporary staffing which is being tracked through the Variable Pay Improvement Board. Further innovation to improve quality metrics include: • There has been success in Ystrad Mynach Hospital (YYF) in reducing patient falls with harm. Oakdale ward has trialled a multi-disciplinary approach to falls risk assessment and have introduced SWARM rounds (staff swarm to work out what has happened, why and what to do to prevent it recurring). Following a patient fall the MDT form a huddle, problem solve and put actions in place to prevent further harm. This concept is now being rolled out to other medical wards. • The medical and surgical divisions have collaborated and reintroduced the pressure ulcer quality improvement collaborative to reduce incidences of hospital acquired pressure ulcers, providing a forum for shared learning and education. • The roll out of safecare to all 25b wards is complete. Wards receive monthly compliance update information. Future annual assurance reports will provide additional data regarding the number of occasions whereby the planned roster was not met. • The E-rostering team are working on developing a power BI programme to provide staff with monthly acuity visualisers. Moving forward this will be more effective in informing the recalculation meetings all year round, rather than a snapshot from the January and June acuity data. • Following presentation to Board, the agreed planned roster template posters are updated recording the date presented to Board. These are distributed to the wards to display along with the patient NSLWA information posters and FAQ leaflets. Assurance will be sought from ward managers in the Bi-annual recalculation meetings, all posters are bi-lingually displayed and up to date and accurate.

Finance and workforce implications	**Financial Impact** **Spring recalculations (March/April 2023)** On completion of the Spring recalculations, six wards in total were identified as requiring amendments to previously agreed rosters, these recalculations were presented to the Executive Committee in August 2023. Two of the 6 wards requiring a change to the planned roster were approved: **D2W RGH**: 16 bedded elective surgical ward with 2 flex beds. Professional discussions and review of the acuity confirmed that the ward did not require a HCSW by night. **Cost Saving: £102, 695** **Bedwas Ward YYF**: 28 bedded Endocrine/COTE ward. The budget and roster template has been amended to align and reflect the required 1WTE supernumerary ward manager (previously only budgeted for 0.5 WTE WM following split from AMU). **Cost: £29, 801.36** The remaining 4 wards requiring a change of establishment following the spring recalculations were, • B4 GUH, C5E RGH, 3/4 NHH, 3/2 NHH However, in view of the decision to re-configure the stroke services, it was recommended any permanent alterations to rosters be put on hold until the reconfiguration process is complete. However, it is recognised there may be a requirement to continue to staff these wards with variable pay in the interim period.

Autumn Recalculations 2023

Scheduled Care

The Autumn recalculations identified minimum proposed changes to planned rosters in the Scheduled care division which have been agreed by the Divisional Management Team (DMT). The scheduled care nurse pool roster for Grange University Hospital (GUH) has been disbanded and resources allocated to the acute surgical wards within GUH. Therefore, the changes to templates are cost neutral. Planned roster templates have increased by one HCSW by night on ward A0 and B0 to support high acuity, this was previously supported by the nurse pool. The remaining pool staff have been transferred to ward C0 to support Machen (ENT surgical unit) which will operate Tuesday to Saturday.

D2W RGH, elective surgical ward has made a further saving by reducing the number of registered nurses over the weekend period due to consistently low activity. If activity levels increase this will be reviewed.

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

Scheduled Care:											
Site	**Ward**	**Pre-Calculation**			**Post-Calculation**			**Difference**		**Cost**	
		RN WTE	**HCSW WTE**	**Total WTE**	**RN WTE**	**HCSW WTE**	**Total WTE**	**RN WTE**	**HCSW WTE**	**RN**	**HCSW**
GUH	A0	25.85	25.20	**51.05**	25.85	27.99	**53.84**	Nil	2.8	Nil	£102,695 Cost neutral re-deployed from SC pool.
GUH	B0	25.85	25.20	**51.05**	25.85	27.99	**53.84**	Nil	2.8	Nil	£102,695 Cost neutral re-deployed from SC pool.
RGH	D2W	12.65	3.59	**16.24**	11.23	3.59	**14.82**	Reduction of 1.42WTE	Nil	Cost Saving: £52, 871	NIL

	Medicine The proposed changes to the medical wards in the Spring. Calculations will remain on hold until the Stroke reconfiguration is complete, however the budget for B4 GUH has been aligned to reflect the inclusion of the 8 medical beds. **Gynaecology ward** No amendments required to ward establishments. **Paediatric Ward** No amendments required to ward establishments.

Conclusion & Recommendations

- 6 wards following the Spring recalculations under Section 25B required alterations to previously agreed planned rosters. 4 of the 6 are on hold until the Stroke reconfiguration is complete.
- Budgeted rosters must be aligned to demand templates on Bedwas ward YYF and D2W RGH.
- 2 wards following the Autumn recalculations under section 25B require a change of template and budget alignment agreed by Scheduled Care DMT and finance, ward A0 & B0. One ward establishment reduced, D2W, following the triangulation process.
- Safecare compliance reports distributed monthly to all 25B wards.
- E-roster team exploring how to create monthly visualisers within power BI
- Future Annual Assurance reports to include the extent to where the planned roster has been met.
- Ensure wards display up to date Bi-lingual posters of agreed planned roster and establishment with date presented to Board, alongside FAQ leaflets.
- Undertake recalculations of wards following completion of stroke reconfiguration.

Appendix 2: Annual Presentation of the Nurse Staffing Level to the Board report. A summary of Nurse Staffing Levels for wards where Section 25B applies.

Health board/trust:	ABUHB
Period of the report	October 2022-September 2023
Adult Acute Medical wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

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

Adult Acute Medical inpatient wards

		Reported to the Board in November 2022						Calculated during spring 2023 cycle							Calculated during autumn 2023 cycle								Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2022)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2022) including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2023 cycle**		**Required Establishment as calculated by the designated persons during the spring 2023 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned roster calculated by the designated person during the autumn 2023 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2023 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**							
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)			**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)				**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)			**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
	MEDICINE																											
GUH	**Ward A2 Med**	E L LD TW N	 4 3	 3 3	**20.16**	**16.78**	**1**	**E** **L** **LD** **TW** **N**	 4 3	 3 3	**20.16**	**16.78**	**1**	**17/04/2023**	E L LD TW N	 4 3	 3 3	**20.16**	**16.78**	**1**	**16/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
GUH	**Ward A4 Med**	E L LD TW N	 5 4	 4 4	**25.86**	**22.38**	**1**	E L LD TW N	 5 4	 4 4	**25.86**	**22.38**	**1**	**17/04/2023**	E L LD TW N	 5 4	 4 4	**25.86**	**22.38**	**1**	**16/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
GUH	**Ward B4 Med**	E L LD TW N	 3 3	 3 3	**17.32**	**16.77**	**1**	E L **LD** TW **N**	 **4** **4**	 **4** **4**	**23.01**	**22.37**	**1**	**17 April Changes on hold**	E L **LD** TW **N**	 **4** **4**	 **4** **4**	**23.01**	**22.37**	**1**	**16/10/2023**	**Yes**	**Yes**	**Budget already held by medicine-DMT agreed to transfer the budget to staff the 8 medical beds.**	**N/A**			
GUH	**WARD C4 Med**	E L LD TW N	 7 7	 5 5	**40.07**	**27.97**	**1**	E L LD TW N	 7 7	 5 5	**40.07**	**27.97**	**1**	**17/04/2023**	E L LD TW N	 7 7	 5 5	**40.07**	**27.97**	**1**	**16/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
RGH	**Ward C4E Med**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	**17/04/2023**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	**16/10/2023**	**Yes**	**NO**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
RGH	**Ward C5E Med**	E L LD TW N	 3 2	 4 2	**14.48**	**16.78**	**1**	E L LD TW N	 3 2	 4 **3**	**14.48**	**19.56**	**1**	**17 April Changes on Hold**	E L LD TW N	 3 2	 4 **3**	**14.48**	**19.56**	**1**	**16/10/2023 Changes on Hold**	**Yes**	**On Hold**	**Currently cost pressures of an extra HCSW by night to support high acuity-Permanent change on hold until stroke reconfiguration process complete.**	**N/A**			
RGH	**Ward C5W Med**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	**17/04/2023**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	**16/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
RGH	**Ward C6E Med**	E L LD TW N	 3 2	 5 3	**14.48**	**22.42**	**1**	E L LD TW N	 3 2	 5 3	**14.48**	**22.42**	**1**	**17/04/2023**	E L LD TW N	 3 2	 5 3	**14.48**	**22.42**	**1**	**16/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
RGH	**Ward C6W Med**	E L LD TW N	 3 3	 5 3	**17.48**	**22.42**	**1**	E L LD TW N	 3 3	 5 3	**17.48**	**22.42**	**1**	**17/04/2023**	E L LD TW N	 3 3	 5 3	**17.48**	**22.42**	**1**	**16/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
RGH	**Ward D4E Med**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	**17/04/2023**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	**16/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
RGH	**Ward D4W Med**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	**17/04/2023**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	**16/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
NHH	**Ward 3/1 Med**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	E L LD TW N	 3 2	 5 4	**14,48**	**25.2**	**1**	**17/04/2023**	E L LD TW N	 3 2	 5 4	**14.48**	**25.2**	**1**	**16/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate.**	**N/A**			
		E L						E L							E L									**Currently cost pressures of an extra HCSW by night to support**				

NHH	Ward 3/2 Med	LD	3	5	14.48	22.42	1	LD	3	5	14.48	25.2	1	17/04/2023 On Hold	LD	3	5	14.48	25.2	1	16/10/2023	Yes	On Hold	high acuity-Permanent change on hold until stroke reconfiguration process complete.	N/A						
		TW						TW							TW																	
		N	2	3				N	2	4					N	2	4														
NHH	Ward 3/3 Med	E			14.48	25.2	1	E			14.48	25.2	1	17/04/2023	E			14.48	25.2	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A						
		L						L							L																	
		LD	3	5				LD	3	5					LD	3	5														
		TW						TW							TW																	
		N	2	4				N	2	4					N	2	4														
NHH	Ward 3/4 Med	E			14.48	22.42	1	E			14.48	25.2	1	17/04/2023 On Hold	E			14.48	25.2	1	16/10/2023	Yes	On Hold	Currently cost pressures of an extra HCSW by night to support high acuity-Permanent change on hold until stroke reconfiguration process complete.	N/A						
		L						L							L																	
		LD	3	5				LD	3	5					LD	3	5														
		TW						TW							TW																	
		N	2	3				N	2	4					N	2	4														
NHH	Ward 4/3 Med	E			14.48	25.2	1	E			14.48	25.2	1	17/04/2023	E			14.48	25.2	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A						
		L						L							L																	
		LD	3	5				LD	3	5					LD	3	5														
		TW						TW							TW																	
		N	2	4				N	2	4					N	2	4														
NHH	Ward 4/4 Med	E			20.16	13.98	1	E			20.16	13.98	1	17/04/2023	E			20.16	13.98	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A						
		L						L							L																	
		LD	4	3				LD	4	3					LD	4	3														
		TW						TW							TW																	
		N	3	2				N	3	2					N	3	2														
YYF	Bedwas ward Med	E			17.32	22.36	1(budget 0.5)	E			17.32	22.36	1 (1 WTE budgeted)	17/04/2023	E			17.32	22.36	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A						
		L						L							L																	
		LD	4	4				LD	4	4					LD	4	4														
		TW						TW							TW																	
		N	2	4				N	2	4					N	2	4														
YYF	Oakdale Ward Med	E			17.32	22.36	1	E			17.32	22.36	1	17/04/2023	E			17.32	22.36	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A						
		L						L							L																	
		LD	4	4				LD	4	4					LD	4	4														
		TW						TW							TW																	
		N	2	4				N	2	4					N	2	4														
YYF	Bargoed ward Med	E			14.48	25.2	1	E			14.48	25.2	1	17/04/2023	E			14.48	25.2	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A						
		L						L							L																	
		LD	3	5				LD	3	5					LD	3	5														
		TW						TW							TW																	
		N	2	4				N	2	4					N	2	4														
YYF	Risca ward Med	E			17.32	22.36	1	E			17.32	22.36	1	17/04/2023	E			17.32	22.36	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A						
		L						L							L																	
		LD	4	4				LD	4	4					LD	4	4														
		TW						TW							TW																	
		N	2	4				N	2	4					N	2	4														
Total					366.77	473.02					372.47	486.96						372.47	487	21												

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	ABUHB
Period of the report	October 2022 - September 2023
Adult Acute Surgical Inpatient Wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/25-5-23-agenda-bundle-public-vf2-compressed-n-v3-0/) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Adult Acute Surgical Inpatient Wards

Site	Name of Ward	Reported to the Board in November 2022						Calculated during spring 2023 cycle							Calculated during autumn 2023 cycle							Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
		SHIFT	Planned roster as stated within the annual presentation to the Board report (in November 2022)		Required Establishment as stated within the annual presentation to the Board report (in November 2022) including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	SHIFT	Planned roster calculated by the designated person during the spring 2023 cycle		Required Establishment as calculated by the designated persons during the spring 2023 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	SHIFT	Planned roster calculated by the designated person during the autumn 2023 cycle		Required Establishment as calculated by the designated persons during the autumn 2023 cycle including uplift 26.9%		TOTAL WTE Band 7 supernumerary ward sister/Charge nurse	Date designated person calculated the nurse staffing level	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)			RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)				RN (band 5 &6)	HCSW (bands 2,3 &4)	TOTAL WTE RN (bands 5 &6)	TOTAL WTE HCSW (bands 2,3 &4)									
GUH	A0 Surgical	E			25.85	25.2	1	E			25.85	25.2	1	17/04/2023	E			25.85	27.99	1	16/10/2023	Yes	Yes	SC Nurse pool disbanded- DMT and finance agreed to move funding to acute wards. Template change to an extra HCSW by night	N/A			
		L						L							L												
		LD	5	5				LD	5	5					LD	5	5										
		TW						TW							TW												
		N	4	4				N	4	4					N	4	5										
GUH	B0 Surgical	E			25.85	25.2	1	E			25.85	25.2	1	17/04/2023	E			25.85	27.99	1	16/10/2023	Yes	Yes	SC Nurse pool disbanded- DMT and finance agreed to move funding to acute wards. Template change to an extra HCSW by night	N/A			
		L						L							L												
		LD	5	5				LD	5	5					LD	5	5										
		TW						TW							TW												
		N	4	4				N	4	4					N	4	5										
GUH	C0 Surgical	E			25.85	25.2	1	E			25.85	25.2	1	17/04/2023	E			25.85	25.2	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A			
		L						L							L												
		LD	5	5				LD	5	5					LD	5	5										
		TW						TW							TW												
		N	4	4				N	4	4					N	4	4										
GUH	A3 Gynae	E			20.16	13.98	1	E			20.16	13.98	1	17/04/2023	E			20.16	13.98	1		Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A			
		L						L							L												
		LD	4	3				LD	4	3					LD	4	3										
		TW						TW							TW												
		N	3	2				N	3	2					N	3	2										
RGH	C7E Surgical	E			14.48	22.4	1	E			14.48	22.4	1	17/04/2023	E			14.48	22.4	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A			
		L						L							L												
		LD	3	5				LD	3	5					LD	3	5										
		TW						TW							TW												
		N	2	3				N	2	3					N	2	3										
															2													
RGH	C7W Surgical	E			14.48	19.61	1	E			14.48	19.61	1	17/04/2023	E			14.48	19.61	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A			
		L						L							L												
		LD	3	4				LD	3	4					LD	3	4										
		TW						TW							TW												
		N	2	3				N	2	3					N	2	3										
RGH	D2E Surgical	E			14.48	8.38	1	E			14.48	8.38	1	17/04/2023	E			14.48	8.38	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A			
		L						L							L												
		LD	3	2				LD	3	2					LD	3	2										
		TW						TW							TW												
		N	2	1				N	2	1					N	2	1										
RGH	D2W Surgical	E	1 M-F		12.65	5.59	1	E	1 M-F		12.65	2.8	1	17/04/2023	E	1 M-S		12.23	3.59	1	16/10/2023	Yes	Yes	Cost Saving- Spring recalculation-reduction of HCSW by night Mon-Fri Autumn recalculation -RN reduced to 1WTE from Sat pm- Mon am	N/A			
		L						L							L												
		LD	2	1				LD	2	1					LD	2 M-F (1 S&S)											
		TW						TW							TW												
		N	2	1				N	2	0					N	2 m-F (1 S&S)											
RGH	D3E Surgical	E			17.32	19.61	1	E			17.32	19.61	1	17/04/2023	E			17.32	19.61	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A			
		L						L							L												
		LD	3	5				LD	3	5					LD	3	5										
		TW						TW							TW												
		N	3	2				N	3	2					N	3	2										
RGH	D3W Surgical (formerly D5W)	E			14.48	22.46	1	E			14.48	22.46	1	17/04/2023	E			14.48	22.46	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate.	N/A			
		L						L							L												
		LD	3	5				LD	3	5					LD	3	5										
		TW						TW							TW												
		N	2	3				N	2	3					N	2	3										
RGH	D7E Surgical	E			11.64	11.22	1	E			11.64	11.22	1	17/04/2023	E			11.64	11.22	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate	N/A			
		L						L							L												
		LD	2	3				LD	2	3					LD	2	3										
		TW						TW							TW												
		N	2	1				N	2	1					N	2	1										
SWH	OSU Surgical	E	1		16.91	8.39	1	E	1		16.91	8.39	D2W	17/04/2023	E	1		16.91	16.91	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate	N/A			
		L						L							L												
		LD	3	2				LD	3	2					LD	3	2										
		TW	1 M-F					TW	1 M-F						TW	1 M-F											
		N	2	1				N	2	1					N	2	1										
NHH	Ward 4/2 Surgical	E			14.48	22.4	1	E			14.48	22.4	1	17/04/2023	E			14.48	22.4	1	16/10/2023	Yes	No	No Changes required-following professional discussions-roster deemed appropriate	N/A			
		L						L							L												
		LD	3	5				LD	3	5					LD	3	5										
		TW						TW							TW												
		N	2	3				N	2	3					N	2	4										
Total					228.7	229.64					228.63	226.85						227.21	233.22	13								

Appendix: Annual Presentation of the Nurse Staffing Level to the Board report

Health board/trust:	ABUHB
Period of the report	October 2022 - September 2023
Paediatric Inpatient Wards	

The number of staff per shift needs to be entered. The information should reflect the information on the informing patient template.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report. Further information is provided within the annual assurance report (https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/25-5-23-agenda-bundle-public-vf2-compressed-n-v3-0/) on the additional multi-professional staff that contribute to the coordination and delivery of patient care.

Paediatric Inpatient Wards

		Reported to the Board in November 2022						Calculated during spring 2023 cycle						Calculated during autumn 2023 cycle							Biannual calculation cycle reviews, and any changes made & rationale during the spring 2023 & autumn 2023 calculation cycles			Any reviews outside of biannual calculation, if yes, provide rationale for any changes made			
Site	**Name of Ward**	**SHIFT**	**Planned roster as stated within the annual presentation to the Board report (in November 2022)**		**Required Establishment as stated within the annual presentation to the Board report (in November 2022) including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**SHIFT**	**Planned roster calculated by the designated person during the spring 2023 cycle**		**Required Establishment as calculated by the designated persons during the spring 2023 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**SHIFT**	**Planned roster calculated by the designated person during the autumn 2023 cycle**		**Required Establishment as calculated by the designated persons during the autumn 2023 cycle including uplift 26.9%**		**TOTAL WTE Band 7 supernumerary ward sister/Charge nurse**	**Date designated person calculated the nurse staffing level**	**Completed (Yes/No)**	**Changed**	**Rationale**	**Completed (Yes/No)**	**Date**	**Changed**	**Rationale**
			RN (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)			**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)				**RN** (band 5 &6)	**HCSW** (bands 2,3 &4)	**TOTAL WTE RN** (bands 5 &6)	**TOTAL WTE HCSW** (bands 2,3 &4)									
GUH	**Paediatric 50 bedded unit**	E			**70.22**	**17.06**	**1**	E			**70.22**	**17.06**	**1**	**17/04/2023**	E			**70.22**	**17.06**	**1**	**17/10/2023**	**Yes**	**No**	**No Changes required-following professional discussions-roster deemed appropriate**	**N/A**			
		L						L							L													
		LD	**12**	**3**				LD	**12**	**3**					LD	**12**	**3**											
		TW						TW							TW													
		N	**12**	**3**				N	**12**	**3**					N	**12**	**3**											
Total					**70.22**	**17.06**					**70.22**	**17.06**						**70.22**	**17.06**	**1**								

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Patient Safety, Experience, Engagement and Quality Narrative Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Jennifer Winslade, Executive Director of Nursing
SWYDDOG ADRODD: **REPORTING OFFICER:**	Leeanne Lewis – Assistant Director for Quality and Patient Safety Tracey Partridge Wilson - Assistant Director of Nursing

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

As an NHS Wales organisation, there are clear expectations set out for the quality standards that must be maintained. The Health Board must ensure that they follow the expectations set by the Health and Social Care (Quality and Engagement) (Wales) Act 2020; and A Healthier Wales. Our aim is to improve continuously and learn. The quality strategy supports the new legislative requirements.

Cefndir / Background

In April 2023, the Health Board launched its first Quality Strategy and Patient Experience & Involvement Strategy. As part of ensuring successful implementation of both Strategies, a Quality Outcomes Framework (QOF), implementation plan and Quality Governance and Assurance Framework has been developed.

This report illustrates how the organisation is improving the insight into intelligence for data. It provides a summary of the six-month performance aligned to the six pillars of quality as defined in the quality strategy. It focuses on patient safety, patient experience, health and safety, safeguarding and infection prevention and control activity from April – September 2023.

Asesiad / Assessment

The Health Board's Quality Indicators have been aligned to the Duty of Quality, the six domains of quality: person-centred, safe, timely, effective, efficient, and equitable. These outcomes and indicators establish a set of quality indicators that align with the Health Boards, priorities and strategic goals. The indicators cover all aspects of care, clinical outcomes, patient safety, patient experience, and efficiency.

The report attached provides current data on quality and patient safety as mapped against the Pillars of quality:

- Patient and staff experience and stories
- Incident reporting – falls, pressure ulcers, medicines management and mortality
- Complaints, concerns and compliments
- Health, safety and security
- Infection Control and Prevention
- Safeguarding

These 'pillars of quality' run through the organisation, ensuring that delivery is of the highest standard under these domains. Providing data in these Pillars of Quality will enable the organisation to review performance. The pillars are the Quality Markers in the quality management system. Strengthening the quality management system helps the services make sure our decision-making focuses on improving the quality of health services. The Quality enablers are also instrumental to the organisation achieving success in delivering the strategy and are also a primary focus for the Health Board. These include leadership, workforce, culture, information, whole systems approach and learning, improvement, and research.

Reflections to date in updating this report shows evidence of the hard work and commitment from teams throughout the Health Board to develop the strategy and strive to make improvements in the quality agenda. The report demonstrates how striving to better understand the systems of care. We are maturing our Quality Management System is maturing and refining our QOF is being refined to establish and set meaningful targets, monitor, measure and report our performance.

Following the welcomed response from the first quality narrative report, this report will now form a part of regular reporting to Board. This Quality Report ensures that the Health Board discharges its duties for "Always On" reporting of quality under the Duty of Quality and will contribute to the new Annual Report for Quality.

The organisation continues to develop the learning forum which highlights the creativity, passion, expertise, and our commitment to learn from experiences. This report illustrates how the organisation is improving the insight of data and developing understanding on insights from multiple sources of information throughout the entire system. The key objectives outlined for the first year in the strategy, are on track to be delivered to publish our annual quality report. Our quality reporting structure will provide a way for the organisation to set progressive implementation plans, adapt plans based on experiences and learning, and monitor progress against the strategic goals.

As part of this work, the governance structures will be strengthened through Board-to-Floor connections that promote cross directorate and multi-professional working. Work has been initiated to ensure that the implementation, measurement and monitoring of the strategy is hardwired through good governance and integrated performance reporting.

Argymhelliad / Recommendation

This report is to provide assurance to the Board on the ongoing work to implement and deliver the Quality Strategy and Patient Experience & Involvement Strategy.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable currently
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3. Effective Care 5. Timely Care 6.3 Listening and Learning from Feedback Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	The Health and Social Care (Quality and Engagement) Wales Act (2020)). Duty of Quality.
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Quality Report
April – September 2023

Contents

1 Introduction

Following the positive response from the first draft of the quality narrative report, this will now form a regular part of reporting to Board. The report provides an overview of the delivery of the Quality Strategy for the first six months of 2023/24. This report should be read in conjunction with the Quality Outcomes Framework and provides the narrative to support the Quality and Safety assurance to Board.

This Quality Report ensures that the Health Board discharges its duties for "Always On" reporting of quality under the Duty of Quality and will contribute to the new Annual Report for Quality.

1.1 Summary of positive progress, risks and issues

As an NHS Wales organisation, there are clear expectations set out for the quality standards we must maintain. We are ensuring that we are following the expectations set by the Health and Social Care (Quality and Engagement) (Wales) Act 2020; and A Healthier Wales. We have been clear on our aims to continuously improve and learn. Our quality strategy supports the new legislative requirements.

We continue to pledge to deliver the Duty of Quality by ensuring our services provide the highest quality of care. We are committed to improve the experience of care and seek opportunities to provide positive patient experiences through the patient journey across our services. We have worked at pace and successfully engaged with stakeholders throughout the organisation to produce the Quality Strategy, implementation plan, Quality Outcomes Framework (QOF) and assurance structure for quality.

Our vision is quality-driven, and we continue to review our data to drive improvement and learning through experience. We are ensuring the experiences of our staff and patients will continue to be the most important measure of our progress. It is the delivery of the Quality Strategy, together with the supporting strategies of patient experience, risk management, clinical effectiveness, and employee wellbeing to deliver high quality, person centred and effective health and care services for our local population.

Reflections to date in updating this report shows evidence of the hard work and commitment from our teams throughout the Health Board to develop the strategy and strive to make improvements in the quality agenda. We are determined to produce validated and reliable data. Our commitment demonstrates we are striving to better understand our systems of care. We are building capability through an all teach/all learn philosophy, encouraging innovation and engaging patients, relatives, carers, staff and communities.

Following a recent Board Development Session, we shared the progress of our Quality Outcomes Framework (QOF) and our maturing Quality Management System. We will continue to refine our QOF to ensure it allows us to routinely set meaningful targets, monitor, measure and report our performance. This will include rich narrative to compliment the data. We will ensure we continue to have ambitions to provide excellent standards of care and set quality goals to continuously improve the services we provide.

This report illustrates how we are improving our insight into intelligence of our data. We are improving our understanding of safety by drawing on insights from multiple sources of information. We have reviewed our involvement through the strategy by taking a person centered approach. This will continue to be embedded and ensure we have the skills and opportunities to improve patients' safety throughout our entire system.

Through improvement methodology and ongoing Programmes (such as work on deteriorating patients; never events in theatres and interpretation of radiological events) we are enabling effective and sustainable change in the most important area. We have showcased the ongoing improvement work as part of the safer care collaborative to the Board.

The narrative in this report demonstrates we are on track to deliver the key objectives outlined for the first year in the strategy, and on track to publish our annual quality report. We will continue to refine and produce an overview of our quality achievements. This includes reviewing our reporting on issues identified through our quality management system.

We are establishing a learning forum which highlights our creativity, passion, expertise, and our commitment to learn from experiences. We will continue to update and set specific annual quality improvement goals. Our quality reporting structure will provide a way for us to set progressive implementation plans, adapt plans based on experiences and learning, and monitor progress against our strategic goals.

Our ongoing progress gives assurance on how we will strengthen our governance structures through Board-to-Floor connections that promote cross directorate and multi-professional working. We have initiated work to ensure that the implementation, measurement, and monitoring of our strategy is hardwired through our governance and integrated performance reporting.

2 Strategy

This Quality Strategy is now fully into the implementation phase throughout Aneurin Bevan University Health Board, which was launched in April 2023. A key focus in the development of this Strategy was progressing what we had already accomplished and building on existing structures throughout the organisation. It is recognised that it is important to ensure Quality is embedded in our culture, and we are committed to continuous

improvement and Quality, Safety and Learning are at the heart of everything we do.

The Quality vision of the Health Board will be "widely recognised for delivering the six domains of quality:

- Person-centred care
- Safe care
- Timely care
- Efficient care
- Effective care
- Equitable care

Our first and most important commitment to our patients is to keep them safe. Over the next three years, this Quality Strategy will improve the delivery within these six domains of quality, while continuing to improve patient and staff experience and outcomes.

The Quality enablers are also instrumental to us achieving success in delivering the strategy and are also a primary focus for us as a Health Board. These include leadership, workforce, culture, information, whole systems approach and learning, improvement, and research.

The key to delivery of our plans is to develop a 'Quality Management System' approach to embed a culture of learning: a culture where people listen, think, feel and act 'quality' - promoting openness and learning, continuous improvement, and service transformation. This includes work to embed positive cultures of continuous improvement and working together. We will further develop our Quality Management System to routinely set meaningful targets to monitor, measure and report performance to ensure we provide excellent standards of care and set quality goals to continuously improve the services we provide.

The strategy focuses on delivering against the Pillars of quality:

- Patient and staff experience and stories
- Incident reporting Complaints, concerns, and compliments
- Health, safety and security
- Infection Control and Prevention
- Safeguarding

These 'pillars of quality' run through our organisation, ensuring that we deliver the highest standards of care under these domains. Providing data in these Pillars of Quality will review our performance. We must put the quality and safety of our health services above everything else. This strategy signals our intention to progress these six pillars of quality to establish our level of performance. The pillars will be our Quality Markers in our quality management system. Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services.

The key actions since April in support of delivery of the strategy include:

- Development of the Quality Outcomes Framework and reported to PQSOC for Q2.
- Developed a robust implementation plan for the quality strategy.
- Currently review and alignment of the QPS resources is out to Organisation Change Process (OCP) which will create a resource structure to deliver the strategy.
- Alignment of the organisation's improvement resources with ABC*i* work programme and capability building supporting the delivery teams including Theatres and Pressure Ulcers.
- Key milestones achieved to capture and understand patient experience with the launch of CIVCA.
- Building our understanding – significant work completed on the outputs of the DATIX system to improve data quality and understanding.
- Established a new quality impact assessment process which has recently been successfully tested.

3 Reporting

As part of ensuring the successful implementation of both the Quality Strategy and the Patient Experience and Involvement Strategy, a Quality Outcomes Framework (QOF) has been developed. The indicators in the outcomes framework will be used to provide a systematic approach to measure, monitor, and enhance the quality of our healthcare services.

The primary objective of implementing a quality outcomes framework is to drive continuous improvement in the delivery of healthcare services by focusing on measurable outcomes. The QOF will be presented quarterly in line with the IMTP cycle.

The framework aims to:

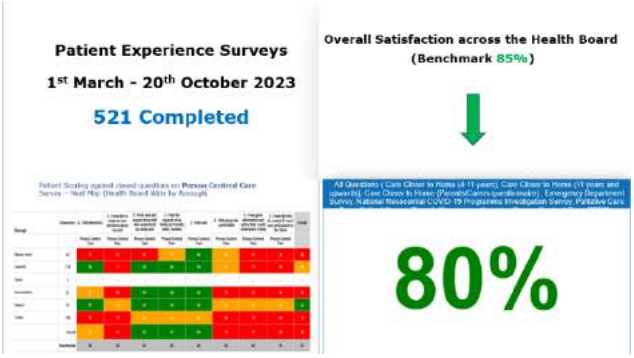
- Identify areas of improvement and potential risks to patient safety.
- Establish quality indicators and benchmarks to measure and compare performance.
- Promote evidence-based practices and standardise care processes.
- Enhance patient satisfaction and experience.
- Ensure compliance with regulatory standards and accreditation requirements.
- Facilitate data-driven decision-making and resource allocation.
- Foster a culture of accountability, transparency, and learning.
- The first reporting of the QOF is due for Q2, detailed in this report are relevant updates and Qualitative outputs to date.

It is vital through the reporting and analysing of outcomes that a feedback loop is established by continuously monitoring the impact of improvement

initiatives and quality indicators. Regular evaluation of the effectiveness of implemented changes, identifying barriers to success, with the ability to make the necessary adjustments as required. The outcomes and indicators will also help us to deliver and complete the Annual Quality Report to Welsh Government and support future reports to NHS Executive.

4 Person Centred Care and Patient Experience

4.1 Civica



The Quality Outcomes Framework details the implementation of the Civica patient experience system with a broadly positive response from patients. The Civica Lead continues to engage with clinical teams to determine hierarchy's and provide training.

4.2 Patient Stories

Several digital patient stories have been produced which support organisational learning and these have been shared at internal meetings and committees. From January 2024, in-person experience stories will be shared at Board.

People attending Board to relay their experience will be supported to do so. A Board briefing template will be provided ahead of the story being heard (appendix 1).

4.3 Volunteer to Career

A successful Volunteer to Career Pathway has been developed in partnership with Helpforce Cymru. The Pilot has since finished with Helpforce and the pathway have been easily embedded into our process. Volunteers who complete 30 hours of volunteer activity are able to join the Bank and seek paid employment. 3 volunteers have gained permanent employment within ABUHB. 4 volunteers have gained paid employment outside of healthcare. 1 volunteer has gained a university placement to commence adult nursing.

We currently have 47 volunteers that have expressed an interest in the pathway of which we are working with 9 individuals to gain further experience, training and to look at employment opportunities.

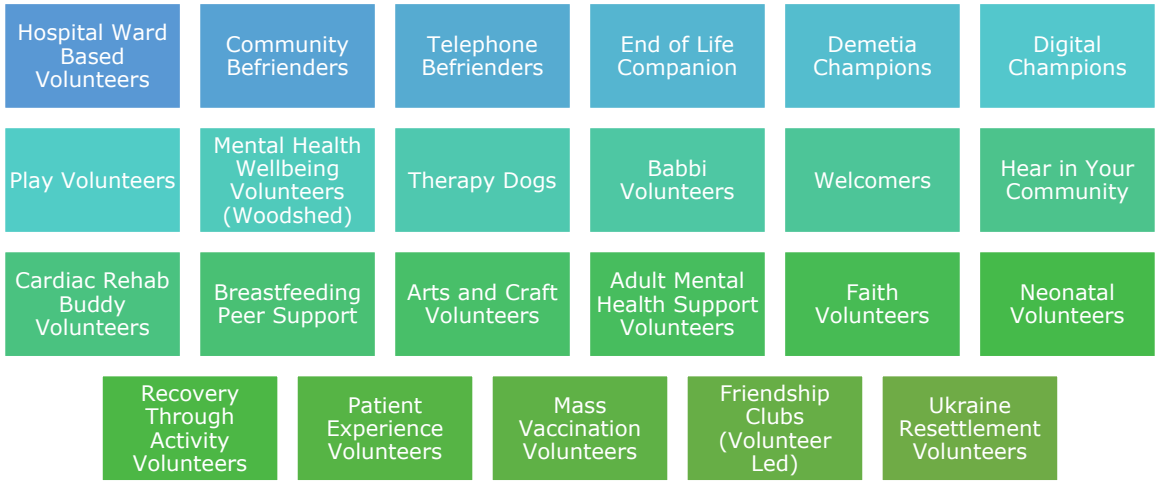
We have attended the Coleg Gwent College Fayres and emailed 63 Secondary Schools and attending assembly for years 10+ to promote, linking in with Careers Wales. We are also meeting with Monmouth School for Boys/Girls to train and induct students at NHH.

In addition, we are working with Welsh School of Pharmacy and Pharmaceutical Science through which we have delivered Volunteer Core training to 75 students the first cohort of students commenced at St Woolos and RGH in September between October 2023-March 2024.

Earlier this year we received a referral from the Domestic Violence Team who thought volunteering may support this young lady with a purpose. This volunteer commenced at YAB and thoroughly enjoyed it but wanted more, the team arranged for her to volunteer additionally in a local care home to gain further experience. In October of this year, she was successful in getting a part time job in another Care Home in her Borough but after only a few weeks of volunteering in her local care home they offered her a full-time job. On congratulating the volunteer, we asked if she would be happy for us to share her story her response "I would be more than happy to let you share my story, if I could even help one person it would make me so happy."

4.4 Volunteering

The Volunteering Team proactively work with clinical teams, voluntary sector partners and the wider public to promote the value of volunteering both for people who want to volunteer and for those who require support. To date there are 292 volunteers registered and 39 going through recruitment. Responding to feedback, 23 volunteer role profiles have been developed:



A number of new roles are being developed in Cancer Services including Telephone Befrienders, Meet and Greet Volunteers, Cancer Café Volunteers and Experts by Experience. The Cancer Cafes in Blaenau Gwent and

Caerphilly have commenced with Newport and Monmouthshire in the next few months. The meet and greet role at Cancer outpatient's clinic at Nevill Hall Hospital will commence in November 2023.

In Stroke Services, new volunteer roles in development include Peer Support Volunteers, Telephone Befriending, Young Persons Friendship Group, and Carers Supporting Carers. Volunteers have commenced their roles at Ysbyty Ystrad Fawr and County Hospitals. Volunteers have arranged to have a meeting with the Physiotherapists at Ysbyty Ystrad Fawr to discuss supporting patients as part of their role and lived experience.

In addition to these roles, we are working with the Gastroenterology Team to commence an Alcohol Support Group linked in with the professional run group taking place at County Hospital. Patients from the group have expressed an interest to commence this group and will run it as volunteers, with patients being signposted from the Gastro team. One volunteer has completed her recruitment and following discussion with the Gastro team we are going to place the volunteer on A4 at the Grange University Hospital to encourage patients to attend a group support session.

Case Study: Meaningful Engagement at End of Life

Frieda has late-stage dementia and so was not really able to communicate. After I had spoken quietly to her for several minutes, without any obvious response, I decided to try playing some quiet music to her on the iPad that I had brought along for the purpose. That had a dramatic effect. She opened her eyes and took the iPad from me so that she could concentrate on the music. When the piece that I had selected came to an end, I tried something else that I thought she might like. However, after a few minutes, I gathered from her facial expressions that this selection was not being well received. I consequently stopped that and tried instead the beginning of Richard Burton's reading of Under Milk Wood. Fortunately, that choice seemed to be to her taste because she listened to it for about 30 minutes before drifting off to sleep. As I was packing to up to leave, she woke up again, took my hand and kissed it. I could see that she was mouthing "Thank you" even though no sound came out.

4.5 Patient Advice and Liaison Service (PALS)

The PALS service was launched on 6th November 2023. Bi-lingual public information leaflets have been produced and posters advertising the service will be placed across all hospital sites and Mental Health and Learning Disability Units. The Team will support clinical teams in managing concerns that can be dealt with through early resolution.

4.6 Bereavement

The National Bereavement Framework supports those commissioning or providing bereavement services. This is to ensure that good quality services are available for those who need support.

Aneurin Bevan University Health Board has an established Care After Death service. This service focusses predominately on the care of the deceased person and advising relatives on the practical aspects should a person die in hospital. This will include liaising with families around the death certification, coroner and Medical Examiner services. The team do not offer direct bereavement support outside of signposting.

Feedback from the Covid Bereaved Cymru families has indicated that more needs to be done at a local level to ensure bereavement information and support is available at a point when it is needed.

Actions to date:

- Bereavement is now a standing agenda item on the End-of-Life Care Board.

- The Nursing Directorate have reviewed the National Bereavement Standards and developed an organisational bereavement implementation plan. A bereavement collaborative has been established that will include our own staff, partners, and bereaved families.

- A number of bereavement roadshows are being planned across the hospital sites. This will afford people who have been bereaved and staff an opportunity to talk about their bereavement experiences. Feedback from the roadshows, complaints and the Medical Examiner Service will be used to develop a new bereavement model (based on the SWAN model).

- The Patient Experience and Involvement Team, Communications and Welsh Language Teams have reviewed the public facing website and a single point of access bilingual Death and Bereavement Website is being finalised. This will be live within the next few days.

  The website supports the Accessible Information requirements of the National Bereavement Standards, including accessible information for those with protected characteristics, as indicated below:

Local Bereavement Support Organisations
National Organisations providing Bereavement Support
Supporting People with **Learning Disabilities** who are Bereaved
Bereavement Support and Information for People **whose first language is not English**
LGBTQ+ Bereavement Support and Information
Bereavement Support and Information for **Children and Young People**
Bereavement Support and Information for **People who have lost Children**

- A Job Description for a dedicated Clinical Bereavement Lead has been matched. This post is available in all other Health Boards in Wales. However, Welsh Government funding for this post is available only until the end of March 2024.

- PALS Officers have attended the End-of-Life Companion training. This will enable them to better support people they talk to who may be bereaved.

- A review of the End-of-Life Companion role has identified that they could offer more pastoral support for people who are bereaved. Additional training will be provided to the Companions so that they can offer follow up calls going forward.

4.7 Dementia Standards

The Regional Dementia Board continues to oversee the implementation of the Dementia Standards through the Dementia Workstreams. There are challenges in the Memory Assessment Service (MAS) Pathway Workstream due to clinical service demands and actions to mitigate the risks to taking this workstream forward will be discussed at the December Dementia Board.

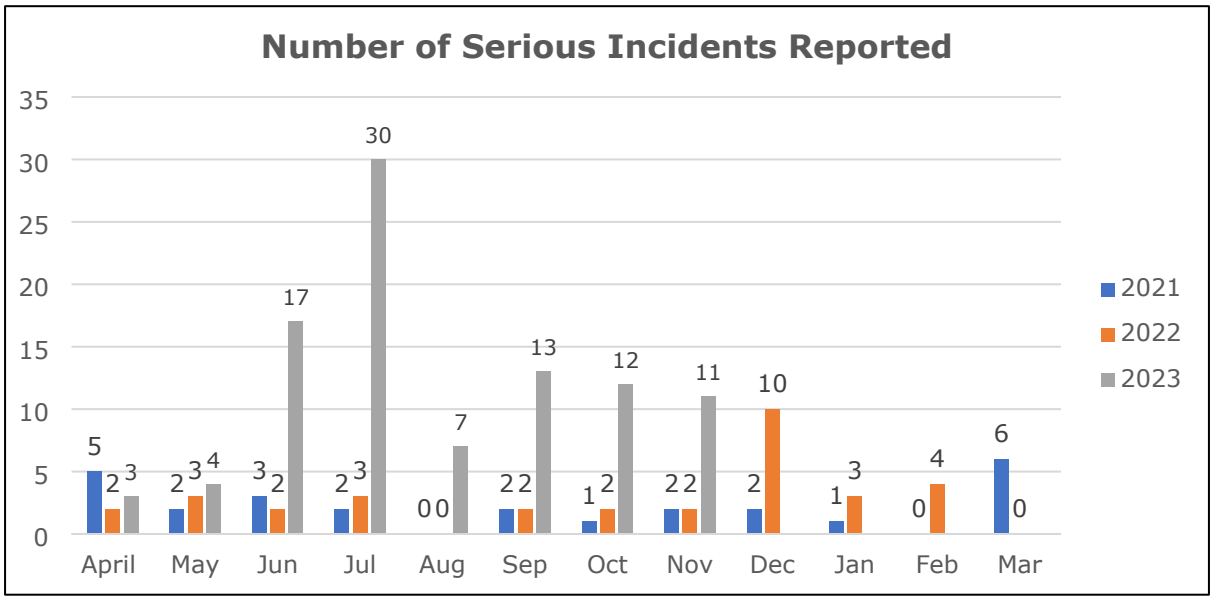
5 NRI's/SI's/Never Events

Background

The NHS Wales National Incident Reporting Policy was introduced in June 2021. During May 2023 *'NHS Wales National Policy on Patient Safety Incident Reporting & Management',* was launched, this document merged the Policy and Guidance into one. Aneurin Bevan has adapted this policy to come in line with local practices. This has been presented to Board in October and has now been signed off by PQSOC. The Health Board's Patient Safety Incident Process is currently under review, with work being led by the Executive Director of Nursing.

5.1 NRI's

Highlights:
74 incidents have been reported to the NHS Executive, since April 2023. There was a marked increased during June and July, when the Health Board were advised to review their reporting criteria. For assurance, investigations were undertaken, but not all incidents were reported as Nationally Reportable Incidents (NRI's).



The top three NRI themes related to: -

1. Delayed treatment
2. HCAI
3. Treatment or misdiagnosis resulting in harm and/or death

Delayed treatment was the highest category reported as a result of 'failure to follow up' in Ophthalmology services. These incidents are being managed as a single corporate led investigation, but were reported as individual cases, ensuring appropriate management and dissemination of the recommendations/learning. The Executive Director of Therapies and Health Sciences is leading the investigation process. A Principal Optometrist has been recruited, with a noticeable increase in outpatient activity. A business case has been presented to the Executives and has been supported to address the learning identified.

5.2 Learning and Improvement

- Recognition and management of deteriorating patients continues to be a theme. Deterioration is one of the Safer Care Collaborative Improvement Workstreams which the Health Board is actively engaged in. Specific actions have included the Primary Care & Community education team having reviewed the education provided and the training delivered at a community hospital. This has been modified to ensure learning regarding the identification of a deteriorating patient alongside specific education for epistaxis management. The training was delivered in May 2023 and the learning and improvement has been shared across all wards. As part of the wider learning from a previous Serious Incident, the Deteriorating Patient Policy is currently under review and is on the agenda for the next Clinical Policy Group to be held in November 2023.

- On 5 October 2023, the Health Board hosted an improvement collaborative event with an experienced external improvement expert

on the "deteriorating patient". This combined learning event and accelerating quality improvement project, examined sharing data and current work to date and provided an ideal opportunity for colleagues across the Health Board to share improvement and initiative projects with others.

- Due to an increase in the number of incidents relating to nutrition. A task and finish group has been convened to formulate an organisational plan. The inaugural meeting took place in September. Future meetings are now being planned.

- Prescribing errors caused by accidentally using another patient's medication history continue to happen, albeit with low or no harm. An ALERT to all prescribers has been re-circulated.

- No security presence at a Local General hospital, which could have assisted given a patient absconded. This resulted in a review of security services, with recommendations to follow.

- A review of step-down processes at an eLGH, inappropriate transferring of patients had resulted in poor patient experience. A step-down transfer documentation tool has been developed to improve the safety of the patient handover process. This will ensure that key clinical information remains with the patient and informs their ongoing care when they are moved geographically and across Divisions.

- A Pressure Ulcer Collaborative has been established and ABCi and the Infection Prevention Team have developed a draft Pressure Ulcer Driver Diagram which is currently being consulted on.

- A pilot commenced on 3 April 2023 at a Local General Hospital to implement an MDT SWARM huddle led by the Medicine Division as a quality improvement project. Healthcare organisations across the globe have used swarm-based huddles to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning. The aim is that this pilot will inform the use of SWARM at ward level across the Health Board.

- Health and Safety have commenced an evaluation of the availability of flat lifting equipment across ABUHB in support of falls management with a range of agreed action to address equipment gaps and support training.

- Rollout of the digital falls Multifactorial Risk Assessment for Inpatients wards (MFRA). Completed for the GUH and RGH.

- Work is being undertaken to explore how Physiotherapy and Occupational Therapy can further promote a person's mobility in terms of "Getting Up, Getting Moving and Getting Dressed'.

- A pilot project is being designed in which visual assessments can be undertaken at the bedside.

- Further opportunities are being explored to build upon the falls training that is already being delivered to support an MDT approach with the inclusion of digital platforms.

- Work in support of the provision of a modified MFRA for the Emergency Department setting. This is currently in a pilot phase of implementation and is supplemented with training.

- Working in partnership with WAST to provide dashboards on falls to provide greater insight into incidents, hospital conveyances, falls in care homes etc.

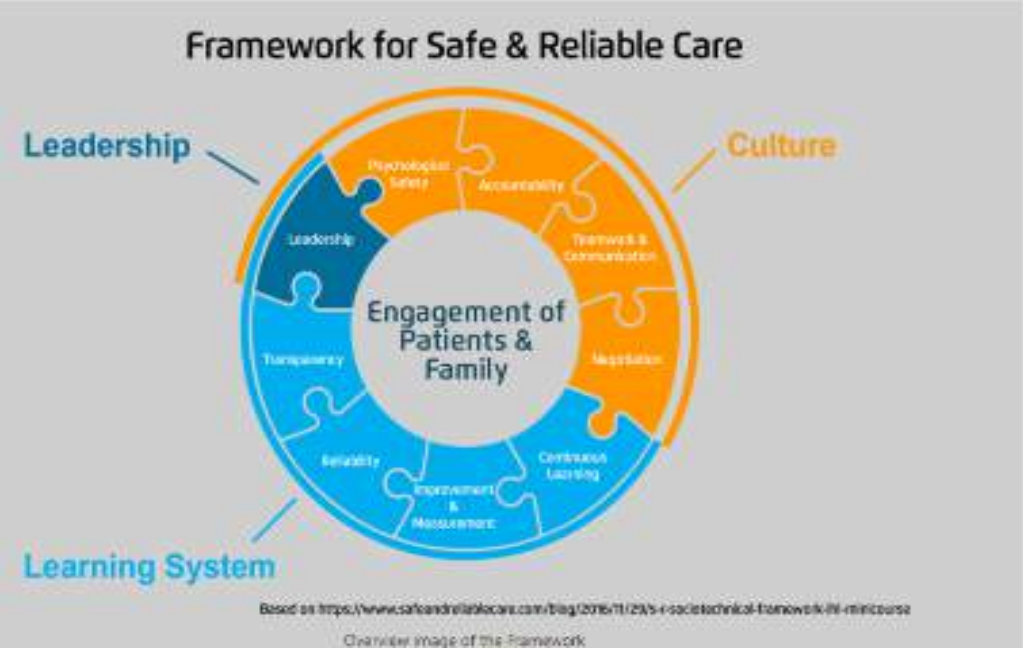
- Engaging in projects utilising Assisted Technology (AT).

- Supporting care homes with utilising I Stumble as an assessment tool. This tool has recently been subject to revision following the development of an associated App. This work has been undertaken collaboratively between WAST and the Primary and Community Care Division.

- Scoping how CRT's approach the delivery of exercise as a component of falls referral and the links with the National Exercise Referral schemes.

- Engaging with the Fire Service for the inclusion of falls as part of their home assessments.

A Safer Care Collaborative was also established November 2022, resulting in an All Wales 18 month focus on common safety priorities with teams applying evidence-based change packages to test and learn what works locally, including learning and sharing with colleagues nationally.



Workstream
Safe and effective community care: Keeping people safe care in community settings through prevention of deterioration and appropriate response to acute health care needs is achieved.
Safe and effective acute care: Keeping people safe in hospital, ensuring that structures and processes are robust in response to acute deterioration or concern.
Leadership: Working together to support the development of the culture and learning system within each health system and across NHS Wales, ensuring the whole system is working towards a common and well-aligned goal.

5.3 Never Events

There has only been **1** never event reported since April 2023, a retained foreign object. There were **7** never events reported between April 22-March 23, of those the majority were attributed to 'wrong site' surgery. There is a considerable amount of work being undertaken to prevent reoccurrence. This is being led by the Medical Director and includes Human Factors training, and a focus on Psychological Safety. A thematic review

was undertaken by the Corporate PTR Team, which was presented to the Divisional Triumvirates.

A report will be presented at December's QPSOC, outlining the Improvement Programme for Theatres. It will encompass, a summary of incidents, themes, the Human Factors programme and a plan for the subsequent 12 months.

5.4 Early Warning Notifications (EWN)

During this reporting period **54** Early Warning Notifications has been submitted to Welsh Government. The purpose of an Early Warning Notice is to ensure timely communication of potential incidents that could attract media attention or cause organisational embarrassment. Themes include, Absconsion, Covid Outbreaks, suicide, physical assault, PRUDIC, lost to follow up and safeguarding. The rise in reporting is due to an increased focus on identification of areas for learning through supporting staff to raise concerns.

April to September	
2020	7
2021	11
2022	51
2023	54

6 Complaints and Concerns

6.1 Concerns

The number of complaints received and managed through PTR was **761** and 711 were managed via Early Resolution. The number of complaints opened and closed remains comparable.

Organisational performance of concerns 'managed through PTR' since April 2023 has been a **57.17%** mean performance with a median at **58.37%** as illustrated below:

	2020	**2021**	**2022**	**2023**
April	52%	78%	51.55%	58.41%
May	53%	78%	60.58%	49.62%
June	71%	75%	47.90%	55.38%
July	73%	70%	57.45%	60.68%
August	76%	77%	35.43%	58.33%
September	67%	75%	51.85%	60.58%

A focused approach has been undertaken organisationally to close historic concerns. Monthly data provided to the Executives now illustrates concerns 6-9 and 9-12 months old. Previously they were encompassed in 6-12 months. The top four themes identified were: -

1. Delay in appointment/waiting time/transport
2. Delay/Lack of treatment or Assessment
3. Incorrect/insufficient treatment or Assessment
4. Communication with patient/service user

During this reporting period there has been an increased trajectory in Public Services Ombudsman for Wales (PSOW) settlements. This is due to a delay in responses, promoting complainants to access the PSOW service to expedite the response. There has also been an increase in financial renumeration, with £2725 (£975 in settlements and £1750 in draft reports), offered to complainants during the reporting period. An increase from £1500 (£500 in settlements and £1000 in draft reports) awarded in the same period of 2022/23. The PSOW have a four-level redress payment system. Level 1 can award £50-£450 for minor injustice and no long-term impact, i.e., delays in complaint response, failure to update complainant. The sum awarded is at the discretion of the individual PSOW officer, and number of updates given to complainant. Level 2 can award £500-£950 for moderate injustice with no or little long-term impact, level 3 £1000-1950 for significant injustice and Level 4 for Very significant injustice.

In 2022/23 the sums awarded were one case of £1000 and two cases of £250 each. In comparison, the reporting period for 2023/24 has seen one case of £750, one case of £500, four cases of £250, one case awarding £100 and five cases of £75. The PSOW are engaging earlier in the process for complainants than in previous years, hence there is an increase in financial renumeration. There is extensive work being undertaken across the divisions, investing in education and training for staff investigating and administering concerns received. This work endeavours to get it right first time for the complainant, thereby negating the need to approach PSOW.

A multifaceted approach has been adopted to support improvements. This includes increased focus on the quality and timeliness of complaint responses, undertaking a scoping exercise of Quality, Patient Safety resource across the organisation and a changed approach to the management of complaints through the introduction of a PALS Team October 2023 to allow for a more person-centred approach. These actions will ultimately improve the experience of the complainant and staff involved.

Additional Informal Themes:

- Unable to access GP Surgeries by telephone, e.g., affecting ability to make appointments, results etc.
- Timeliness of medication reviews in Mental Health, affecting repeat prescriptions
- Waiting times particularly in T&O and ENT.
- Unable to contact T+O booking lines in a timely way.

Learning and Improvement:

1. Fundamentals of care were not being met on a general medical ward. Learning discussion was arranged where experience was presented. The importance of maintaining high standards of care, including a person's dignity and respectful care, has been communicated to all ward staff.

   Significant changes and improvements in the delivery of fundamental care, including continence care has taken place. The ward manager has implemented daily checks each shift, which is carried out by the registered nurse in charge, to ensure that all patients receive high standards of fundamental care delivered by all staff every day. The Senior Nursing team will continue to monitor.

2. Poor communication with families and inclusion in care decisions, in addition to plans to transfer the patient to a different hospital within the Health Board.

   Medicine is introducing a pilot providing dedicated time slots within the ward so that families/carers can meet with the members of the medical

team to discuss any concerns and receive updates on management plans.

3. Safe and Timely discharge planning has been identified in a recent PSOW Report. As part of this initiative all Senior Nurses across the Health Board have been asked to review and audit the 'Board Rounds' that currently take place daily in every area where the discharge needs are discussed for all patients.

   Baseline audits are undertaken, and training of ward staff took place during May 2023, following which the changes will be implemented and subsequently audited for evaluation. As part of the same initiative all wards will be implementing "afternoon huddles". Ward staff will be asked to provide an update on the plans for each patient to the nurse in charge. This will provide senior oversight to decisions being made so that plans are carried out safely and in a timely manner.
   The Senior Nurses have been asked to feedback audit results regarding the changes made on a monthly basis to provide assurance.

4. A booklet 'The Waiting Game' had been developed for cardiology patients to help them understand why there is often a wait to undergo procedures, how patients our prioritised and why procedures may be cancelled or put on hold etc. Senior Nurse advised to re circulate.

5. Patient Advice and Liaison Service: The Corporate PTR team have been involved in the planning discussions in preparation of the PALS service going live and will have strong links with the service once it is established.

6.2 Datix Incidents

During the period April to September 2023 a total of 11,979 Datix incidents have been reported relating to patients via the Datix system.

This equates to an incidence rate of 19.9 per 1,000 people based on the current Gwent population.

The table below provides comparative data for the same period in previous years:

Datix Incidents	Number of Reports
April to September 2020	10,052
April to September 2021	11,380
April to September 2022	10,573
April to September 2023	11,979

All Datix incidents are being referred to the relevant Divisions whereby local managers remain responsible and accountable, for conducting the management review.

It is widely acknowledged within the Patient Safety literature that a positive and supportive safety culture is evidenced by a high reporting culture indicating an open and transparent safety culture with proportionately low levels of harm overall. This is evident from the Health Board's incident data presented below.

However further work is required on the high number of incidents where the investigation has yet to be completed.

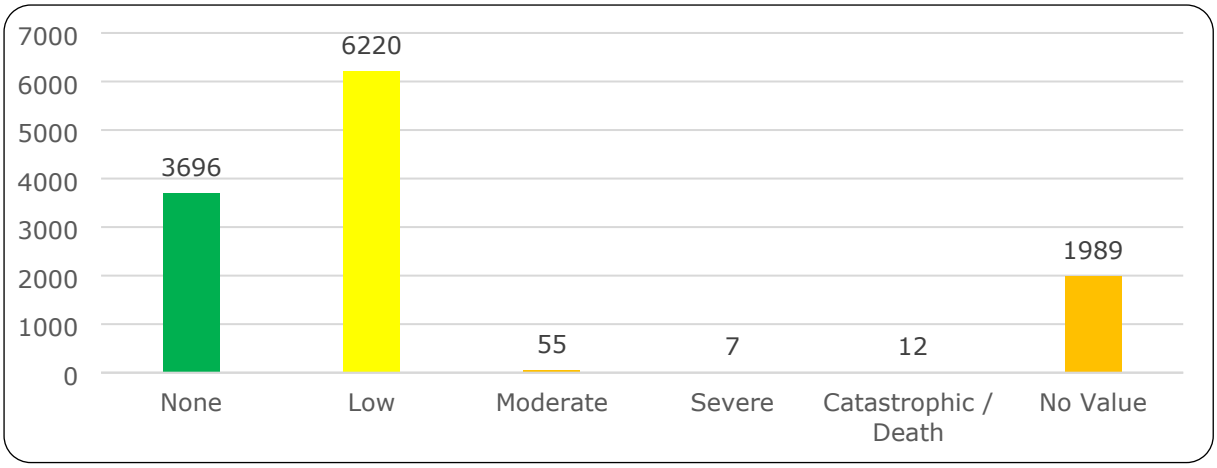
6.2.1 Incident Severity

There are currently three levels of harm that are recorded within the Datix system against Datix incidents.

The table below provides more information on the harm fields within the Datix system.

Field Name	Definition
Reporters view on level of harm	Initial harm reported by incident reporter
Following the Initial / Management review, what level of adverse outcome was considered?	Assessment of the level of harm at time of initial management review
Severity of Incident Post Investigation	Outcome or harm caused by the organisation

The chart below illustrates the '**Severity of Incident Post Investigation**' for all Datix incidents reported during the period 1 April 2023 to 30 September 2023.



The data highlights that 83% of incidents have a post investigation severity of either 'None' or 'Low'. However, these incidents often have the highest propensity for learning and prevention of reoccurrence.

Currently for 16% of incidents the investigation has not been concluded, therefore the '**Severity of Incident Post Investigation**' field has not been populated on the Datix system. This is being addressed by Datix Project Group. This will be reported by the Quality and Patient Safety Operational Group going forward.

The Datix system currently holds 4,787 open Datix incidents, 737 (15%) of these incidents occurred prior to 2023. The Health Board are developing a plan to address the backlog of open incidents.

6.2.2 Incident Themes

The top five main reporting themes during the period 1 April to 30 September 2023 were:

- **Patient falls:** (1,899 incidents reported within this category).
- **Healthcare acquired pressure damage:** (1,168 incidents reported within this category). 15% of these incidents were reported as either Grade 3, Grade 4 or Unstageable.
- **Medication incidents:** (809 incidents reported within this category). 46% of medication incidents reported relating to administration errors. Several learning bulletins and prescribing messages have been shared as part of Medicines Safety Week.
- **Healthcare acquired infections:** (454 incidents reported within this category).
- **Self-harm/self-injurious behaviour incidents:** (350 incidents reported within this category).

All of these themes are included with the Health Boards quality priorities in terms of quality improvement.

7 Claims, Redress & Inquests

ABUHB Legal Services oversee the management of clinical negligence claims, personal injury claims, concerns progressed under the PTR Redress Scheme, and Coroner inquests.

7.1 Claims

Total clinical negligence claim numbers remain steady at 394 live matters, up slightly on the preceding 6 months 369 (parity year on year).

Personal injury claims continue a year-on-year reduction, currently at 77 live matters, a 10-year low, representing only 10% of the claim's portfolio. This is testament to the commitment and work of multiple teams across the Health Board to mitigate and prevent personal injury incidents on our Health Board sites.

7.1.1 Themes raised in claims

Claims are spread across Divisions and Directorates. Numbers are higher as expected in our higher risk areas, including surgery, T&O, Urgent Care, and Obs & Gynae.

Whilst clinical treatment remains the largest class of cases, there continues to be a very mixed picture in the detail of the cases, spread over multiple Divisions/Directorates, sites and timescales, with key themes:

Delays: Diagnosis / Treatment
Misdiagnosis
Deteriorating patients / observations
X-ray: reporting and interpretation
Medication: prescribing / administering
Procedure/technique/human error

7.2 Redress

It is nationally recognised that the Redress aspect of the all-Wales 'Putting Things Right Regulations' has provided a much-needed alternative to formal legal proceedings for patients and their families, achieving resolution within much shorter timeframes, and cost savings of legal proceedings.

April – September 2023	
Redress Panels held	x4 Scheduled & x1 Extraordinary in May
Panels cancelled	x2 – Sept & Apr
Cases heard at Panel	May x5 & x1 June x5 & x4 July x6 Aug x5

Qualifying liability established	May x3 June x5 June x3 July x5 Aug x2 Bring back circulated on papers x1
Qualifying Liability not established	May x2 July x1 Aug x2
Further investigations needed	May x1 June x1 Aug x1
Exit Redress process: exceeding value	Aug x1

7.2.1 Learning & Improvement: Claims and Redress

A Learning from Events Report (LFER) is produced, supported by accompanying evidence and assurance, for every settled legal claim and Redress matter where failings in care are identified. Each LFER is then subject to extensive scrutiny from the Welsh Risk Pool (WRP), thereby providing very robust assurance on actions taken, improvements and learning. Where suitable assurance is not provided within prescribed time frames, the Health Board may face financial During the index period ABUHB received 13% of All-Wales Penalties, on appeal reduced to 5%. Following a rolling review to target and complete outstanding matters, no further penalties have been applied.

Focus during summer 2023 has included: -

- Welsh Risk Pool LAP – Learning Advisory Panel
- Working closely with the Safety Learning Advisors aligned to ABUHB
- ABUHB focus on all aged cases > 6 months
- Over 100 submissions of evidence/learning/assurance
- No Financial Penalties at July WRP Committee
- ABUHB representation at LAP October Panel and ongoing now 2024
    - Maternity Complaints lead
    - Head of Nursing Urgent Care
    - Legal Service Managers 2023-2024

7.3 Inquests

In September, ABUHB Legal Services team attended the Civic Centre Newport Local Authority to meet with the Senior Coroner for Gwent, her Officers and administration team. This was a 'first of its kind' meeting. As a Health Board we have always endeavoured to maintain close and effective working relations to enable the Coroner to discharge her Coronial duties, supporting families and staff through a complex and emotive process. The purpose of the meeting was to better understand the needs of service,

overcome operational challenges, and agree improved ways of working and communications. The session was greatly received by all parties, relations strengthened, and agreements reached on improved processes and ways of working to benefit all.

Overall inquest numbers have steadied, current live inquests standing at **192,** whilst fluctuating all the time as we constantly close and open new matters on a daily basis.

Over the last 6 months the Health Board has seen a significant improvement in the quality of Patient Safety Incident investigation reports, staff statements, action plans and learning. We approach every inquest with a spirit of openness and candour, endeavouring to answer the key questions that matter to families and the Coroner. Our approach to learning and assurance is honest and proactive. We will always look to submit evidence of actions and improvements taken to prevent future harm. Where matters have moved on since the completion of any formal Action Plan, we are now supplementing and updating by way of 'Learning Statements' to which a member of staff can then talk to the learning at the Inquest. These have proved to be very effective, providing comfort to families and assurance to the Coroner.

During the index period, April – September 2023, the Coroner issued two Regulation 28 reports (ENT + Mental Health) – reports sent to the Health Board seeking assurance of actions taken to prevent future deaths. Both reports have been responded to and actions complete.

Feedback from the Coroner October 2023

'I have to say that the concerns report produced on behalf of the board is one of the most helpful reports I have ever had the opportunity to see as a Coroner or as an advocate. Frankly it is a model of its kind. Not least because of the candour it demonstrates and on behalf of the Health Board who instructed the report to be carried out.

'One of the most detailed and helpful concerns report I have ever seen.

That approach was mirrored in the recommendations which flowed and the Action Plan which was drawn up'.

8 Health, Safety and Security

8.1 South Wales Fire and Rescue Service

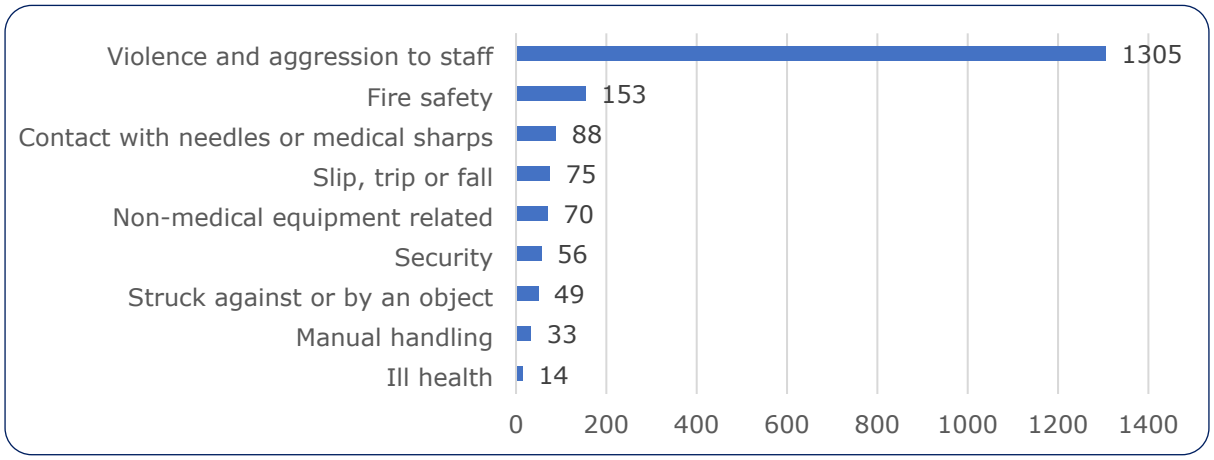
South Wales Fire & Rescue Service continue to actively inspect the Health Board and recent visits to Nevill Hall Hospital have been undertaken. The findings of the Fire & Rescue Service inspections are recorded on the Health

Board fire risk register and monitored through the Health Board Fire Safety Committee.

8.2 Health and Safety Incidents

A total of 2,016 incidents relating to Health, Safety, Fire and Security were reported during the period 1 April 2023 to 30 September 2023. This is an increase of approximately 6.2% compared with the same period in 2022.

The table below shows a breakdown by type of the top 10 incident themes reported for the period 1 April 2023 to 30 September 2023:



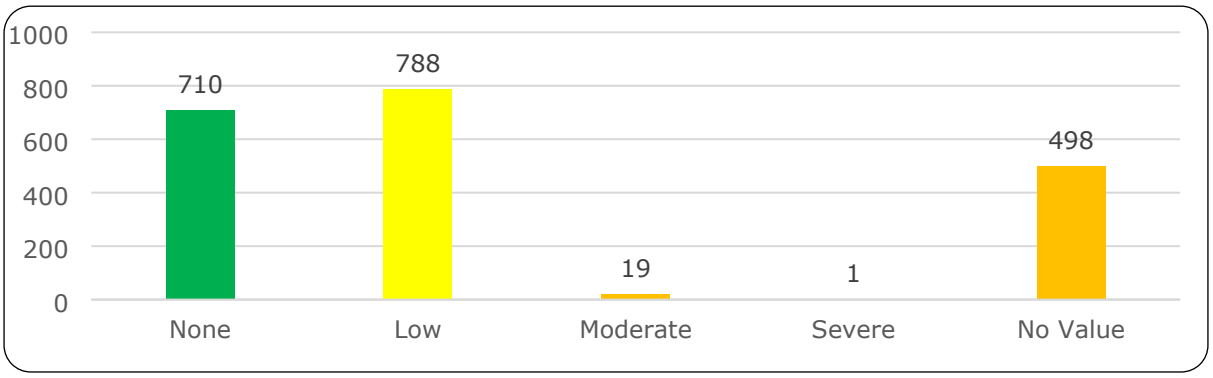
Violence and aggression to staff is significantly the highest reported incident and highlights the risks faced by the workforce from violence in the workplace. The monthly average for the period April to September 2023 is 217 incidents per month, which equates to approximately to 7 incidents of violence and aggression per day.

Physical assaults to staff account for approximately 28% of violence and aggression incidents.

Contact with needles or medical sharps is the second highest reported health and safety incident causing an injury to staff. On average there have been approximately 14 incidents per month during the reporting period. 86% of the 88 incidents reported related to incidents involving contaminated needles of sharps.

Of the 33 manual handling incidents reported during the period, 17 of these relate to patient handling activity.

The table below illustrates the level of harm based on the '***Severity of Incident Post Investigation***', which highlights that there are currently 498 incidents that are still to be investigated and the final severity recognised. This is being addressed via Divisions. 12 of the 19 moderate incidents are related to violence and aggression.



8.3 Violence Prevention & Reduction Plans

The Violence & Aggression Team are currently reviewing the suite of policies and procedures. The plan is to revise the policy and strengthen the supporting procedures/protocols to support local managers to reduce violence and aggression in the workplace.

8.4 Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) Compliance

50 incidents were reported to the Health and Safety Executive (HSE) in accordance with RIDDOR during the period 1 April to 30 September 2023.

The table below shows a breakdown of incidents reported:

RIDDOR Notification Type	Number of Reports
Dangerous Occurrence	4
Over 7 days injuries	32
Injury to a member of the public, taken directly to the hospital or injured on hospital grounds	1
Specified Injury	13

3 incidents relating to injuries to patients were slips, trips and falls incidents.

Of the 4 dangerous occurrences reported, 2 related to contact to needles or sharps contaminated with a blood borne virus (BBV).

Violence and aggression (11 incidents) contributed towards the highest reported number of over 7-day injury. Slips, trips and falls reported 8 incidents and manual handling reported 6 incidents.

Slips, trips and falls reported the highest number of specified injuries (12 incidents). The following are reportable to RIDDOR specified injuries if they arise '*out of or in connection with work*':

- fractures, other than to fingers, thumbs and toes;
- amputations;
- any injury likely to lead to permanent loss of sight or reduction in sight;
- any crush injury to the head or torso causing damage to the brain or internal organs;
- burns (including scalding) which:

    1. cover more than 10% of the body; or
    2. cause significant damage to the eyes, respiratory system or other vital organs;

- any scalping requiring hospital treatment;
- any loss of consciousness caused by a head injury or asphyxia;
- any other injury arising from working in an enclosed space which leads to hypothermia or heat-induced illness; or
- requires resuscitation or admittance to hospital for more than 24 hours.

68% of the RIDDOR reports were submitted to the HSE within the legal timeframe. On the 16 occasions where the timeframe was not met, this was due to the incident reports being submitted late by the injured party / Line Manager or the Corporate Health and Safety Department had inadequate information to submit the report (awaiting investigation to take place).

8.5 Security Incidents

There were 56 incidents relating to security reported during April and September 2023.

The highest reported security incidents are as follows:

Incident Type	Number of Reports
Intruder/Trespasser	17
Theft of property (personal or organisational)	8
Vandalism	4

The Health Board have recently recruited a new Security Manager who will lead on a security management review and develop an improvement plan.

8.6 Workplace Inspections

The Corporate Health and Safety Department are revitalising the health and safety workplace inspections. The plan is to undertake an inspection of all In-patient care areas by end of March 2024. The findings of the inspections

will be reported and monitored by the Health Board's Health and Safety Committee.

8.7 Health and Safety Training Compliance

The following table provides an overview of core health and safety training compliance across the Health Board reported at end of September 2023.

Training	Compliance Rate
Health and Safety	86%
Fire Safety	82%
Manual Handling	55%
Violence & Aggression	84%

Challenges remain in the delivery of manual handling training. The Manual Handling Team continue to explore different ways of working to ensure the Health Board has a competent workforce to deliver manual handling tasks and meet the requirements of the All Wales Manual Handling Passport.

Since April 2023 there has been an increase in the delivery of face-to-face fire safety and violence & aggression training.

The Corporate Health and Safety Department is working to provide training/refresher training to all Board Members on Leading Safely and this should be achieved by end of March 2024.

The Corporate Health and Safety Department are currently exploring opportunities to record and monitor compliance with Display Screen Equipment (DSE) training and risk assessment, including DSE risk assessment completed for hybrid workers.

8.8 Fire Safety

There have been no fires reported during the period April to September 2023. However, there have been 139 unwanted fire signals reported across the Health Board.

The following table provides a breakdown of the unwanted fire signals by site:

Site	Number of unwanted fire signals
County Hospital	26
Grange University Hospital	3
Llanfrechfa Grange	4

Maindiff Court	1
Nevill Hall Hospital	22
Rhymney Integrated Health and Social Care Centre	1
Royal Gwent Hospital	47
St Cadocs Hospital	13
St Woolos Hospital	5
Twyn Glas	2
Ysbyty Aneurin Bevan	2
Ysbyty Ystrad Fawr	13

The Fire Safety Team investigate all fire safety incidents to identify the cause(s) and extract the learning.

A programme of fire risk assessments across the Health Board is conducted by the Fire Safety Team. There is currently a backlog of assessments that are overdue, and these are being prioritised for completion.

9 Safeguarding

9.1 Safeguarding Training

Safeguarding Training continues to be provided and monitored, in line with the recommendations of the Intercollegiate Documents for Safeguarding of Children and Adults.

Training Module	Compliance %
Adult Safeguarding Level 1	77%
Children Safeguarding Level 1	84%
Adult Safeguarding Level 2	86%
Children Safeguarding Level 2	85%

Compliance with Adult Safeguarding Level 1 is below the agreed threshold of 80%, however on further interrogation of the data it has been noted that this is support staff and not amongst clinical staff caring for patients. Improvement plans are in place at Divisional Level to ensure that this is addressed in a timely and effective way.

Level 3 Children's and Adults continues to be a challenge and further work is required across the Health Board to ensure that this is mandated to staff appropriately via ESR, and that compliance data can then be analysed.

9.2 Domestic Abuse – IRIS and MARAC

The health Board continues to support agendas in the Multi Agency arena aimed at tackling Domestic Abuse. The Corporate Safeguarding Team are working with partner agencies to mitigate risk and support the continuation of both projects on a cost neutral basis.

9.3 Serious Violence

The 2022 Serious Violence Duty places an ask on ABUHB to collate data and work with partners to understand and mitigate the issues across Gwent in relation to serious Violence. At this current time there are neither systems or processes in place to enable us to appropriately identify victims of serious violence or to produce reports on a monthly basis. ABUHB have been successful in securing funding from the Home Office for a Serious Violence Worker to undertake some development work to ensure that Serious Violence is reported and recorded, to enable us to have submit the data required.

9.4 Safeguarding Activity and Audit

At this current time the Safeguarding Team collect a high volume of activity data in relation to safeguarding, however the volume of safeguarding incidents are not an indicator of the safety or effectiveness of services. As such, a programme of case audit is being trialled in one division, to understand the timeliness and appropriateness of both safeguarding reports and investigations. Once trialled, this information can better inform us of quality and effectiveness, appropriately informing reports of this type.

10 Infection Prevention and Control

10.1 Guidance/Governance

The Infection Prevention, Decontamination and Antimicrobial Resistance Annual Report was presented to Quality and Patient Safety Committee. The report illustrates the Aneurin Bevan University Health Board performance and assurance against the following:

- Infection Prevention Team and Governance Arrangements
- Welsh Government Antimicrobial Resistance (AMR) and Healthcare Associated Infections (HAI) Improvement Goals
- Respiratory Infections (Covid-19, Influenza, Respiratory syncytial virus (RSV)
- Covid Investigation Team
- Decontamination strategy

- Infection Prevention Incidents

The Annual Programme of Work outlines how the Infection Prevention Team (IPT) will work collaboratively with Divisions to deliver key aspects such as, surveillance reporting of Welsh Government reduction expectation goal and maintaining a safe, clean patient environment through audit, training and education.

The Infection Prevention intranet page hosts a library of policies and standard operating procedures together with links to National guidance. Staff also have access to advice for respiratory illnesses, C difficile and care bundles promoting best practice. There is a separate intranet page for Patient Information leaflets.

Infection Prevention audits are available on the Audit Management and Tracking (AMaT) system. This platform enables more control over audit activity, provides real-time insight and reporting can be shared instantly with multiple users.

RLDatix is used to investigate and identify themes for all hospital acquired C difficile, Staph aureus and E coli, Pseudomonas and Klebsiella blood stream infections.

Infection Prevention is one of six pillars of the Quality Act. The health board has a strategy for the implementation of safe, efficient, effective, person centred, timely focus and equitable standards with the overarching aim of zero tolerance for all preventable infections.

Infection Prevention training is readily available for staff to access via ESR. Staff are able to attend face to face or via Teams. An e learning package is also available. To support staff education, the IPT constantly review resources available on the intranet and have recently re-established the link champion role. This has been well received across the Health Board including Primary Care and a study day has been arranged for October 2023.

The infection prevention team support the wider community in primary care with advice, audits and education covering all aspects of the patient journey, this promotes a consistent message around best practice for infection prevention.

10.2 Welsh Government Reduction Expectations

Welsh Government reduction expectation goals are unchanged from 2022/23. An action plan has been developed and is monitored via the Reducing Nosocomial Transmission Group (RNTG).

A total of 100 cases of C difficile has been reported from Apr - Sep 2023 which equates to a Health Board rate of 32.77 per 100, 000 population. This is currently above trajectory.

- 7 wards have been affected by outbreaks of healthcare associated C difficile infection. Learning from outbreak control meetings has highlighted suboptimal antimicrobial prescribing and lapse with fundamental infection prevention measures. A lack of timely isolation and contaminated mattress has been identified as a theme and has been addressed.

- Delays in proactive HPV clean may also impact.

In response to the learning the Antimicrobial Pharmacist and IPT have undertaken medical education to promote prudent prescribing.

A new mattress poster has been developed promoting regular checking and the team has linked with the operational hubs re: patients' infectious status and cleaning required for transfer or discharge.

A total of 174 cases of E coli reported from Apr - Sep 2023 which equates to a Health Board rate of 58.51 per 100,000 population. This is the lowest rate in Wales.

Urine infections continue to be the largest burden. The infection prevention team continue to promote the concept of HOUIDIN - a tool designed for nurses to promote timely removal of urinary catheters. We are delighted to be finalist for the NHS awards for this work.

A total of 61 cases of Klebsiella reported from Apr 2023 - Sep 2023 which equates to a Health Board rate of 21.06 per 100,000 population. This is above the Welsh average. The ongoing issue of multidrug resistance is contributing to this infection as patients are taking longer to respond to treatment. It is therefore essential to advocate prudent antimicrobial prescribing. The antimicrobial Pharmacist is an active member of the Reducing Nosocomial Transmission Group.

A total of 11 cases of Pseudomonas reported from Apr 2023 - Sep 2023 which equates to a Health Board rate of 3.68 per 100,000 population. Although numbers are small, the same investigation process still occurs via Datix.

A total of 55 cases of Staph aureus bacteraemia (3 MRSA) reported from Apr - Sep 2023 which equates to a Health Board rate of 1.0 per 100,000 population for MRSA and 17.72 for MSSA. This is below the Welsh average. The majority of cases are identified on admission to secondary care with the largest number associated with skin or wound infection. The IPT continue to promote aseptic non-touch technique and are in the process of gathering information to achieve national bronze accreditation for the work being undertaken.

10.3 Measles

- The Health Board received notification from the centre for communicable disease surveillance indicating current measles epidemiology in Wales

and actions required to prevent measles outbreaks and resurgence. In response, Aneurin Bevan University Health Board formed a task and finish group and developed an action plan around the recommendations. The IPT has reviewed admission screening criteria and developed action cards to support health care professionals for safe management of measles. No reported cases have been identified within Aneurin Bevan University Health Board area to date.

10.4 MPOX

The MPox pathway has been reviewed in collaboration with Sexual and Reproductive Health considering the relocation to B6W. Fortunately, the guidance has softened referencing the different risk assessment dependant of travel risk to West and Central Africa. There are no reported cases within Aneurin Bevan University area to date.

10.5 Covid-19

Since 1st April 2023, there have been 29 ward closures reported as outbreaks on RLDatix where 2 or more patients have been linked to a recent admission on the ward. The majority of incidents have occurred at the Royal Gwent, Nevill Hall and community hospitals and no outbreaks have been identified at The Grange University Hospital.

Contributing factors include the change to staff testing, increase of visitors and shared facilities within the ward environment. The Health Board have local patient placement and step-down policies and procedures in place to minimise the ongoing risk of transmission within healthcare settings. The IPT also supports the clinical site teams to risk assess patient placement as capacity is an ongoing concern. The IPT continue to monitor the number of Covid-19 patients on a daily basis.

10.6 Infection Prevention Incidents

There have been three incidents outside of Covid and C difficile outbreaks.

- Two wards were affected by patients with unexplained diarrhoea and vomiting
- Patients exposed to chicken pox virus
- Patients exposed to TB infection
- Increase in C-section infection

Incidents have been investigated and patients followed up accordingly. There was no significant patient harm caused by these incidents. Learning identified is the timely isolation of patients with unexplained rashes and for staff to know their own immunity status.

10.7 National Reportable Incidents (NRI)

Since April, there have been 16 infection prevention related incidences reported as an NRI: -

- 16 ward closures due to healthcare associated Covid
- 2 wards affected with an outbreak of diarrhoea and vomiting
- 2 linked to periods of increased incidence of C difficile infection
- 2 incidents where C difficile death was cited on death certification
- One incident linked to the management of Carbapenmase Producing Organism (CPO)

10.8 Ongoing Overall Risks

- Inpatient capacity
- Sustainable workforce
- Increase in prevalence of infection
- Local Divisional ownership
- Compliance with Health Board policy for prudent antimicrobial prescribing and infection prevention practice

To support the risk assessment there are evidence-based policies available, the infection prevention team has a robust monitoring system via the use of ICNET promoting early identification of clusters. The team are also available promoting best practice within the clinical areas and challenging any non-conformities.

11 Recommendation

This report is to provide assurance for the committee on the ongoing work to implement and deliver the Quality Strategy and Patient Experience & Involvement Strategy and therefore the delivery of Compliance with the Duty of Candour and the Duty of Quality.

The Board are requested to note the report and request additional assurance through PQSOC where required.

12 Appendix 1: Template for In-Person Attendance at Board

Template for In-Person Attendance at Board

Initials of Person			Date of Board		
Designation of person telling their story	Patient	Carer	Staff	Other (please state)	
Person Consented to Visual Appearance	Yes	No	*If no, to ensure person is out of view of camera		
Division/Department Story relates to			Staff member accompanying		
Theme of Story (e.g., communication)					
Quality Pillar the Patient Experience Story relates to (please tick)					
Person Centred	Safe	Timely	Effective	Efficient	Equitable
Brief outline of story.					
Most significant impact.			**Note:** This is an action that has an important, notable consequence. Whether or not an action is likely to have a significant impact depends upon the sensitivity, value and quality of the care experience that is impacted, and upon the intensity, duration, magnitude and organisational extent of the impacts.		
Why is the person telling their story? What changes do they want to see?					
Actions taken as a result of the story.					
Actions still to be taken.					
Potential or actual risks.					
What are Board being asked to do?					
Suggested questions for Board based on the experience.					

Agenda Item: 4.4

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Integrated Medium Term Plan (IMTP) 2023/26 Quarter 2 Progress Report
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Hannah Evans (Director of Strategy, Planning and Partnerships)
SWYDDOG ADRODD: **REPORTING OFFICER:**	Trish Chalk (Interim Assistant Director of Insight, Improvement & Planning) Marie-Claire Griffiths (Head of Strategic Planning) Jennifer Keyte (Senior Corporate Planning & Service Improvement Manager)

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

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to provide the Board with a progress report against the Aneurin Bevan University Health Board's Integrated Medium-Term Plan (IMTP) 2023/26. This report summarises the Health Board's progress during Quarter 2, through the lens of the following chapters:

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

The Board is asked to:

- Note the progressed achieved during Quarter 2

Cefndir / Background

The IMTP for 2022/2026 sets out the vision for the organisation, that is to improve population health and reduce health inequalities experienced by our communities. In order to achieve this vision, the IMTP focusses on 5 life course priorities.

Outcomes and Performance Framework

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 it is 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 measured at the moment realistically.

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 Mid-Year of 2023, with a focus on delivery against key national targets included within the performance dashboard.

In response to feedback, this section of the report has been strengthened with specific improvement actions against those indicators where there has been deterioration.

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 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.

Ministerial Priorities

Through the templates underpinning the IMTP, the health board made a number of commitments in response to the Minister's priorities for delivery. This report now includes a chapter that updates on those commitments.

IMTP Planning Scenario

The report provides an update against the dynamic modelling and forecasting that was included in the IMTP, what was planned, what took place and forward projections.

This information has supported refreshed profiles included in the updated Minimum Data Set for Quarter 2; this is required to be submitted to Welsh Government as part of the IMTP process.

It is acknowledged that there is overlap between the different chapters and future iterations of the report will seek to minimise this. In addition, the report will evolve to take into account the developing Quality Outcomes Framework and, again, seek to ensure there is no duplication.

Asesiad / Assessment

In Quarter 2 there has been sustained performance in this quarter in line with the forecasted activity levels, with increases in activity and strong indicators that the Health Board is recovering activity to pre-Covid levels. Our planning assumptions were set out in the IMTP, and they are in line with expected delivery.

Outcomes and Performance Framework

Of the 41 indicators including in the outcome's framework, 26 have newly available data to be reported upon during this quarter. 16 measures have either improved or

are statistically similar and 7 indicators have deteriorated since the last reporting period.

Outcome measures reported across Children and Young People demonstrate good progress with only one measure over life course priority areas 1 and 2 having deteriorated, namely the CAMHS 4 week waiting list. There is mixed progress across the Adult life course outcomes with three indicators having deteriorated two within maximising an individual's time and one for maximising cancer outcomes. Three out of the four outcome indicators for Older People have deteriorated including assessments undertaken by Community Resource Teams and Emergency admissions. Across the Dying well as part of life priority area good progress has been made with a decrease in inpatient mortality rate and an increase in urgent palliative care assessments within two days.

Under each life course section, clarity is provided on improvement actions initiated to recover performance where required.

Priority Programme Progress

Good progress continues to be made across the priority programmes with key achievements that deliver system change coupled with enabling actions to improve service delivery and ultimately patient outcome.

The Clinical Futures Priority Programmes are leading the service changes committed to as part of the financial recovery commitments including:

- Right sizing bed base
- MIU reconfiguration
- Planned care scenarios
- Stroke reconfiguration

The patient safety team intervention has supported a reduction of 16 beds with a plan for further bed reduction and reconfiguration end of October. Momentum has continued with Stroke reconfiguration to deliver the temporary consolidation to a single Hyper Acute Stroke Unit at the GUH and single rehabilitation site due to an urgent service risk by the end of November 2023. The six goals for urgent care programme continues to deliver improvements including the Safety flow process which has reduced average handover times to 1 hour 12 mins and the number of long waits and infrastructure is in place to commence the implementation of Community Resource Team (CRT) review that aims to optimise and standardise the offer across the ABUHB footprint.

Ministerial Priorities

Across the Ministerial Priorities, good progress has been made during Quarter 2 in some areas. However, the current financial context has limited progression of service developments in others. There continues to be high demand on services which is evidenced in performance against forecast in some areas.

Cancer demand continues to increase, despite prioritisation of capacity performance against the forecast in reduction in backlog of cancer patients waiting over 62 days and percentage of patients starting definitive cancer treatment within 62 days from point of suspicion. These have not been achieved.

The number of patients waiting more than 52 weeks for treatment is slightly above the forecast performance for quarter 2. The number of patients waiting more than

104 weeks is significantly off track at 1,442 rather than the forecast of 903. The number of patients waiting more than 52 and 104 weeks for new outpatient appointments is both off track for Quarter 2.

Mental Health assessment within 28 days of referral performs at 20.5% (position at August) and interventions less than 28 days following assessment at 13.1% (position at August). Both of these areas are significantly below target and a 90-day action plan to improve performance is in place and being monitored by Executive Committee.

Within Primary Care, there has been an increase in NHS Dental Care and Community Dental services units of activity and new patients. Additionally, the number of new patients accessing NHS Optometry services has increased. Both areas are exceeding forecast levels at the mid-year point.

Urgent Care progress against priorities has been positive. Whilst the target for the number of delayed ambulance handovers over 1 hour has not been met, there has been a decrease during the second quarter. The reduction in the number of Pathways of Care Delays target for Quarter 2 has not been met but a reduction has been maintained. Good progress continues to be made against milestones including the implementation of the Safety Flow System and alignment with SDEC supporting a continued upward trajectory of the number of medical patients assessed.

IMTP Planning Scenario

The organisation is ahead or within tolerance on four of the six ministerial targets. The focus on reducing the number of long waiters has resulted in being ahead of forecast trajectories in eliminating and maintaining the position of no patients waiting over 156 weeks for treatment. Whilst not meeting the forecast for 104 week waits, there are currently 1,442 waiting for treatments and 1,913 waiting for a first outpatient appointment. There continues to be targeted work in those specialities behind trajectories. The Quarter 2 forecasts were in line with the actual activity for ED attendances with a total of 47,930 attendances during the quarter across all sites. The bed plan has continued to follow the overall expected occupancy levels and demand patterns with Medicine Division running at 99% occupancy against their bed plan and the Community Division at 107%.

This Quarter 2 assessment sets out the organisation's understanding of its system and plans remains robust and the priority decisions made in the IMTP remain valid areas of focus now and into next year's IMTP planning.

Argymhelliad / Recommendation

Board is asked to:

- Note the progressed achieved during Quarter 2.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol:	The report highlights key risks for delivery against the IMTP

Corporate Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability 1.1 Health Promotion, Protection and Improvement 2. Safe Care 2.1 Managing Risk and Promoting Health and Safety
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. This is a Quarterly report against the Integrated Medium-Term Plan and the key organisational priorities informed by our detailed understanding of how our system operates.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse

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

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

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

Aneurin Bevan University Health Board

IMTP

Integrated Medium-Term Plan

2023/26

Quarter 2

1. INTRODUCTION

This report summarises the Health Board's progress for Quarter 2 against the Integrated Medium-Term Plan (IMTP), bringing together reporting on outcomes, performance, priority programmes, Ministerial Priorities and a review of the underpinning planning scenarios.

Key achievements from quarter 2 include:

- ✓ Patient safety team interventions to reduce bed base to facilitate early supported discharge.
- ✓ Ahead of trajectory in eliminating the number of patients waiting over 156 weeks from referral to treatment waits with 79 patients waiting at the end of September 2023 compared to the March 2023 position of 553.
- ✓ Outpatient Did Not Attend (DNA) rate has reduced from has reduced from 6.4% (1,540) in March 2023 to 6% (1,372) in September 2023.
- ✓ Increase to 58.9% (Q4 2022/23) of breastfeeding uptake, optimising a child's long term potential from the last reported position of 56.5% (Q3 2022/23).
- ✓ Ty Cynnal Mental Health Crisis Support House winner for Mental Health Award in South Wales Health and Care.
- ✓ A consistent increase in volume of patients treated at the Same Day Emergency Care centre in Ysbyty Ystrad Fawr
- ✓ Completed building on Breast Centre at Ysbyty Ystrad Fawr
- ✓ On track to open new Endoscopy suite at Royal Gwent Hospital at the start of November.
- ✓ Reduction in number of ambulance patient handovers over 1 hour ahead of the forecasted trajectory for Quarter 2.

Risks in a number of pathways have endured into Quarter 2 and these pathways will continue to need attention to address underlying capacity constraints and sustained urgency profiles that mean reducing the numbers of patients waiting will continue to be challenging:

- Number of patients waiting more than 104 weeks for treatment in planned care, predominantly in the specialities of Orthopaedics mainly Spines, Ear Nose and Throat and Ophthalmology,
- Continued pressures with extended lengths of stay in medical and community beds,
- Children receiving 2 doses of the Measles Mumps and Rubella (MMR) vaccine by the age of 5 has reduced compared to this time last year at 89.7% in Q2 (2023).
- Delivery of Mental Health interventions (Part 1b) in a timely way with 13.1% receiving an intervention within 28 days of an assessment, a 90 day action plan is in place to address
- The proportion of Child and Adolescents Mental Health waiting four weeks plus has reduced from 82.9% to 45%
- Backlog of Cancer patients waiting over 62 days with Urological and Colorectal pathways needing targeted improvement plans.

The actions to improve the position and risk level have been included in our plans set out later in this document.

Structure

This report is structured across four sections as follows:

2. OUTCOMES FRAMEWORK & PERFORMANCE SUMMARY

The vision set out in the IMTP 2023-2026 is to:

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

In order to achieve this vision, the IMTP focuses on 5 life course priorities. The Outcomes Framework is updated quarterly and, depending on data availability, the latest data is reported for each indicator. For the 2023/26 IMTP, the Outcomes Framework was reviewed and aligned, where appropriate, aligned with the newly published Public Health Outcomes Framework. The timescales for indicators vary according to the data source. Indicators are classed as 'Similar' if the percentage change is between -2 and +2 and either 'Improved' or 'Deteriorated' if not. The 'No Data' category is used where the indicator is in development.

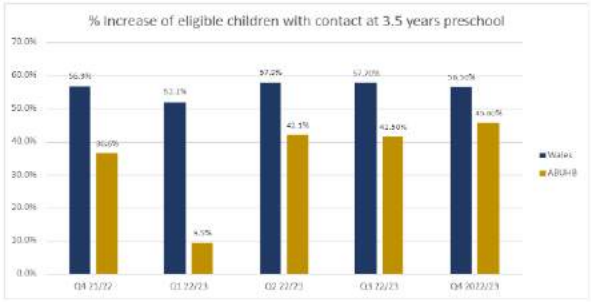
Of the 41 indicators including in the Outcomes Framework, 23 have newly available data to be reported upon during this quarter. 16 of the 23 measures have either improved or are statistically similar and 7 indicators have deteriorated since the last reporting period. The full Outcomes Framework can be found in Appendix 1 and a breakdown of the type of change by priority between Quarter 1 and 2 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	3	1	5	0	2	**11**
Similar	2	0	1	1	1	**5**
Deteriorated	0	1	3	3	0	**7**
Total indicators	**5**	**2**	**9**	**4**	**3**	**23**

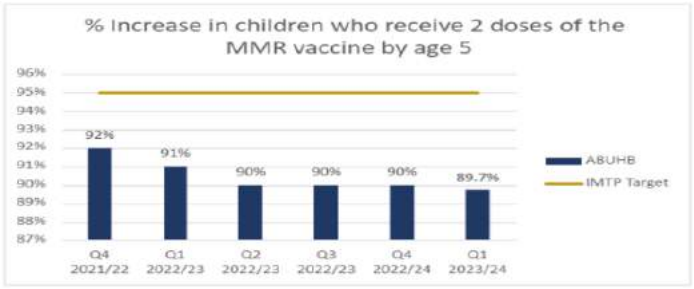
Early childhood experiences, including before birth, are key to ensuring improved health outcomes. The Health Board's IMTP committed to working with partners to take forward actions and activities that have a positive impact on the first 1000 days of life. The table below sets out three core outcomes 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	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 1 - Every child has the best start in life	Optimising a child's long term potential	Increase uptake in mothers breastfeeding (any breastfeeding)	59.2%	65%	Q3 2022/23	56.5%	Q4 2022/23	58.9%	Improved	Indicator value has improved by 4% between Quarter 3 and Quarter 4.
		Increase of eligible children measured and weighed at 8 weeks	62.5%	60%	Q3 2022/23	35.0%	Q4 2022/23	39.7%	Improved	Improvement in indicator over the last 4 quarters, however this remains significantly below the all Wales average.
		Increase of eligible children with contact at 3.5 years pre-school	64.4%	60%	Q3 2022/23	41.5%	Q4 2022/23	45.6%	Improved	Indicator value has improved by 9.9% between Quarter 3 and Quarter 4.
	Increasing childhood immunisation and preventing outbreaks	Percentage of children who received 2 doses of the MMR vaccine by age 5	91%	95%	Q4 2022/23	90%	Q1 2023/24	89.7%	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%	Q4 2022/23	94%%	Q1 2023/24	94%	Similar	Indicator value has remained stable.

There has been an improvement in all three indicators of the outcome **'Optimising a child's long term potential'** with a slight increase from the last reported position of 56.5% (Q3 2022/23) to 58.9% (Q4 2022/23) in the increase of breastfeeding uptake. As part of the Healthy Wales Child programme, there has been an increase over the last 4 quarters in the number of eligible children measured and weighed at 8 weeks and is currently reported at 39.7% (Q4 2022/23), however this remains significantly below the all Wales average of 71.2%. Similarly, there has been an observed improvement in the increase of eligible children with contact at 3.5 years pre-school from 41.5% (Q3 2022/23) to 45.6% (Q4 2022/23). Contacts that were not completed are largely due to workforce capacity constraints or contact not attending an appointment.

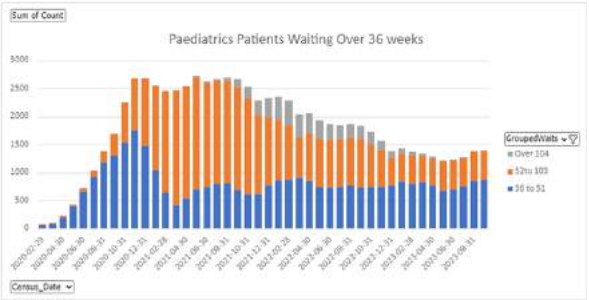


The position in the reported indicator in the outcome **'Increasing childhood immunisation and preventing outbreaks**' has remained similar as the previous reporting period with 89.7% of children receiving 2 doses of the MMR vaccine by the age of 5. Additionally, 94% of children received 3 doses of the hexavalent '6 in 1' vaccine by age 1, demonstrating sustained strong performance.



The number of children on the Health Board's waiting lists who have been waiting over 36 weeks increased during the pandemic and peaked during the summer of 2021. As of September 2023, there were 251 children waiting

over 52 weeks for a new outpatient appointment. There continues to be focused efforts to reduce paediatric waiting times and consequently, intensive plans have been developed to reduce and maintain the waiting time for first outpatient appointments across all specialities.



Priority 1 Improvement Actions		
Indicator	**Improvement Action**	**Monitoring Arrangement**
Percentage of children who received 2 doses of the MMR vaccine by age 5:	Dedicated MMR catch up clinics are being delivered using a combination of Vaccination Centre appointments and pop- up clinics in areas of low uptake.	Divisional Assurance meetings
Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1:	Referral pathways are under development to ensure that professionals within Health Visiting are able to directly refer to the Vaccination Service to allow vaccinations or immunisations to be delivered outside the usual route	Divisional Assurance meetings
Children waiting over 52 weeks for a new outpatient appointment:	Bi-weekly Directorate RTT special measures meetings established to monitor the implementation of a recovery plan with the aim to increase compliance.	Divisional Assurance meetings
Increase of eligible children measured and weighted at 8 weeks: Increase of eligible children with contact at 3.5 years pre-school Increase uptake in mothers breast feeding	A 6-part control measures plan has been developed, with continued implementation during Quarter 3 including: • Wider health visiting improvement programme – particular focus on standardisation of clinical and non-clinical aspects of the service and development of robust project plan. • Partnership – delivery of interventions through partnerships and delegated working across organisations. • Improving data collection – improvement plan to increase accuracy of data capture. • Integration of Flying Start and Generic Caseload – integration has taken place over the last 2 years with the aim to increase workload equity and service delivery. • Clinic availability – renewed focus on providing a significant increase in clinic provision. • Workforce – modernisation of workforce structure to maximise clinical time and ensure workforce sustainability.	Strategic Health Visiting Service Improvement Board / Divisional Assurance meetings

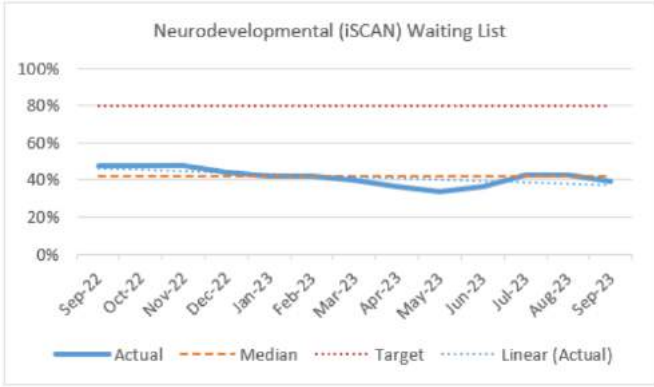
Priority 2

Getting it right for children and young adults

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

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 2 - Getting it right for children and young adults	Improve Mental Health Resilience in Children and Young adults	Decrease in 4 week CAMHS waiting list	95%	80%	*Jun-23*	*82.9%*	*Sep-23*	*45.0%*	Deteriorated	NB: The implementation of WCCIS has impacted upon validation and the reported performance. For the purpose of the report, locally reported data has been used within the narrative report.
		Decrease in neurodevelopmental (SCAN) waiting list	80%	80%	Jun-23	36.2%	Jun-23	39.3%	Improved	Indicator has improved between Q1 (36.2%) and Q2 (39.3%), however still remain below the IMTP target.

Progress within the **'Improve Mental health Resilience in Children and Young Adults'** outcome remains mixed. The CAMHS Neuro-developmental (ND) Service remains committed to achieving the 80% target of completing ND assessments within 26 weeks. Quarter 2 of 2023/24 has seen a continued demand of referrals requesting consideration of a ND assessment and this challenge has resulted in an RTT compliance for the end of September 2023 of 39.3%. A robust ND recovery plan was implemented in April 2023 to be able to support the current waiting lists across the 0 -18 years pathway by separating the cohorts of 0 - 5 years and the 5 - 18 years.



PCAMHS 1a performance against the ministerial target of 80% compliance has remained steady since 2022, however the implementation of WCCIS has impacted upon validation. Due to this reporting issue, for the purpose of this report, locally sourced data has been used. As of September 2023, the reported position was 87.4% which is a slight decrease to the end of Quarter 1 position of 91%. The Part 1b intervention measures will be incorporated into the Quarter 3 outcomes and performance report.

Priority 2 Improvement Actions		
Indicator	**Improvement Action**	**Monitoring Arrangement**
Decrease in 4 week CAMHS waiting list:	Continued implementation of the CAMHS recovery plan with a particular focus during Q3 and 4 on: • Monitoring 1b weekly in PCAMHS performance meetings (1b) • Monitoring and reviewing 6 session model (1b) • Improvement plan to come to Executive Committee • Note will include Part 1a and 1b in Q3 report	Divisional Assurance meetings / PCAMHS performance meeting

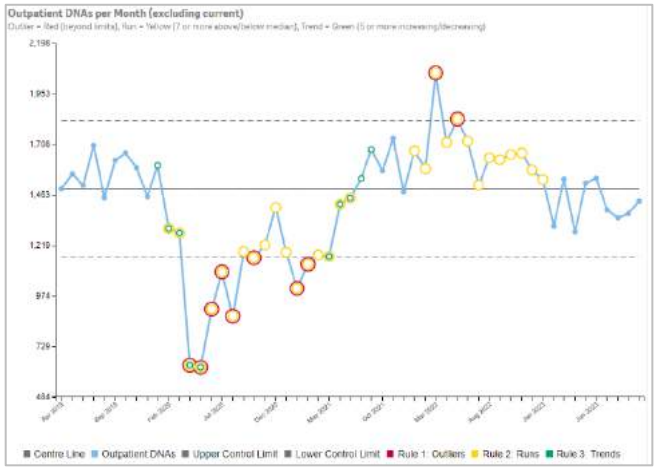
CAMHS Neuro-developmental (ND) Service 80% target of completing ND assessments within 26 weeks	Continued implementation of the CAMHS recovery plan with a particular focus during Q3 and 4 on: • Workforce plan – including recruitment of assistant psychologists during, SALTs, and additional community Paediatrician sessions during Quarter 3 to increase capacity. • Pan-Gwent pathway to be developed and merged into one multi-disciplinary group including the membership from a community paediatrician, speech and language therapist and psychologist with training and experience in working with ND children and young people. This will provide a single point of access for referrals to the autism team.	Divisional Assurance meetings

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 Chapter 3.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 3 - Adults living healthily and aging well	Maximising an individuals time	Reduction in the number of patients waiting more than 36 weeks for treatment	32202	32168	Jun-23	35813	Sep-23	36985	Deteriorated	Indicator value has increase since Jun 23 and Sep 23 by 3.3%
		Reduction in the number of patients waiting for a follow-up outpatient appointment	113107	69268	Jun-23	123736	Sep-23	126708	Similar	Indicator value has increased by 2.4% between Q1 and Q2.
		Increase in Urgent Primary Care Contacts	5336	8000	Jun-23	3347	Sep-23	7,233	Improved	Significant increase in the number of UPCC contacts between Jun 23 and Sep23.
		Reduction of ambulance handovers over 1 hour	737	0	Jun-23	962	Sep-23	873	Improved	Improving trend over the last 12 months, reducing by 9.3% between Q1 and Q2.
		Reduction in patients never waiting in ED over 16 hours	417	0	Jun-23	358	Sep-23	367	Deteriorated	Decrease in indicator value between Q1 and Q2. Rate has increased by 2.5%. Decreasing trend observed since Dec 22.
		Reduction in time for patients to be seen by first clinician	1.6 hours	2 hours	Jun-23	4.4 hours	Sep-23	2.3 hours	Improved	Improvement from 4.4 hours in Jun 23 to 2.3 hours in Sep 23.
		Reduction in time for bed allocation from request	11.5 hours	8 hours	Jun-23	9.6 hours	Sep-23	9.1 hours	Improved	Improving trend overserved over the last 6 months.
	Improved mental health resilience in adults	Increase in percentage of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	80%	90%	Jun-23	79%	Aug-23	83%	Improved	Measure has improved between June 2023 and August 2023 from 79% to 83%.
	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%	Jun-23	56.2%	Sep-23	54.5%	Deteriorated	Deterioration in indicator value from 56.2% (Jun 23) to 54.5% (Sep 23)

Maximising an Individual's Time- Planned Care

Maximising an individual's time is a core element of planned care. The Health Board is ahead of trajectory in eliminating waits of over 156 weeks for treatment with 79 patients waiting at the end of September 2023 compared to the March 2023 position of 553. Improvements have also been made with 104 week waits for treatment which has reduced from 1,935 in March 2023 to 1,442 at the end of September 2023. Despite this reduction, the Health Board remains off track to meet the Quarter 2 trajectories by 539. There is a particular issue emerging in General Surgery where capacity has been prioritised to accommodate an increase in urgent colorectal cancer activity. A comprehensive plan is in place to support Ophthalmology, including a regional solution to increase regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise the use of our assets across the region.



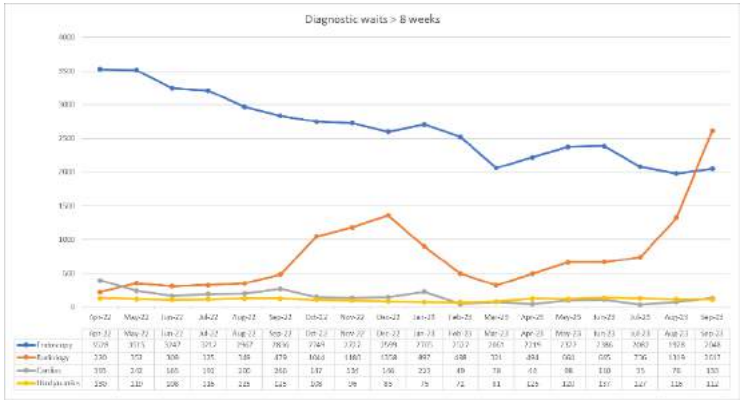
Improvement in outpatient performance remains essential to make the most of an individual's time and is a core focus of the Planned Care Programme. At the end of September 2023, there were 1,913 patients waiting over 104 weeks for a first outpatient appointment. There is mixed progress across specialities with ENT, Orthopaedics and Urology currently behind trajectory. There are extensive recovery plans in place across ENT and Urology including a clinical review of patients on the waiting list along with other solution (eg audiology) supporting ENT and a focus on improving treat in turn prioritisation across the Board. However, despite plans being implemented it is likely to take time in to Quarter 3 to recover the 104 week position, although significant improvement has been noted within the ENT and Urology 52 week position due to the implementation of the recovery plan and the specialities are now ahead of trajectory.

The outpatient transformation programme is focussing on its outpatient Did Not Attend (DNA) plan, of which the current rate for new outpatient appointments has reduced from 6.4% (1,540) in March 2023 to 6% (1,372) in September 2023. Additionally, the programme is continuing to work alongside finance and divisional teams, with a particular focus next quarter to further explore opportunities of virtual activity to meet the needs of those waiting for an appointment.

Maximising and Individual's Time- Diagnostics

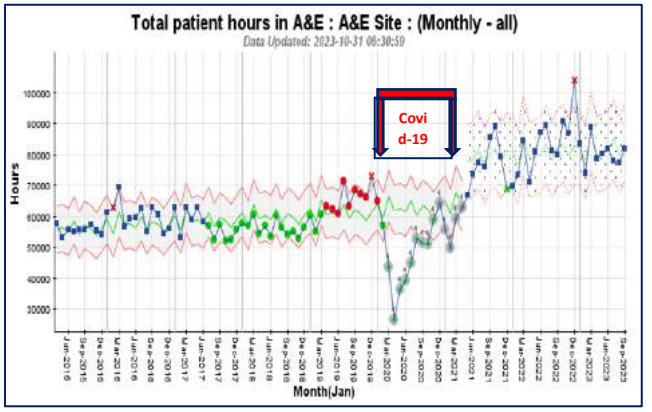
As seen in the graph on the right, cardiology maintained its position, driven by use of an insourcing company to deliver additional echo capacity. Further key areas in diagnostics include:

- continued insourcing of additional endoscopy capacity has supported a reduction in the 8-week backlog with a small decrease in the numbers of people waiting at the end of September (2,048),
- radiology diagnostics have increased during Quarter 2 from 665 at the end of June to 2,617 at the end of September as forecasted, due to the ceasing of outsourced MRI capacity and additionally funded sessions to support ultrasounds,
- the future developments of the Royal Gwent Hospital endoscopy unit has progressed with approval to recruit ahead of the new unit opening in November 2023. It should be noted that this is to sustain services and is predicated on the backlog being cleared by the point of opening.

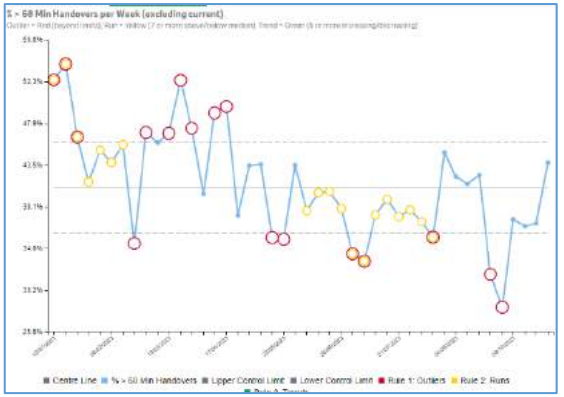


Maximising an Individual's Time- Urgent Care

Urgent Care services continue be under significant pressure both nationally, regionally and locally, making delivering timely care challenging. There has been increasing demand for urgent primary care, increased ambulance call demand, increasing numbers of self-presenters at Emergency Departments and Minor Injury Units, increased acuity, increased bed occupancy for emergency care and high levels of delayed discharges linked with significant social care workforce challenges.



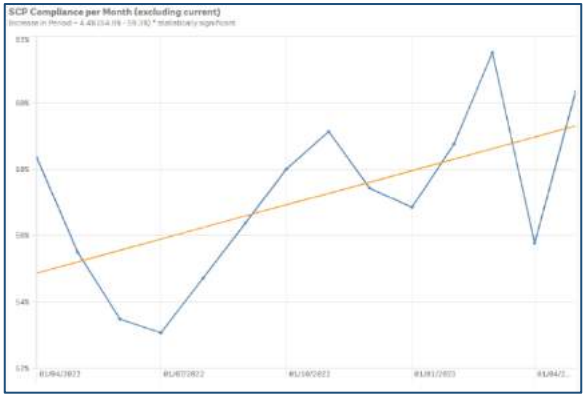
Over the last 3 months, there have been on average 524 daily attendances to the Emergency Department or a Minor Injury Unit and the pressure on the urgent care system has resulted in patients staying in hospital for longer. The average time from arrival to departure in the GUH Emergency Department continues to be above target and significantly above pre-covid levels as the chart on the left demonstrates. During September, a total of 1,285 patients waited for over 60 minutes to be transferred to the Emergency Department from an Ambulance. Whilst this remains high as a result of poor flow through the system, there has been a concerted effort to decrease the number of delayed ambulance handovers and as such this has reduced significantly from 1497 reported in March 23.

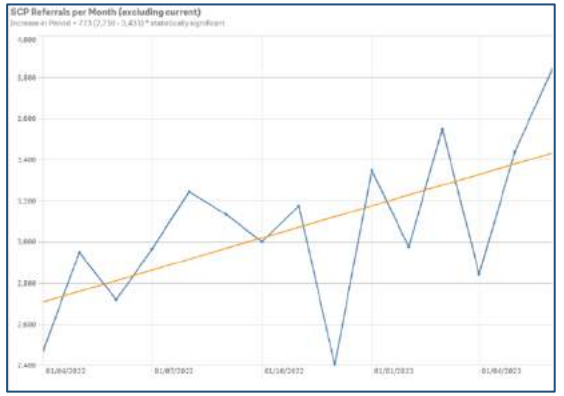


Despite the extreme pressures upon the urgent care system, the performance measures of patients waiting less than 4 hours in ED has slightly improved at 73% in September 23 against a national target of 75%. The most recent national performance data reports that whilst the 95% target for 4 hour ED waits has not been met, the Health Board's performance is higher than the Welsh average of 66% and remains the best performing Health Board in Wales (excluding Powys). Patients waiting over 12 hours in Emergency Departments was 1,537 in September 23 against a national target of 1,415.

Maximising cancer outcomes

Compliance against the 62-day target for definitive cancer treatment has increased from 51.6% (Mar 23) to 54.5% at the end of September 2023. Significant increases in demand relating to suspected cancer referrals have continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500 and whilst SCP compliance is improving, this increased demand is continuing to have an impact on performance creating capacity challenges throughout the pathway for services provided by the Health Board and those provided at tertiary centres.





There are a number of factors which have had an impact on overall performance. A primary driver is a considerable reduction in skin treatments. The volumes for this specialty have historically contributed in increasing the performance denominator. This reduction has been influenced by the current pathology pressures. The pressure on the diagnostics part of the pathway is a significant constraint with actions continuing to improve the position through outsourcing of services.

Mental Health in Working Adults

Mental wellbeing and life satisfaction result in better subsequent health outcomes on some physical health indicators, health behaviours and psychosocial indications, including depressive symptoms. Mental wellbeing remains a key priority for the organisation and improvements have been observed in **the 'improved mental health resilience in adults'** outcome. As of August, 83% of Health Board residents over 18 in receipt of secondary mental health services have a valid care and treatment plan, which is an increase from 79% in reporting in June 2023. There are concerns on the provision of assessment by mental health service within 28 days from referral which is currently at 20.5% (August 23) and interventions less than 28 days from assessment which is currently 13.1% both areas are being addressed in a 90 day action plan monitored by Executive Committee to ensure targeted assurance. Since the implementation of WCCIS, there is a reported data capture issue which has affected the accuracy of reported performance data which is being addressed by the Division and the Informatics Directorate as a priority.

Priority 3 Improvement Actions		
Indicator	**Improvement Action**	**Monitoring Arrangement**
Reduction in the number of patients waiting more than 156 weeks for treatment	Improvement action here will include the focused oversight and delivery plans to improve the ENT and spines position for 156 weeks by end of Dec 23 led by Deputy COO.	Divisional Assurance meetings
Patients waiting over 104 weeks for a first outpatient appointment	Actions in the challenged services include: • ENT – joint model with audiology, GP review of lists, treat in turn rates • Ophthalmology – progress with regional solution to increase capacity for cataract outpatient and inpatient stages • Spines - a lower backpain pathway is in development between MSK therapy and orthopaedic services. This work has already redirected patients from the spinal waiting list to the physio waiting list	Divisional Assurance meetings
Increased compliance of the number of patients starting their first definitive cancer treatment within 62 days from point of suspicion	Focused action via new Cancer Services Manager including: • Thorough cleanse of entire cancer waiting list (n > 3000) • A review all patients on day 42-52 of pathway with a view to avoiding unnecessary breaches. • Review all patients between days 87-97 with a view to prevent as many patients as possible from 'tipping' into the 104+ days category. • Review the 104+ days to move them on wherever possible and identifying what is blocking progression (this will include tertiary provider delays).	Divisional Cancer Weekly Assurance meeting
Maximising and Individual's Time- Diagnostics	Recruitment plan in place to address vacancies within Sonographers and increase number of available sessions.	Divisional Assurance meetings
Assessment by mental health service within 28 days from referral	90 day action plan in place to address significant performance issues	Executive Committee via escalation arrangements
Interventions <28 days following assessment by mental health service	90 day action plan in place to address significant performance issues	Executive Committee via escalation arrangements

Priority 4

Older adults are supported to live well and independently

Our Outcomes:

Prevention and keeping older adults well

Delivering care closer to home

Reducing admissions and time spent in hospital

Supporting older adults to live well and independently is a core component of the Health Boards' plan for a sustainable health and care system. We know we need to deliver improvement for this section of our population in our service offer. Within the Urgent and Emergency Care 6 Goals programme there is prioritisation in Goals 1 and 2 for redesigning services for older people.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 4 - Older adults are supported to live well and independently	Delivering Care Closer to Home	Increase in accepted referrals to Rapid Response Services (CRT)	343	375	Jun-23	393	Sep-23	356	Deteriorated	Indicator has deteriorated by 9.4% between Jun 23 and Sep 23
		Increase in accepted referrals to Reablement & Falls Services (CRT)	331	375	Jun-23	222	Sep-23	83	Deteriorated	Significant reduction in the number of accepted referrals between Jun 23 (222) to Sep 23 (83).
	Reducing admissions and time spent in hospital	Reduction in the number of Emergency Admissions >65 years of age	1297	1000	Jun-23	1439	Sep-23	1737	Deteriorated	Significant increase in the number of emergency admissions by 20.7% between Jun and Sep 23.
		Decrease (from 65 - 55%) in LOS over 21 days	65%	55%	Q1 2023/24	55%	Q2 2023/24	54%	Similar	Statistically similar to last reported position.

The indicator values have deteriorated for the '**Delivering Care Closer to Home'** outcomes. As of September 2023, there were 356 accepted referrals to the Rapid Response Services and 83 to the Reablement & Falls Services. Goal 1 of the Urgent Care Transformation programme have progressed the development of redesign of frailty services, including the extension of CRT hours to 8am-8pm Monday to Friday and it is anticipated that the rate of accepted referrals will start to increase during the remainder of the financial year to enable people to remain at (or close to) home, where this is safe and appropriate.

The outcome **'Reducing admissions and time spent in hospital'** has seen a varied progress, with the number of emergency admissions for over 65 years of age increasing during Quarter 2 and reported at 1,737 at the end of September. Whilst the indicator 'decrease in the length of stay over 21 days' has remained statistically similar to the previously reported position, the gradual decrease from 55% in June 2023 to 54% in September 2023 has resulted in the IMTP target of 55% being met.

Priority 4 Improvement Actions		
Indicator	**Improvement Action**	**Monitoring Arrangement**
Increase in accepted referrals to Rapid Response Services (CRT)	Infrastructure in place to commence the implementation of findings of CRT review (principles work) that aims to optimise and standardise offer across ABUHB footprint.	Divisional Assurance meetings Six Goals for Urgent Care
Increase in accepted referrals to Reablement & Falls Services (CRT)	Redesign of services for older people programme taking forward actions to increase referrals to reablement and falls. Development of a consistent offer across Gwent monitoring service availability across the Health Board and relevant Local Authorities.	Divisional Assurance meetings Six Goals for Urgent Care
Reduction in the number of Emergency Admissions >65 years of age	Plan to implement an Acute Frailty Unit (AFU) are underway with appropriate stakeholders. Realigning resource to provide daytime Urgent Primary Care support and utilisation of HCSWs to support keeping patients at home.	Divisional Assurance meetings Six Goals for Urgent Care

Priority 5
Dying well as a part of life

Our Outcomes:

Improved end of life care experience

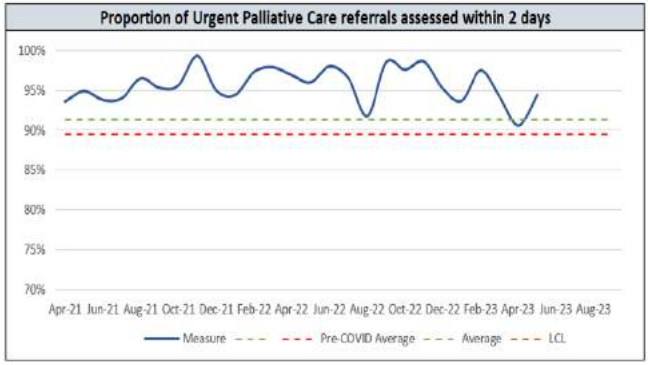
Improved planning and provision of end of life care

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 organisation's understanding of how it is delivering in this area to support the population to die in their place of choice and have access to good care.

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 5 - Dying well as part of life	Improve care at end of life	Decrease in inpatient mortality rate	2.0%	1.5%	Q1 2023/24	1.8%	Q2 2023/24	1.7%	Improved	Improved rate of inpatient mortality from 1.8% in Q1 22/23 to 1.7% in Q2 23/24
	Improved planning and provision of end of life care	Increase in referrals to Palliative Care Services	141	200.0%	Jun-23	158	Aug-23	153	Similar	Indicator has remained statistically similar.
		Increase in propotion of Urgent Palliative Care referrals assessed within 2 days	91%	95%	Jun-23	92%	Aug-23	99%	Improved	Improvement in the indicator value from 92% (Jun 23) to 99% (Aug 23). IMTP target has been met.

Progress against all three outcomes of this life course priority remains mixed. For the outcome measure **'Improve care at the end of life'**, it is recognised that the relationship between mortality rates and the quality of patient care is a complex one. For this reason, the indicator 'decrease inpatient mortality rate' is used as a measure and trigger for further investigation, understanding that it may not indicate any deficiency in the quality of care. The rate in inpatient mortality further decreased from 1.8% during Quarter 1 2022/23 to 1.7% during Quarter 2 of this financial year and has been following a downward trend since December 2022 as forecasted.

For the outcome **'Improved planning and provision of end-of-life care'**, an increase in referrals to palliative care services has remained statistically similar, however the proportion of urgent palliative care referrals assessed within 2 days has improved from 92% (June 2023) to 99% (September 2023) and has resulted in the IMTP target being met.



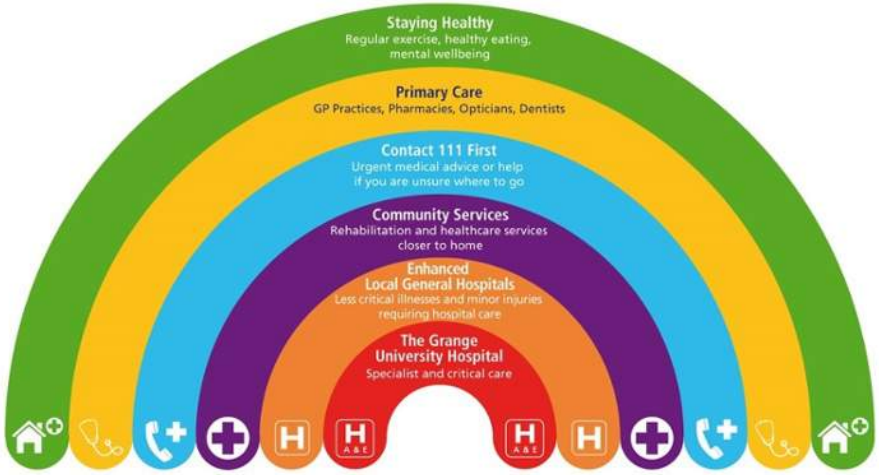
Priority 5 Improvement Actions		
Indicator	**Improvement Action**	**Monitoring Arrangement**
Increase in referrals to Palliative Care Services	Continued collaborative approach to advanced care planning programme working with primary care, secondary care, care homes and voluntary sectors, driven by the End of Life Care delivery plan to raise awareness.	Divisional Assurance meetings

3. PROGRESS OF CLINICAL FUTURES PROGRAMMES

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

We have adopted a rigorous and systemic programme management approach to support the delivery of key components of our strategy. We have refocussed our Clinical Futures Transformation and Delivery Team to support the delivery of a finite number of organisational priorities in response to the challenges identified through the dynamic planning model.

This chapter of the reports sets out the Clinical Futures priority key achievements made during Quarter 2 and what the key areas of focus are for the next quarter. During Quarter 2 the 7 key priorities refocused to align delivery of the value and sustainability programme. The Clinical Futures programmes are an important vehicle in developing, testing and implementing priorities that align to service and financial sustainability opportunities.



Clinical Futures Programmes:

1. Urgent Care Transformation (including Redesigning services for older people)
2. Enhanced Local General Hospital network
3. Place Based Care
4. 6 Goals for Planned Care
5. Optimising Cancer Outcomes
6. Net Zero Decarbonisation including Agile Working
7. Mental Health Transformation

1. Urgent & Emergency Care – 6 Goals

The Health Board has seen broadly positive momentum through each of the goals in the context of significant operational pressure. Engagement with Welsh Government continued to build momentum with national goal lead representation at programme board.

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.

Achievements and progress made this quarter:

Goal 1	Goals 2, 3 & 4	Goals 5 & 6
• Infrastructure in place to commence the implementation of findings of Community Resource Team (CRT) review (principles work) that aims to optimise and standardise offer across ABUHB footprint. • Approach to engaging with workforce to meet demand, of CRT rapid response team agreed. • Productive engagement with members of the Urgent and Emergency Care team based at Grange University Hospital (GUH) to agree GUH pull model and ensure no duplication of efforts. • Scoping of Acute Frailty Unit (AFU) underway with appropriate stakeholders.	• Established Ambulatory Care Strategic Group, aligned to the Value and Sustainability Work Programme, develop plan to increase volume, simplify and review value for money including reviewing WAST access to Same Day Emergency Care (SDEC). • Welsh Ambulance Service Trust (WAST) and Health Board Workshop held on Improving handover and non-conveyance • Confirmed funding through for Same Day Emergency Care in Ysbyty Ystrad Fawr until March 2024 • SDEC at the GUH, a continued upward trajectory of medical patients assessed through, average of 30 patients per week, pathway established via the Flow Centre. • Flow Centre development, introduction of single telephone number for Flow Centre/Single Point of Access/Urgent Primary Care over the winter to improves access and streamline the referral process. Progression of hub model, frailty input at the Flow Centre to avoid admission, aim to commence in 6 weeks. • Safety flow process rigour has reduced average handover times to 1 hour 34 mons down from 2 hours 11 mins in April 23 (across all sites).	• Hospital 2 Home service launched in June (Caerphilly and Monmouthshire), enabling patients to leave hospital by continuing to provide NHS care at home while waiting for a package of care, 11 patients accessed the pathway, RIF funding application approved to expand the project across Gwent. • Weekly Delayed Transfer of Care (DTOC) review meetings with Divisions to expedite discharges, chaired by Head of Patient Discharge, cleansing of the complex list. • Patient Safety Team events delivered at Royal Gwent Hospital & Ysbyty Ystrad Fawr (RGH & YYF), aligned to the Value and Sustainability Work Programme, working with local authority and community partners to rapidly improve the timely discharge of patients, delivering a step change in performance, safety and patient experience, reduction of 16 beds at RGH, site reconfiguration, further intervention at RGH on 25th October. • 'Ready to Go' ward following reconfiguration at RGH, establish ward aligned to the Discharge Hub, ready for winter.

	• The Health Board has received funding via the Six Goals national 'Innovation Fund' to support the implementation of an electronic triage solution for Emergency Department (ED), software development ongoing, cabling and kiosks purchased, site map completed.	

Key areas of focus for the next quarter:

Goals 1	Goals 2, 3 & 4	Goals 5 & 6
• Set up workforce group to ensure sufficient available capacity to enable safe and effective workstream delivery. • GUH pull model, community frailty in reach, three times a week, starting 20th November 2023. • Agree and implement professional hub within flow centre in line with available workforce capacity.	• Continue to establish the WAST and Health Board Collaborative following successful event • Commence a front door rapid assessment pilot in November to improve flow • Go live of electronic triage solution for ED in December 2023 • Work collaboratively with Trauma & Orthopaedics for referral improvement within the ED. • Continue safety flow process to sustain ambulance handover improvement and move towards 2 hours with a focus on wait to be seen time	• Delivery of further patient safety events at RGH & YYF, front door and step down. Work is being undertaken to establish weekly events during Winter. • Scale and spread of Hospital 2 Home facilitating early discharge. • Identify new high-risk patients in hospital and enhance their discharge process.

2. Enhanced Local General Hospital Network (eLGH)

Why is this a priority?

The Enhanced Local General Hospital structure was established when the Grange University Hospital (GUH) opened in November 2020. The roles of the Royal Gwent (RGH) and Nevill 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

This programme is focused on optimising the design of the hospital network across the Health Board, including the reconfiguration of clinical service models, workforce sustainability, optimisation of services to enhance patient outcomes and experience and the delivery of a sustainable system of care.

Key achievements and progress made this quarter:

- Reduction in bed base, reconfiguration at RGH aligned to the Patient Safety Team intervention, reduction of 16 beds, plan for further bed reduction and reconfiguration end of October. Develop plan for intervention at Community Hospitals.
- D6W has been identified as ready to go ward aligned to the Discharge Hub, with support from local authority and wider partners to ensure improved discharge.
- Stroke reconfiguration, a temporary consolidation of the stroke service to a single Hyper Acute Stroke Unit at the GUH and single rehabilitation site within (YYF) due to an urgent service risk, OCP complete and feedback to staff, communication with staff, stakeholders and patients, implementation of the temporary service model by end of November 2023, reduction of 8 beds, plan engagement for long term strategic service model.

- NHH Planning Group meetings established, terms of reference drafted, fortnightly meetings, chaired by Director of Strategy, Planning and Partnerships, validate baseline of services, communication to staff re the RAAC, service planning workshop to be held on 1st December.
- Review of Acute Medical Model – modelling updated to include revised scenarios based on Clinical Futures model, Task and Finish Group established, next steps include map implications and dependencies of a reduction in acute takes by end of January 2024.
- Review of Critical care model aligned to the Value and Sustainability Work Programme, identified as a priority in September 2023 via the Clinical Advisory Board, terms of reference drafted and group membership scoped, agreed phase one at GUH, phase two outreach services, ongoing engagement with services by the Assistant Medical Director, workshop planned in November.

Key areas of focus for the next quarter:

- Delivery of Patient Safety Team event at Royal Gwent Hospital and St Woolos through October and November, with the aim of a further bed reduction
- Developing plan for the St Woolos site
- Ready to Go ward proposal to deliver on D6W in Royal Gwent
- Critical care workshop to be held on 1st November to test and agree the opportunities to align a number of ITU and higher dependency service models
- Delivery of Urgent service change for Stroke rehabilitation at YYF, timeline beginning of December 2023
- NHH service planning workshop 1st December to develop service and site plans in response to RAAC challenges

3. Placed Base Care (Accelerated Cluster Development)

A core aim of the Placed Based Care priority programme is to ensure accelerated implementation of the Primary Care Model through an improved planning and delivery infrastructure for (Neighbourhood Care Networks) NCNs with wider engagement through professional collaboratives. It requires an asset-based approach to the planning and delivery of services and focus on prevention and wellbeing. Developing and aligning NCNs with Integrated Service Partnership Boards (ISPBs) ensuring greater alignment to and communication with the Regional Partnership Board.

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.

Key achievements and progress made this quarter:

- Further establishment of the Professional Collaborative with launch events undertaken for Optometry, Pharmacy and Dental services, governance arrangements for NCN funded projects developed, evaluation methodology for NCN projects developed, recurrent NCN funding projects evaluated.
- Communication and Engagement – NCN public facing website created and live on ABUHB website, Care Navigation to MIU/ED training package completed.
- Organisation Development and Sustainability – 5 ISPB (Integrated Service Partnership Board) workshops undertaken, developed ideas for integrated working and bespoke evaluation training, delivered internally, initial assessment of workforce challenges undertaken.

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- Planning and Outcomes Framework – NCN business cycle developed and distributed, planning and data leads identified, professional collaborative and service thematic leads templates issues to capture thematic insights.
- Programme Management – finalise benefits realisation plan and measurement framework, undertake self-reflection and maturity matrix.

Key areas of focus for the next quarter:

- Professional Collaborative interface with NCNs
- Scope out approach to developing and testing Place Based care model, considering alignment with Partnerships Service Boards and ISPBs
- Finalise milestones and measurement framework for NCN delivery during 2023/24

4. 6 Goals for Planned Care

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'.

The purpose of the Planned Care Programme is to ensure strategic oversight of a sustainable, whole system approach to improving patient experience and outcomes within Planned Care.

The Programme brings together 6 Goals: Outpatients, Maximising Elective Capacity, Patient Access and Activation, Health Pathways, Diagnostics and Planned Care Academy) in line with the WG national programme and planned care response.

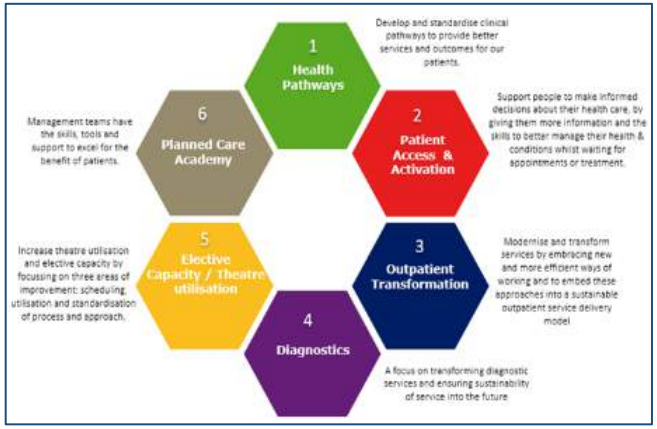
Key achievements and progress made this quarter:

<table>
<tr>
<td rowspan="2">Outpatients
Welsh Government part-funded RGH Outpatient Treatment Unit until March 2024, business case drafted for full funding of the unit, business case drafted for Automated Clinic Booking System to increase clinic efficiencies and utilisation.</td>
<td>Diagnostics:
Endoscopy Unit build due to complete November 2023, with first patients planned for 6th Nov
Continue to engage in regional diagnostics developments, Community Diagnosic Hub, Pathology and Endoscopy.</td>
<td rowspan="2">Maximising Elective Capacity:
GIRFT theatres programme has launched
Second stakeholder event held, focused on dashboard released 09/10/2023, this will provide reliable and usable data on theatre productivity measures, time in motion studies, NHH complete, GUH, YYF and RGH to be complete by December 2023.
Ahead of trajectory in eliminating the number of patients waiting over 156 weeks from referral to treatment waits with 79 patients waiting at the end of September 2023 compared to the March 2023 position of 553.</td>
</tr>
<tr>
<td>Regional Ophthalmology
Appointment of a single clinical lead
Implementation of interim solution for Cataracts regional capacity including the reprofiling of activity due to funding
Workforce Plan development progressing</td>
</tr>
<tr>
<td>Patient Access and Activation:</td>
<td>Health Pathways:</td>
<td>Planned Care Academy:</td>
</tr>
</table>

• Bilingual waiting well brochures are being developed, plans for single point of contact (SPOC) to be submitted to WG for potential funding, engagement with specialties to develop internet pages with patient information.	• The Clinical Editors continue to write up pathways with subject matter experts, communication plan has been implemented, due to a delay with the development of some of the pathways, timeline to go live has been delayed from January 2024 to March 2024.	• Draft training plan has been formulated; meeting arranged for 20/09/2023 to review.

Key areas of focus for the next quarter:

- **Longest Waits:** Continued rigour and focus to reduce 156 week waits for treatment.
- **Maximising Elective Capacity:** Response to GIRFT feedback which will prioritise and focus activity on theatre improvement opportunites, Complete time in motion studies. Consideration of planned care scenarios linked to financial challenge.
- **Patient Access and Activation:** Submit plans to WG for funding to develop a Single Point of Contact service.
- **Health Pathways:** Finalise first pathways. Plan for phase 2 priority pathway development and implementation.
- **Outpatients**: Focus on increased virtual/video/group activity. Implement plans to reduce 100% past target Follow Ups.
- **Planned Care Academy:** Review and refine draft training plan with wider group.
- **Ophthalmology:** Public engagement on sustainable cataracts and development of Stage 2 sustainable cataracts plan. Regional outsourcing anf regional booking team to commence.



5. Cancer Outcomes

The programme provides strategic oversight of cancer activity and delivery in partnership with key stakeholders across the system and specialities. The current structure is under review as the new Cancer Delivery Group is instigated that will oversee operational delivery of cancer services, with Cancer Board focussing on strategic planning, research, innovation and prevention.

Why is this a priority?

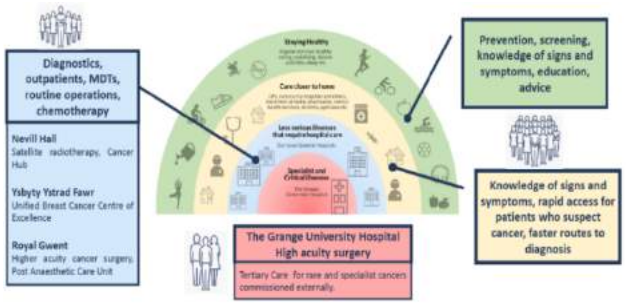
Cancer outcomes need to be improved. The Single Cancer Pathway, supported by Optimal Cancer Pathways for individual tumour sites, provides the roadmap to shorten diagnostic and treatment pathways once a person is suspected as having cancer. The Cancer Strategy, Delivering a Vision 2020-2025 sets out 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.

Key achievements and progress made this quarter:

- Significant progress has been made in establishing the Transforming Cancer Services Programme, identifying and distinguishing areas of work and activity, including newly appointed Cancer Services Manager and Senior Programme Manager.
- NHH Satellite Radiotherapy Unit, Service Level Agreement under review,
- YYF Breast Unit, the unit will offer a wide range of services, tailored to meet the needs of patients. It will focus on timely access to treatment, ensuring person centred care is at the forefront when delivering breast care services. On track to hand over of build on 18th November 2023, first clinic planned 29th January 2024.
- Enhanced psychological programme for those living with and beyond cancer, development of community cancer centres to provide support for patients and their families via informal social meetings. Currently sessions are being held in Caerphilly and Blaenavon with plans to roll out sessions in Newport, Torfaen and Monmouthshire by the end of March 2024.
- Patient Partnership Steering Group held in September 2023, themes identified for future meetings – improved communication, earlier access to support and emotional wellbeing tools.
- Public Health, Cancer Service team to join 'Reducing Cancer Inequalities Group', focus on screening up take in hard-to-reach areas of Gwent and supporting the Marmot work on building a Healthier Gwent.

Transforming Cancer Services Model



Key areas of focus for the next quarter:

- Systemic Anti-Cancer Therapy outreach model with Velindre Cancer Centre (Nov 2023)
- Enhanced psychological programme for those living with and beyond cancer, development of community cancer centres plans to roll out sessions in Newport, Torfaen and Monmouthshire by the end of March 2024.
- Development of Cancer Services Standard Operating Procedure for clarity on responsibilities tracking, Multi-Disciplinary Team and Service staff
- Increase of compliance on Single Cancer Pathway and reduce the number of breaches.
- Patient website development and launch

6. Decarbonisation Programme

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.

The Welsh Government has transitioned the original climate change agenda into a new strategic planning document for Wales and the programme is now known as the Net Zero Decarbonisation Programme for Wales. Aneurin Bevan University Health Board developed a new strategic programme board which met for the first time in September 2022 & currently meet every two months.

Key achievements and progress made this quarter:

- Climate smart champions, 5 people have now qualified as Carbon Literate through the Health Education Improvement Wales training module.
- Green HealthCare's intranet pages have been, and continued to be, developed to support staff within the Health Board to learn about green healthcare and sustainability.
- A member of the digital management team has now joined the decarbonisation board (Sept 2023) and will start to provide the board with plans for carbon reducing projects.
- Funding bid for the purchase of trolleys for cylinders was submitted and are now in place primarily for Royal Gwent Hospital.
- The Theatre Shut Down project was started by the Anaesthetic Sustainability Fellow. The project has estimated energy saving of £23,000 for turning off AGSS pumps that are no longer used across the health board.
- Consistent and accurate reporting of carbon reduction projects and their impact on Welsh Government targets. It has become increasingly difficult to attribute a carbon measure to certain aspects of the improvement projects.
- The Programme is now in an established form with clear goals and programme of work aligned with the National Programme.
- There is further work required to mature the reporting framework to track progress across all workstreams and to understand how the benefits of decarbonisation support our communities prioritising equity.
- 30 places have been funded through Aneurin Bevan Continuous Improvement Department for staff to attend Centre for Sustainable Healthcare's Sustainability in Quality Improvement training (training dates are arranged through until March 2024).

Key areas of focus for the next quarter:

- Funding team development to provide support for any Carbon related funding schemes that come into the Health Board.
- Further dialogue with Crowd house Energy organisation to determine the Photovoltaic Energy (PV energy) feasibility at GUH.
- Refit programme review & approval is now complete and will form part of the evaluation in Qtr 3 2023.
- De-steaming project review on the major infrastructure at RGH.
- GROUP II to continue to promote training opportunities and the planned video of staff training.
- Further work on the theatre shut down project at NHH to replicate the changes in RGH where both scavenging and ventilation systems are now shut down over night via a timer and can also be switched on manually if Theatre is over running.
- Training in the use of Skinman soft to reduce the use of water in the theatres, ongoing through Qtr 3.
- 'Gloves are Off' with group 3 to continue to be rolled out in Critical Care.

- Produce educational posters working with group II communications team.
- Spread and scale the inhaler optimisation and Decarbonisation App.
- Improve the Carbon reporting on the delivery workstreams as part of the Metrics Dashboard.

7. Mental Health Transformation

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.

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.

Key achievements and progress made this quarter:

- Older Adults Mental Health Shared Live service, 9 placements up until the end of September, excellent feedback from Service Users and colleagues, Programme and Board finalist in South Wales Health and Care Awards for service delivery team, Ty Cynnal Mental Health Crisis Support House winner for Mental Health Award in South Wales Health and Care.
- Single Point of Contact (111p2) whole system working (including Police/WAST) to agree benefits measures and tracking.
- Following submission of the Specialist Inpatient Services Unit outline business case, the Health Board has received the matrix response from Welsh Government.
- Acorn Project, is accepting residents, capacity for premises (5 individuals) providing accommodation for young adults with complex needs, requiring intensive support through a community setting.

Key areas of focus for the next quarter:

- Acorn House, Shifting the Balances in Complex Needs mental health event to be held (postponed Sept) and develop workstream plans for Rehabilitation Pathway
- Establish a complex needs demand & capacity workstream in Learning Disabilities.
- MSc student finalising evidence in mathematical model that can predict the course of mental health disorders and guide the delivery of person-centred care safely and close to home in our communities.
- Complete the responses raised on the Welsh Government Matrix return on the Specialist Inpatient Services Unit Outline Business Case and secure Executive approval to submit reply to Welsh Government.

4. PROGRESS OF MINISTERIAL PRIORITIES

This chapter of the report updates on delivery against the Ministerial Priorities. There are overlaps in this section with the other chapters. There is a high degree of synergy between the Ministerial Priorities for 2023/24 that are designed to support a swift recovery of business as usual and to reduce growing waiting lists and waiting times. All priorities are underpinned by a focus on quality, safety and prevention as a part of the planned activity, with good medical outcomes at the heart of NHS services.

This chapter provides a quarterly update on progress made against key milestones, planned actions for the next quarter and measurement against trajectories. Below is a table summarising a number of the key metrics, which are also reviewed within each priority update.

Ministerial Priority	Measure / Outcome	Baseline	Planned vs	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer Recovery	Reduction in backlog of cancer patients waiting over 62 days	343	Planned	<300	<250	<250	<250
			Actual	347	379		
	Percentage of patients starting definitive cancer treatment within 62 days from point of suspicion	56%	Planned	60%	65%	70%	>75%
			Actual	56.20%	54.50%		
Mental Health and CAMHS	Assessment by LPMHSS within 28 days from referral	78.3%	Planned	80%	80%	80%	80%
			Actual	18.80%	20.5%(Aug)		
	Interventions <28 days following assessment by LPMHSS	18.1%	Planned	80%	80%	80%	80%
			Actual	30.90%	13.1% (Aug)		
	CAMHS 4+ week waiting list	98.1%	Planned	80%	80%	80%	80%
			Actual	82.90%	45%		
Planned Care, Recovery, Diagnostics and Pathways of Care	Number of patients waiting more than 52 weeks for a new outpatient appointment	9,834	Planned	10,729	10,979	10,311	9,802
			Actual	11,357	12,286		
	Number of patients waiting more than 36 weeks for a new outpatient appointment	20,031	Planned	19,138	19,240	19,228	19,463
			Actual	19,871	20,897		
	Number of patients waiting more than 104 weeks for treatment	1,821	Planned	1,260	903	428	0
			Actual	1,577	1,442		
	Number of patients waiting more than 104 weeks for a new outpatient appointment	781	Planned	625	284	127	0
			Actual	1,467	1,913		
	Number of patients waiting more than 52 weeks for treatment	8,547	Planned	7,822	7,462	7,377	7,173
			Actual	7,460	7,538		
Primary care access to services	Units of Dental Activity (UDAs) delivered	410,048	Planned	92,777	185,554	278,331	371,108
			Actual	116,878	282,744		
	Number of patients accessed NHS Opthometry Services	139,860	Planned	35,496	70,992	106,488	141,984
			Actual	39,910	80,215		
Delayed transfer of care	Reduction in the number of Pathway of Care Delays	275	Planned	<249	<232	<217	<203
			Actual	241	260		
Urgent & Emergency Care	Number of ambulance patient handovers over 1 hour	1,497	Planned	1,066	1,347	1,471	1,521
			Actual	1,285	1,197		

4.1. Cancer

Key focus should be on delivering: Reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion

Quarter 2 update against actions & milestones:

- Reduction in backlog of patients waiting over 62 days to < 250 is off track, the end of September position is 379. New leadership for this area is now in place and are hopeful to make progress in Quarter 3.
- Optimal pathway work ongoing with specific focus on Urology, Gynae, Head & Neck and Lower Gastrointestinal working with Radiology on Accelerated Imaging and Pathology on turnaround times.
- Continued Did Not Attend (DNA) reduction pilots in target areas with navigators established and next phase planned for Quarter 3.

Planned actions & milestones for next quarter:

- Maintain backlog of patients waiting over 62 days to recover to trajectories.
- Review of tertiary pathways, working with tertiary partners to address opportunities in pathways to reduce waits.
- Review of alignment to optimal pathway.
- Review of progress against recruitment plans required to significantly increase capacity.

4.2. Cancer SCP Pathway

Key focus should be on delivering: Implement the agreed national cancer pathways within the national target, demonstrating annual improvement toward achieving target by March 2026

Quarter 2 update against actions & milestones:

- 54.5% compliance against a target of 65% compliance for Percentage of patients starting definitive cancer treatment within 62 days from point of suspicion.
- Head and Neck, Urology and Lower GI are off track to be aligned to National Optimal Pathway. Task and Finish groups are scheduled for the end of Quarter 3 to progress completion by end of year.
- Waiting times reduced through maximising capacity is in place focusing capacity on urgent suspected cancer.

Planned actions & milestones for next quarter:

- 70% performance compliance
- Opening of endoscopy suite, endoscopy to be compliant with <14 day wait time.

4.3. Mental Health 111

Key focus should be on delivering: Implement 111 press 2 for urgent mental health issues (24/7) basis

Quarter 2 update against actions & milestones:

- All planned milestones for quarter 2 are significantly off track due to lack of resource to deliver service improvements.
- Emergency funding from Welsh Government is being used to deliver core service.
- The move of the service into new accommodation is being considered as part of wider organisational work on estates.

Planned actions & milestones for next quarter:

- Maintain compliance with service targets and pathway targets.
- Adapt and develop the service based on evidence.
- Maintain data reporting and ensure the service meets the necessary targets, making changes to processes where needed.

4.4. Mental Health over 18 LPMHSS assessment and intervention

Key focus should be on delivering: Recover waiting time performance to performance framework standards of 18+ LPMHSS assessment and intervention.

Quarter 2 update against actions & milestones:

- Recruitment of 5(wte) High Intensity Therapists was unable to progress as there was no dedicated funding available from Welsh Government.
- Hub based model operating across four Neighbourhood Care Network (NCN) areas is significantly off track as funding constraints impacted estates availability. At present this is on hold until other avenues that require less investment can be agreed.
- Demand and capacity modelling has been completed to identify commissioned therapy requirements.
- The Welsh Community Care Information Systems (WCCIS) backlog has been reduced.

Planned actions & milestones for next quarter:

- Implementation of therapy pathways.
- Hub based model operating across seven NCN areas.
- Further progress matched care model
- Develop and implementation of therapy pathways

4.5. Specialist CAMHS

Key focus should be on delivering: Recover waiting time performance to performance framework standards for Specialist CAMHS

Quarter 2 update against actions & milestones:

- CAMHS have maintained and surpassed 80% compliance for CHOICE (new referrals) to assessment within 28 days, 94.59%
- Monthly demand and capacity review undertaken to ensure that job plans have sufficient capacity to meet CHOICE demand.
- Continued implementation of workforce plans including efficient recruitment into vacancies.
- CCIH and SPACE continue to interface for preallocations and enquiries' CCIH Clinicians also attend SPACE multi agency panels

Planned actions & milestones for next quarter:

- To maintain over 80% RTT Target Compliance for New Choice referrals to assessment within 28 days - CORE CAMHS and CET ED Teams
- CCIH review and monitor referral demand using data to forecast and inform quarterly job plans
- CCIH to continue to work closely with Gwent wide SPACE Wellbeing partners
- CCIH to hold weekly performance meetings to review capacity and demand and expedite potential breachers
- Monthly Performance SMT to continue to review position and propose efficiencies
- CCIH to develop Mid-Year Performance Review Report for SMT

4.6. Mental Health under18 LPMHSS assessment and intervention

Key focus should be on delivering: Recover waiting time performance to performance framework standards of under 18 LPMHSS assessment and intervention

Quarter 2 update against actions & milestones:

- PCAMHS is continuing to meet the Initial Assessment Part 1A 80% target with Sept 23 position 87.64% despite significant vacancies and workforce deficits.
- Initial Assessment Part 1B recovery plan is being implemented, a full recovery of the waiting list is required before the RTT% will increase. Current target for recovery to 80% is on track for April 2024.
- Weekly performance meetings continue and are responsive to the demand ensuring effective use of capacity.

Planned actions & milestones for next quarter:

- PCAMHS Initial Assessment Part 1A maintain steady state RTT 80% Target
- PCAMHS Initial Intervention Part 1B Recovery

4.7. Planned Care Diagnostics

Key focus should be on delivering: Implement regional diagnostic hubs, to reduce secondary care waiting times and meet waiting time ambition in spring 2024

Quarter 2 update against actions & milestones:

- Business Justification Case for second Magnetic resonance imaging (MRI) scanner in GUH was agreed in principle but no funding available to action it at present. The following actions are associated with the funding and on hold;
    - Establish implementation group for the establishment of a community diagnostic centre
    - Progress all recruitment and training requirements
    - Progress procurement requirements
    - Progress enabling actions at GUH
- Workforce plans on track for cellular pathology, chemical pathology, microbiology and blood sciences to support once funding position confirmed

Planned actions & milestones for next quarter:

- Completion of tendering process and order confirmation
- Completion of all recruitment and training requirements
- Completion of documentation and standard operational procedures
- Completion of estates enabling actions

Key focus should be on delivering: Implement pathway redesign – adopting 'straight to test model' and onward referral as necessary.

Quarter 2 update against actions & milestones:

- There were successful appointments in General Surgery and Respiratory appointed to support pathway redesign.
- Urology was unable to appoint the bladder cancer navigator as funding was not secured.
- New additional 'Straight to CT' pathway in cardiology is awaiting Nursing Midwifery Council and Radiology approval. Expecting implementation in

Planned actions & milestones for next quarter:

- Maintain and sustain existing pathways delivering additional capacity in General Surgery and Respiratory with training in place to support.
- Urology implementation of bladder cancer STT service

4.9. Planned Care WP and OP RTT

Key focus should be on delivering: 52 weeks Outpatient Assessment and 104 weeks treatment recovery milestones to be achieved by 30 June 2023 and maintained throughout 2023/24 moving to 36 weeks RTT

Quarter 2 update against actions & milestones:

- All specialties to continue to review targeted scheduling changes.
- Phase 2 sub speciality extensive improvement workstreams implemented with others ongoing across planned care.
- Urology, new substantive consultant to commence in role.
- General Surgery appointment of trainee pelvic floor specialist practitioner to provide additional capacity and recruitment of colorectal physician associates funding limited to single post. Failed to recruit on first attempt however second attempt to recruit currently ongoing
- In Orthopaedics plans to explore opportunities to expand shoulder and spine capacity are on hold until funding can be obtained.

Planned actions & milestones for next quarter:

- Monitoring of RTT to work towards 36 week waits and maintaining forecasted position
- Continue to assess sub specialities
- Continue with virtual work
- Health Pathway review for key pathways and reduction of referrals

4.10. Planned Care WP and OP Speciality Gap

Key focus should be on delivering: Address the capacity gaps within specific specialities to prevent further growth in waiting list volumes and set foundation for delivery of targets by March 2025. (This must include transforming outpatients follow up care, reducing follow up by 25% against 2019/20 levels by October 2023 and repurposing that capacity)

Quarter 2 update against actions & milestones:

- Continuing to implement DNA action Plan and we are currently below target of 5%, ongoing work with high DNA rate areas including Urology.
- Monitoring of actions by divisions to reduce under 6-week Hospital cancellations in place through new performance framework. Current rate is below target of 7.5%
- Increased "advice only" disposition for referrals from 6.3 to 7.3% (target 9%)
- Total follow up waiting lists are increasing in many areas and contingency meetings are being arranged with specialties to mitigate deterioration.
- Use of seen on symptom and patient initiated follow up has increased to 13.3% with work continuing with specialties to identify and implement new pathways to facilitate further increase towards the ambition of 20%.
- Costs are being finalised in readiness for submission of business case for Outpatient Treatment Unit continued funding to Welsh Government.
- GIRFT guidance has been agreed with relevant specialties and is being incorporated into their action plans.

Planned actions & milestones for next quarter:

- Increase advice only by 12% from baseline
- Business Case presentation on Outpatient Treatment Unit and Booking System
- Deliver Follow Up reduction by 25% against 2019/20 levels
- Continue to Implement DNA action Plan to maintain below target of 5%

4.11. Pharmacy

Key focus should be on delivering: Improved use of community pharmacy

Quarter 2 update against actions & milestones:

- Expansion of the independent prescribing service and improvement of uptake is progressing through utilisation of funding allocation for training and mentoring.
- The Sore Throat Test and Treat (STTT) service has been reviewed including engaging with new contractors and promoting pharmacies that are providing the service to improve the use.

Planned actions & milestones for next quarter:

- Review the uptake of the NHS Flu Vaccination Service
- Pharmacy Professional Collaboratives to respond to Population Needs Analysis to inform development of priorities for 2024/25

4.12. Dental

Key focus should be on delivering: Increase access to dental services

Quarter 2 update against actions & milestones:

- Continuing to progress the units and levels of patients accessing NHS and Community Dental Services expected to achieve 30% at mid-year (target 50% by Apr 24)
- Review and monitoring of delivery against Contract reform metrics are in place.
- Re-commission Prison dental services following a robust procurement exercise is on schedule.
- Recruitment to Dental Therapist post to provide access to vulnerable children in the north of ABUHB is off track but within tolerance.

Planned actions & milestones for next quarter:

- Continue to progress the units and levels of patients accessing NHS and Community Dental Services
- Continue to monitor and manage contract delivery, including orthodontic delivery

- Continue to monitor, manage and maintain urgent access
- Review and monitor delivery against contract reform metrics
- Implement new dental contract as part of Tredegar Development
- Where necessary, recommission dental services as a result of contract variations and/or resignations

4.13. GPs and Community Services

Key focus should be on delivering: Improved access to GP and Community Services

Quarter 2 update against actions & milestones:

- Good progress has been made in the implementation of streamlined hot clinic pathway for frail / elderly patients.
- Implemented a two-hour, 72 hour and 10 working day response to referrals, by District Nursing Teams and Community Specialist Nursing Teams (National Community Nursing Specification)
- As part of Redesign of Services for Older and Frail People the Health Board are reviewing the current utilisation of an overarching agreed frailty score ahead of implementation of a frailty score across all community nursing services (National Community Nursing Specification).
- Direct referrals to District Nursing Services out of hours from Urgent Care Services including Out of Hours (OOH) GP, 111 and Welsh Ambulance Service Trust (WAST) are in place to facilitate clinician to clinician communication in a timely and effective manner.

Planned actions & milestones for next quarter:

- Implement Health Pathways Platform to improve adherence to appropriate pathways and utilisation of range of services (pending business case approval)
- Intake for latest cohort of staff into Primary Care Academy (pending business case approval)
- General Medical Services are meeting the requirement of the changes to the contract as set out in 2022/23.
- District Nursing (DN) capacity on Saturday and Sunday daytime is at a minimum of 60% of the usual weekday DN capacity (National Community Nursing Specification)

4 .14 Optometry Services

Key focus should be on delivering: Improved use of optometry services

Quarter 2 update against actions & milestones:

- On target to meet full year forecast of new patients accessing NHS Optometry Services.
- Roll out of Wales National Workforce Reporting System (WNWRS) for optometry is being completed by NHS Wales Shared Services Partnership and is off track but within tolerance
- Service change and or practice closures has been managed as and when required

Planned actions & milestones for next quarter:

- 106,488 new patients accessed NHS Optometry Services (75% of FY forecast)
- Manage service change and/or practice closures as and when required
- Optometry Professional Collaboratives respond to Population Needs Analysis to inform development of priorities for 2024/25

4.15 Urgent Care Ambulance Handover Times

Key focus should be on delivering: Health Boards must honour commitments that have been made to reduce handover waits.

Quarter 2 update against actions & milestones:

- Improvements have been made in reducing ambulance handover times and continuous monitoring is in place through Patient Safety Flow meetings.
- Improvements have been made in movements out of ED every 2 hours and continuous monitoring is in place through Patient Safety Flow meetings.
- There is an agreed extension for the Physician Response Unit until March 2024 with WAST and a business case in development recognising funding constraints.
- Nursing & therapy led pilot to be undertaken of Elderly Frailty Assessment Service at GUH in conjunction with one of the patient safety events to evaluate.

Planned actions & milestones for next quarter:

- Deliver 0 > 4 hour ambulance handovers
- Implementation of e-Triage
- ED referral to speciality improvement

4.16 Urgent Care Pathways of Care (DTOC)

Key focus should be on delivering: Reduction in backlog of delays transfers of care (Pathways of Care)

Quarter 2 update against actions & milestones:

- The target for Pathway of Care Delays for Quarter 2 is <232, in September it stood at 260.
- Key metrics are reported at Discharge Board monthly including monitoring of the RGH discharge pilot and NHH pull model.
- The discharging medically fit patient's education programme was rolled out as part of the patient safety events.
- Implementation of the digital solution is scheduled for December 23.
- Continue to review and refine the dashboard measures.

Planned actions & milestones for next quarter:

- <217 number of Pathway of Care Delays
- Ward audits completed across all sites to monitor the roll out of the framework
- Implementation of short-term digital solution and progress with preferred longer- term solution.

4.17 Urgent Care SDEC

Key focus should be on delivering: Implementation of Same Day Emergency Care services

Quarter 2 update against actions & milestones:

- Medical SDEC have now consistently reached 40 per week with the combined Medical, Surgical and ENT SDEC at over 150 per week.
- General Surgery model at SDEC GUH is now well established and delivering a strong service
- The ENT pathway is integrated into SDEC seeing over 25 patients per week.
- Identify Clinical sessions to enable SDEC GUH
- An additional locum has been recruited to support resilience with clinical sessions identified from Advanced Nurse Practitioners.
- Trends are monitored associated with our eLGH Assessment units where considerable volumes of patients are assessed-out within 12 hours

Planned actions & milestones for next quarter:

- Build a resourcing plan for 7 day per week SDEC coverage (GUH)
- Develop programme around Flow Centre pathway improvement
- Feasibility assessment of Surgical, Medical and Nursing staffing rota resilience

4.18 Urgent Primary Care

Key focus should be on delivering: Implementation of Same Day Emergency Care services

Quarter 2 update against actions & milestones:

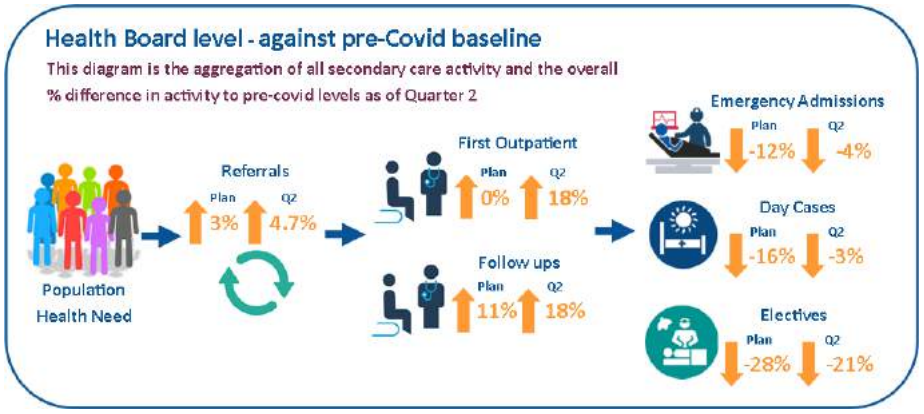
- Linkage with frailty hot clinics within Blaenau Gwent has a scheduled soft launch 6th November 2023, integrated within MIU unit, providing care closer to home for patients attending with Urgent Primary Care Needs.
- GMS Practice escalation process has been reviewed and disseminated to all practices. Urgent Primary Care senior representatives now included within Primary Care sustainability board in order to progress this agenda further.
- Musculoskeletal (MSK) physio starting early November within joint role spanning MIU and ED to drive the development of pathways into MSK transformation programme, to support high level MSK conditions
- Continue to support DHCW in development of national performance matrix.
- Continue to explore availability of clinic area alongside frailty hot clinics in Ysbyty Aneurin Bevan (YAB) aligned with redesigning services for older people workstream
- Attendance at national forums to participate in informing developments of performance matrix.

Planned actions & milestones for next quarter:

- Demand and capacity review of model to ensure appropriate resourcing of pathways on a 24/7 basis
- Roll out of patient satisfaction survey

5. IMTP PLANNING SCENARIO

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 and this information has been updated for the first quarter.
The planning scenario has, in aggregate form, largely followed as predicted by the services and is in line with the pressures on the availability of capacity due to delayed discharges and length of stay. Outpatient and inpatient treatments are ahead of projections as of Quarter 2, reflecting the priority that services are placing on addressing the longest waiting patients and managing demand.

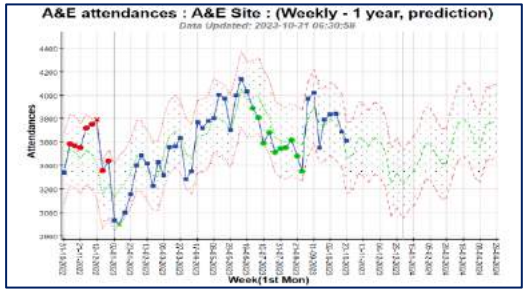


- Referrals during Quarter 2 were higher than forecasted and averaged 4.7% above pre-covid levels.
- Both new and follow-up outpatient levels have been operating above forecasted levels. This is particularly noted in a number of specialties including: Cardiology, Dermatology, Gynaecology, Neurology, Rheumatology, T&O and Urology
- Treatment activity is operating above the forecasted scenario, despite staffing challenges and urgent pressures. This is attributed to the significant drive to increase activity levels to meet demand and reduce waiting times.

Waiting lists

The Health Board continues to make progress reducing the number of the longest waiting patients for planned care treatments and outpatient appointments. There has been a full review of the waiting list, cohorts, our rate of current additions and unreferred 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 urgent and prioritised work. As noted in the report, whilst this influences RTT performance, it is in keeping with the principles of treating the patients with the greatest clinical need first.

With the rate of referrals and current focus on treat in turn, there is a risk of greater wating list growth due to the profile and will mean the Year 2 position may become more challenging without changes in activity.



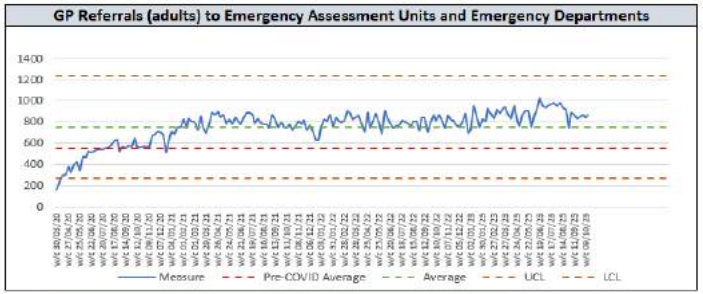
Urgent Care

Overall, the Quarter 2 forecasts were aligned with the actual activity for ED attendances with a total of 47,930 attendances during the quarter across all sites. Emergency attendances are the same as the forecasted position and therefore forward projections will not be amended.

Primary Care

The following is noted for Primary Care in quarter 2 and continues to influence the forecasted projections:

- GMS activity levels have gradually started to decrease from April with more face-to-face activity and is currently ranging between 17,000 – 20,000 a week. Increased demand is reported by practices.
- GP referrals for urgent assessments via Rapid Response, Emergency Departments or Assessment Units have increased against pre-covid level.
- The greatest proportion of bed days lost for patients with complex needs awaiting discharge from hospital are associated with allocation of social workers and this continues to be noted particularly in Newport and additionally Caerphilly in Quarter 2.



Bed Plan

The bed plan has continued to follow the overall expected occupancy levels and demand patterns. During the second quarter of this year, the Medicine Division were running at 99% occupancy against their bed plan and the Community Division at 107%. Beds occupied by patients cared for by Care of the Elderly was in line with the forecast and continues to drive the need for additional inpatient capacity which presents associated workforce challenges. Occupied beds over 21 days is following the seasonal variation and is operating as forecasted.

Summary

Of the 41 indicators including in the outcomes framework, 23 have newly available data to be reported upon during this quarter. 16 measures have either improved or are statistically similar and 7 indicators have deteriorated since the last reporting period.

Good progress continues to be made across the priority programmes with key achievements that deliver system change coupled with enabling actions to improve service delivery and ultimately patient outcomes. The patient safety team intervention has supported a reduction of 16 beds with a plan for further bed reduction and reconfiguration at the end of October. Momentum has continued with Stroke reconfiguration to deliver the temporary consolidation to a single Hyper Acute Stroke Unit at the GUH and single rehabilitation site due to an urgent service risk by the end of November 2023.

Across the Ministerial Priorities, good progress has been made during Quarter 2 in some areas and the current financial context has limited progression of service developments in others. There continues to be high demand on services which is evidenced in performance against forecast in some areas. Within Primary Care, there has been an increase in NHS Dental Care and Community Dental services units of activity and new patients. Additionally, the number of new patients accessing NHS Optometry services has increased.

The focus on reducing the number of longest waiters has resulted in being ahead of forecasted trajectories in eliminating and maintaining the position of no patients waiting over 156 weeks for treatment. Whilst not meeting the forecast for 104 week waits, there are currently 1,442 waiting for treatments and 1,913 waiting for a first outpatient appointment. The bed plan has continued to follow the overall expected occupancy levels and demand patterns with Medicine Division running at 99% occupancy against their bed plan and the Community Division at 107%. This Quarter 2 assessment sets out the organisation's understanding of its system and plan remains robust and the priority decisions made in the IMTP remain valid areas of focus now and into next year's IMTP planning.

Priority Indicator Summary

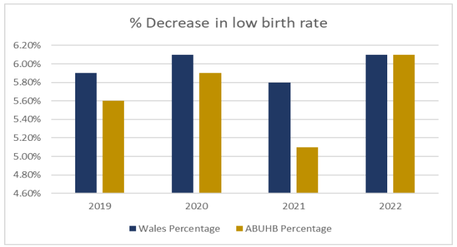
Quarter 2

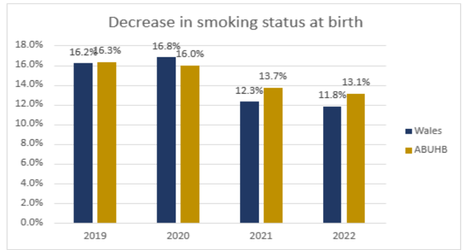
Indicators are classed as 'Similar' if the percentage change is between -2 and +2 and either 'Improved' or 'Deteriorated' if not. The 'No Data' category is used where the indicator is in development.

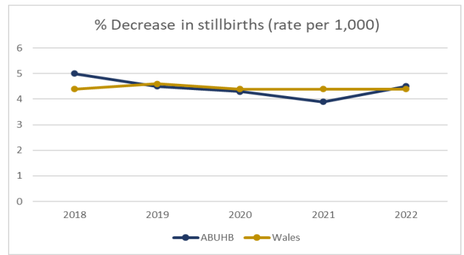
Type of change	P1 - Every child has the best start in life	P2 - Getting it right for children and young adults	P3 - Adults living healthily and aging well	P4 - Older adults are supported to live well and independently	P5 - Dying well as part of life	Total
Improved	3	1	5	0	2	**11**
Similar	2	0	1	1	1	**5**
Deteriorated	0	1	3	3	0	**7**
Total indicators	**5**	**2**	**9**	**4**	**3**	**23**

Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 1 - Every child has the best start in life	Improving Good Health in Pregnancy	Decrease in low birth weight rates	5.6%	4%			2022	6.1%	Deteriorated	Increase in indicator between 2021 and 2022. In line with the All Wales average.
		Decrease in smoking status at birth	16%	10%			2022	13.1%	Improved	Significant decrease between 2021 and 2022, however remains above the all Wales average.
		Decrease in stillbirths	4.8	3.0			2022	4.5	Deteriorated	Increase in stillbirth rates between 2021 and 2022. 10% decrease in stillbirths observed over the last 5 years.
	Optimising a child's long term potential	Increase uptake in mothers breastfeeding (any breastfeeding)	59.2%	65%	Q3 2022/23	56.5%	Q4 2022/23	58.9%	Improved	Indicator value has improved by 4% between Quarter 3 and Quarter 4.
		Increase of eligible children measured and weighed at 8 weeks	62.5%	60%	Q3 2022/23	35.0%	Q4 2022/23	39.7%	Improved	Improvement in indicator over the last 4 quarters, however this remains significantly below the all Wales average.
		Increase of eligible children with contact at 3.5 years pre-school	64.4%	60%	Q3 2022/23	41.5%	Q4 2022/23	45.6%	Improved	Indicator value has improved by 9.9% between Quarter 3 and Quarter 4.
	Increasing childhood immunisation and preventing outbreaks	Percentage of children who received 2 doses of the MMR vaccine by age 5	91%	95%	Q4 2022/23	90%	Q1 2023/24	89.7%	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%	Q4 2022/23	94%%	Q1 2023/24	94%	Similar	Indicator value has remained stable.

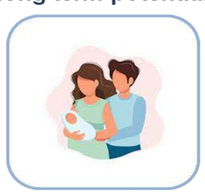
Improving Good Health in Pregnancy

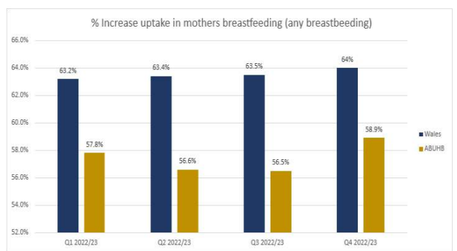


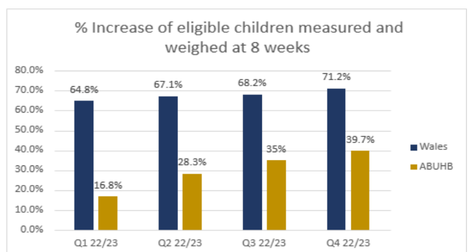


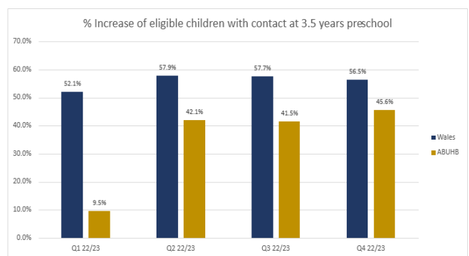


Optimising a child's long term potential

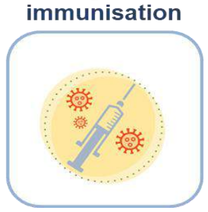


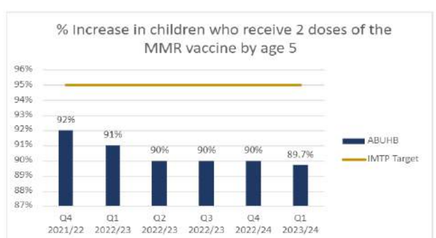


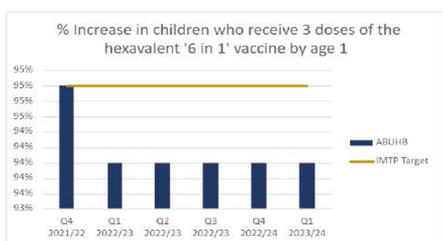




Increasing childhood immunisation

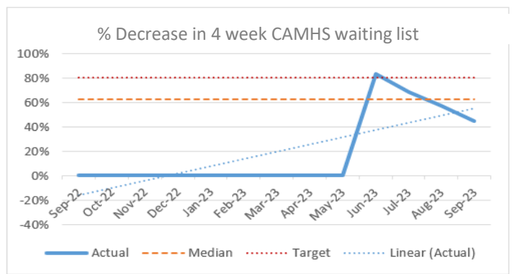


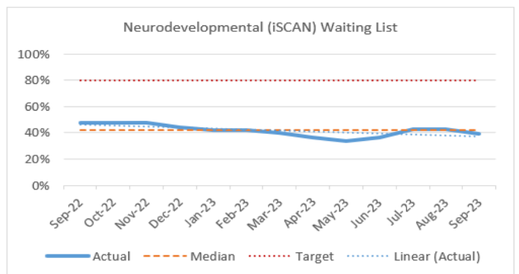




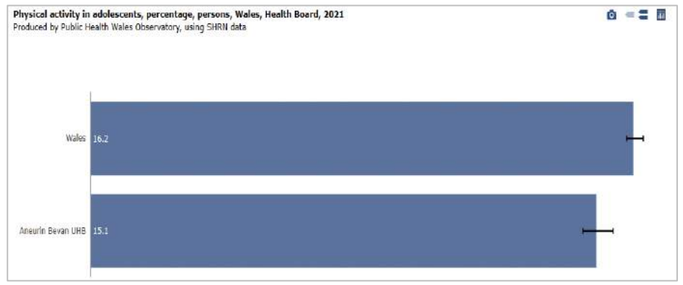
Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 2 - Getting it right for children and young adults	Improve Mental Health Resilience in Children and Young adults	Decrease in 4 week CAMHS waiting list	95%	80%	Jun-23	82.9%	Sep-23	45.0%	Deteriorated	Significant deteriation in metric from 82.9% at the end of Q1, to 45% at the end of Sep 2023.
		Decrease in neurodevelopmental (SCAN) waiting list	80%	80%	Jun-23	36.2%	Jun-23	39.3%	Improved	Indicator has improved between Q1 (36.2%) and Q2 (39.3%), however still remain below the IMTP target.
	Support being a healthy weight	Increase in physical activity (for at least 60 minutes a day) in adolescents	15.1%	20%			2022	15.1%	Similar	Indicator is lower than the welsh average of 16.2%. Please note, trend data is not yet avaiable.
	Improve healthy lifestyle behaviours	Decrease in adolescents using alcohol	40.9%	30%			2021	40.9%	Similar	Indicator is higher than the welsh average of 40.2%. Please note, trend data is not yet avaiable.
		Decrease in adolescents drinking surgary drinks once a day or more	18.5%	10%			2021	18.5%	Similar	Indicator is higher than the all welsh average of 16.4%. Please note, trend data is not yet available.

Improve mental health resilience

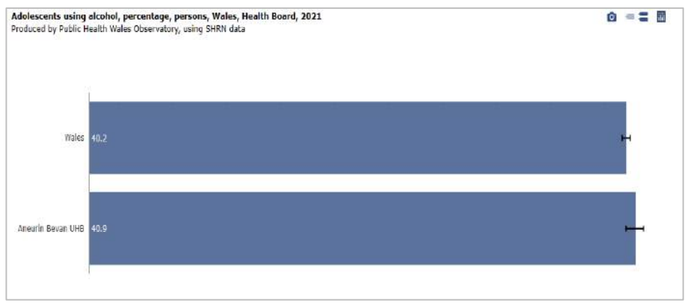


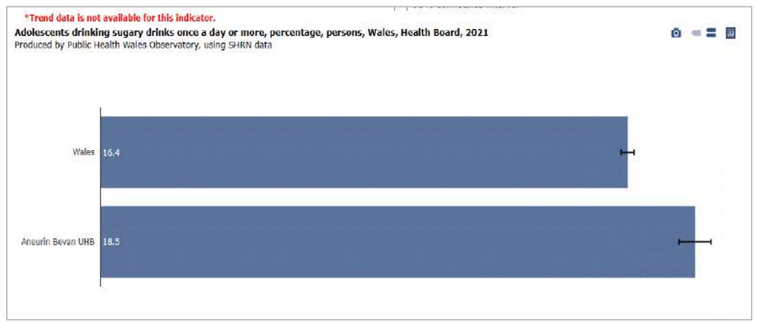


Support being a healthy weight



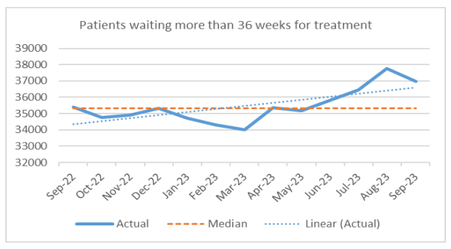
Improve healthy lifestyle behaviours

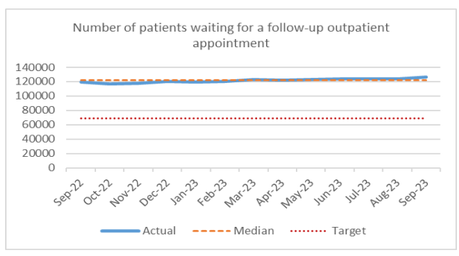


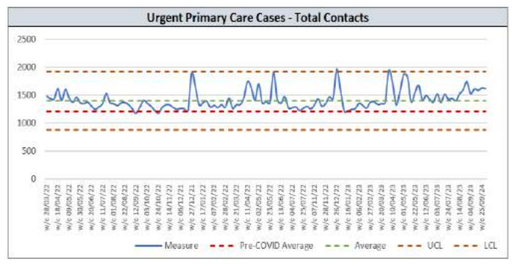


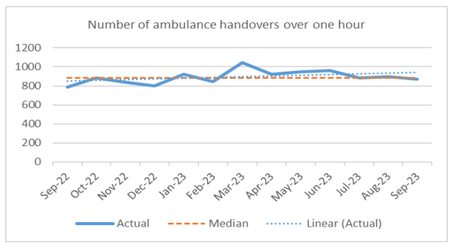
Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
					Data Available	Indicator value	Data Available	Indicator value		
Priority 3 - Adults living healthily and aging well	Maximising an individuals time	Reduction in the number of patients waiting more than 36 weeks for treatment	32202	32168	Jun-23	35813	Sep-23	36985	Deteriorated	Indicator value has increase since Jun 23 and Sep 23 by 3.3%
		Reduction in the number of patients waiting for a follow-up outpatient appointment	113107	69268	Jun-23	123736	Sep-23	126708	Similar	Indicator value has increased by 2.4% between Q1 and Q2.
		Increase in Urgent Primary Care Contacts	5336	8000	Jun-23	3347	Sep-23	7,233	Improved	Significant increase in the number of UPCC contacts between Jun 23 and Sep23.
		Reduction of ambulance handovers over 1 hour	737	0	Jun-23	962	Sep-23	873	Improved	Improving trend over the last 12 months, reducing by 9.3% between Q1 and Q2.
		Reduction in patients never waiting in ED over 16 hours	417	0	Jun-23	358	Sep-23	367	Deteriorated	Decrease in indicator value between Q1 and Q2. Rate has increased by 2.5%. Decreasing trend observed since Dec 22.
		Reduction in time for patients to be seen by first clinician	1.6 hours	2 hours	Jun-23	4.4 hours	Sep-23	2.3 hours	Improved	Improvement from 4.4 hours in Jun 23 to 2.3 hours in Sep 23.
		Reduction in time for bed allocation from request	11.5 hours	8 hours	Jun-23	9.6 hours	Sep-23	9.1 hours	Improved	Improving trend overserved over the last 6 months.
	Adults living healthily and aging well	Increase in adults active at least 150 minutes a week	53.0%	60%			2021/22	51%	Deteriorated	Since Covid-19, there has been a decrease in physical activity from 55% (19/20) to 51% (21/22)
		Decrease in the % of adults smoking	19%	15%			2021/22	11.9%	Improved	IMTP target met. Decrease in percentage of adults smoking and in line with national trends.
		Increase in working age adults of healthy weight	39.5%	50%			2021/22	35.4%	Deteriorated	Since Covid-19, there has been an small increase in the number of overweight or obese adults.
		Increase in working age adults in good or very good health	69%	80%			2021/22	70.5%	Deteriorated	**New Indicator** Deteriation in indicator from 76.9% to 70.5% between 2020/21 and 2021/22
		Increase uptake of National Screening Programmes	64.2%	80%			2020/21	70.2%	Improved	Improvements in indicator value observed. Next update scheduled Quarter 3 (provisional).
	Improved mental health resilience in adults	Increase in life satisfaction among working age adults	76.4%	55			2021/22	79.5%	Improved	**New Indicator** Increase in value between 2020/21 and 21/22
		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%	Jun-23	79%	Aug-23	83%	Improved	Measure has improved between June 2023 and August 2023 from 79% to 83%.
	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%	Jun-23	56.2%	Sep-23	54.5%	Deteriorated	Deterioration in indicator value from 56.2% (Jun 23) to 54.5% (Sep 23)
		Increase in 5 year cancer survival	49.1%	60%			2015-19	54%	Similar	Indicator value is similar and has been sustained. Next update scheduled Q3 (provisional).

Maximise an individuals time

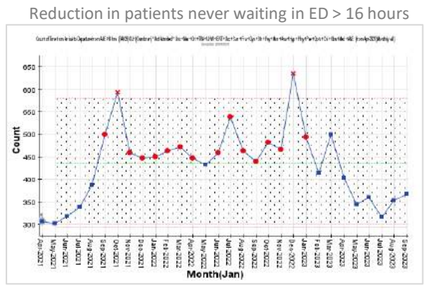




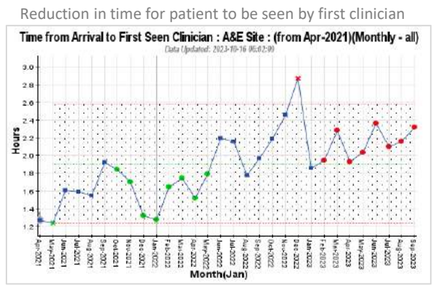




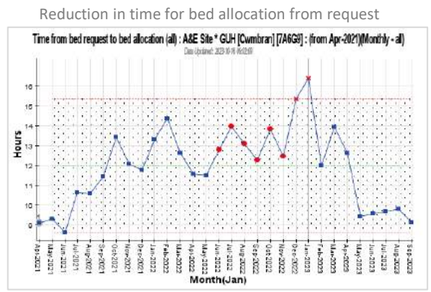
Reduction in patients never waiting in ED > 16 hours



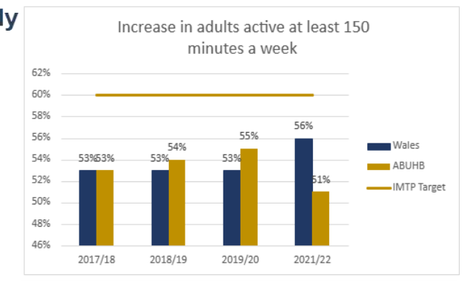
Reduction in time for patient to be seen by first clinician

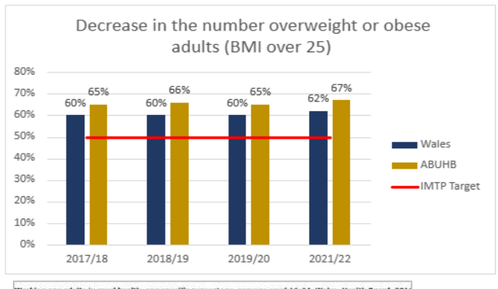


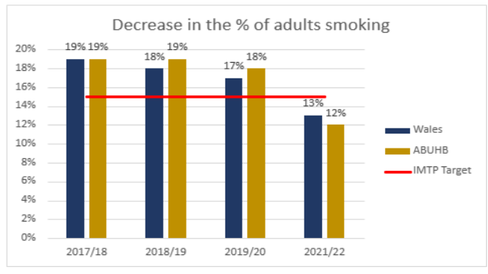
Reduction in time for bed allocation from request

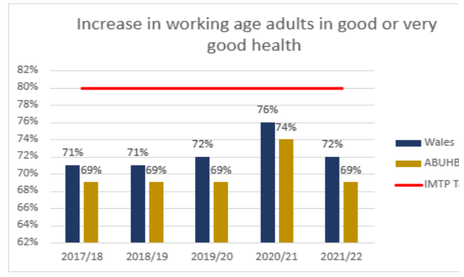


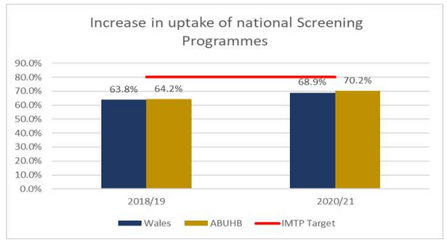
Adults living healthily and aging well

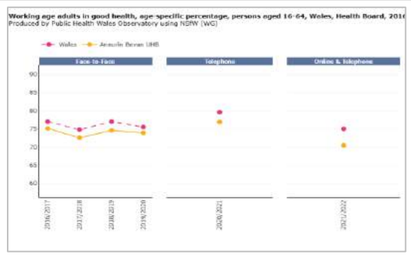




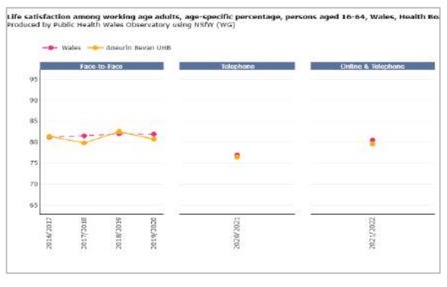


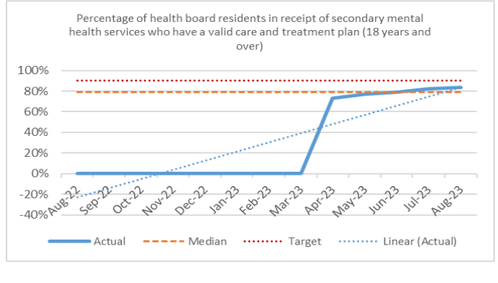




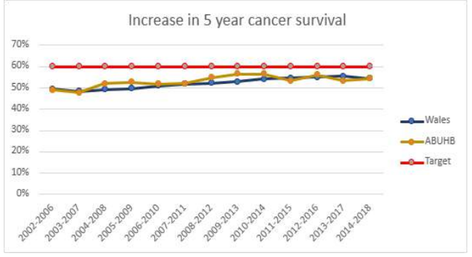


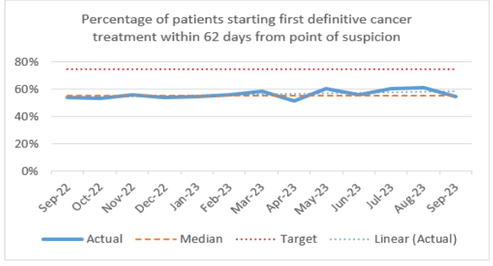
Improve mental health resilience





Maximise cancer outcomes





Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
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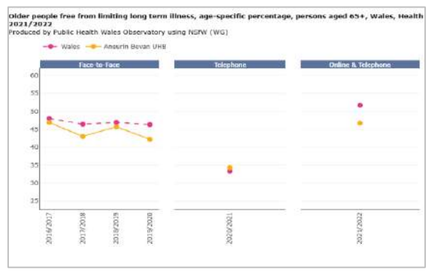
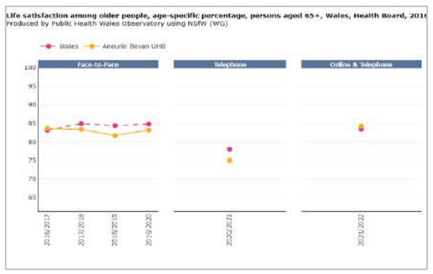
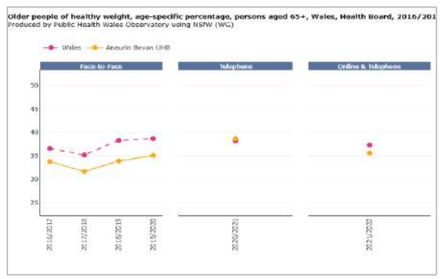
Priority 4 - Older adults are supported to live well and independently	Prevention and keeping older adults well	Increase in older people free from limiting long term illness	43.3%	50%			2021/22	46.7%	Improved	Improvement in indicator from 43.3% (2020/21) to 46.7% (2021/22). However, this remains below the all Wales average of 51.7%
		Increase in life satisfaction among older people	75.0%	85%			2021/22	84.2%	Improved	Improvement within indicator from 75% to 84.2%, surpassing the all Wales average of 82.4%.
		Increase in older people of healthy weight	38.7%	45%			2021/22	35.6%	Deteriorated	Measure has deterioated between 2020/21 and 2021/22 by 8%.
	Delivering Care Closer to Home	Increase in accepted referrals to Rapid Response Services (CRT)	343	375	Jun-23	393	Sep-23	356	Deteriorated	Indicator has deteriorated by 9.4% between Jun 23 and Sep 23
		Increase in accepted referrals to Reablement & Falls Services (CRT)	331	375	Jun-23	222	Sep-23	83	Deteriorated	Significant reduction in the number of accepted referrals between Jun 23 (222) to Sep 23 (83).
	Reducing admissions and time spent in hospital	Reduction in the number of Emergency Admissions >65 years of age	1297	1000	Jun-23	1439	Sep-23	1737	Deteriorated	Significant increase in the number of emergency admissions by 20.7% between Jun and Sep 23.
		Decrease (from 65 - 55%) in LOS over 21 days	65%	55%	Q1 2023/24	55%	Q2 2023/24	54%	Similar	Statistically similar to last reported position.

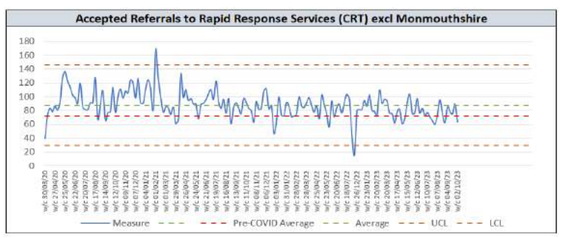
Prevention and keeping older adults well

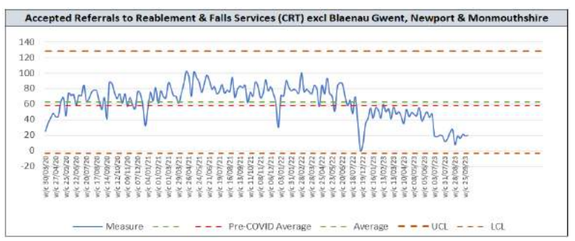




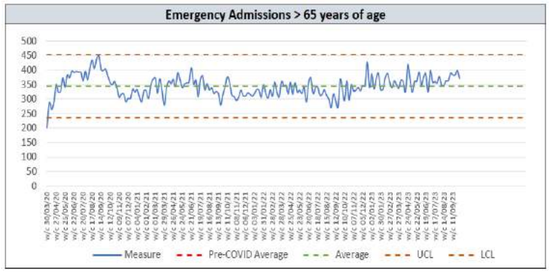


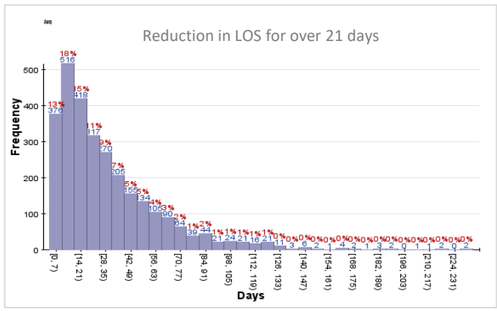
Delivering care closer to home





Reducing admissions and time spent in hospital





Priority	Outcome Description	Indicator	Baseline Value	IMTP Target	Last reported position (Aug 23)		Current reported position (Oct 23)		Change over the last time period	Latest findings
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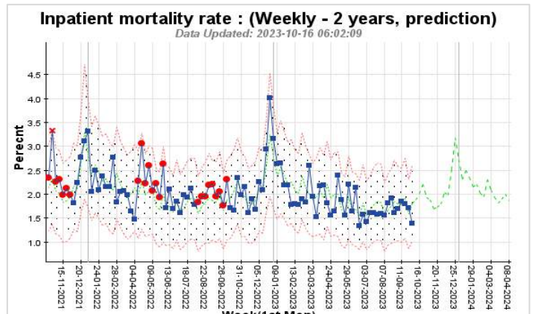
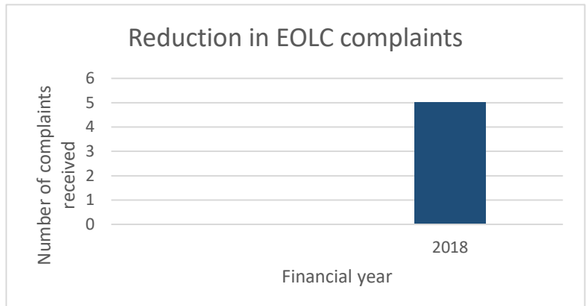
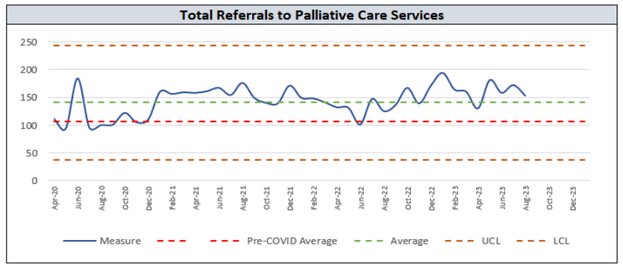
Priority 5 - Dying well as part of life	Improve care at end of life	Decrease in inpatient mortality rate	2.0%	1.5%	Q1 2023/24	1.8%	Q2 2023/24	1.7%	Improved	Improved rate of inpatient mortality from 1.8% in Q1 22/23 to 1.7% in Q2 23/24
		Reduction in compliants	11	0			2022/23	21	Deteriorated	Deterioration in indicator from 11 complaints received during 2021/22 to 21 during 2022/23.
	Improved planning and provision of end of life care	Increase in referrals to Palliative Care Services	141	200.0%	Jun-23	158	Aug-23	153	Similar	Indicator has remained statistically similar.
		Increase in propotion of Urgent Palliative Care referrals assessed within 2 days	91%	95%	Jun-23	92%	Aug-23	99%	Improved	Improvement in the indicator value from 92% (Jun 23) to 99% (Aug 23). IMTP target has been met.
	Minimising avoidable ill health	Reduction in the number of deaths from non communicable diseases	324.8	300			2019-21	326.1	Similar	**New Indicator** The rate of deaths from non communicable diseases has remained statistically similar over the reporting period.

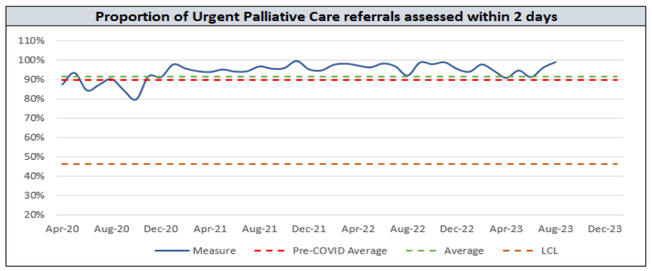
Improved end of life care experience



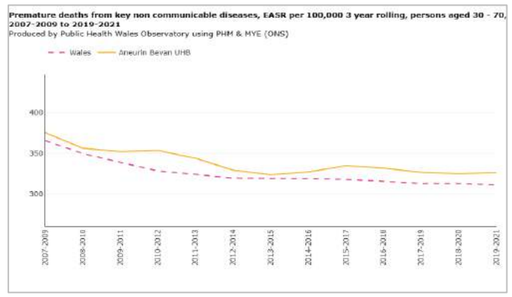


Improved planning and provision of end of life care





Minimising avoidable ill health



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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Finance Performance Report – October 2023 (2023/24 Month 7)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rob Holcombe - Director of Finance, Procurement & VBHC
SWYDDOG ADRODD: **REPORTING OFFICER:**	Suzanne Jones – Interim Assistant Director of Finance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

This report sets out the following:

- The financial performance at the end of October 2023 and the forecast position against the statutory revenue and capital resource limits,
- The savings position for 2023/24,
- The revenue reserve position on the 31st of October 2023,
- The Health Board's underlying financial position, and
- The Capital position.

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report sets out the financial performance of Aneurin Bevan University Health Board, at the 31st of October 2023 (month 7).

The 2023/24 financial performance is measured by comparing actual expenditure with the budgets as delegated and approved by the Board and CEO. The Health Board has statutory financial duties and other financial targets which must be met.

The table below summarises these and the Health Board's performance against them.

Oct-23
Performance against key financial targets 2023/24
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Movement	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	(40,283)	41,864	↓	57,627
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000 £52,541	4,278 8.1%	27,369 52.1%	↑	0
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	97.0%	97.1%	↔	>95%

Performance against requirements 23/24		20/21	21/22	22/23	3 Year Aggregate (20/21 to 22/23)
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	×	(245)	(249)	36,842	36,348
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	✓	(13)	(50)	(43)	(106)
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	×				

Underlying Financial Position (Brought Forward ULP)	20/21	21/22	22/23	23/24
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	£16.261m Deficit	£20.914m Deficit	£89.6m Deficit	£81.2m Deficit

The ABUHB month 7 year to date budget performance identifies an adverse variance of **£41.864m.**

In month the Health Board has received an allocation from Welsh Government of £89m (£9m anticipated), this funding has improved the month 6 position from a £145m deficit to a £57m deficit.

Welsh Government correspondence received on the 20th of October, (referred to in the circulated Board briefing paper), where this allocation is explained, describes the expectation of ABUHB to achieve a control total of £13m deficit for 2023/24. The current forecast variance is above the pro-rata control total by £44m.

During the last few months, the Board, Executives, budget holders and staff have engaged in a rigorous and thorough review of the opportunities to improve the financial forecast for 2023/24. This review included identifying further opportunities to make savings and avoid costs. This process involved a multi-professional clinical

group performing an impact assessment of proposals with consideration of what is an acceptable patient risk. During the mid-year review process further rigour and ideas were considered & identified a further stretch target for savings delivery and a likely forecast deficit of a £145m deficit, reported for month 6.

At this point the WG target and revised control total for ABUHB of £13m deficit is not considered achievable without significant service impact and risks, however, the Health Board will continue to review and re-examine all savings options and further opportunities.

The revised Health Board forecast of £57m is c.£44m greater compared with the control total of £13m. The reasons driving the overall forecast are as follows: -

- **Annual Plan deficit £112.848m**
- WG Funding – (£88.4m) (f)
- **Annual plan deficit off-set by WG funding - £24.4m**
- IMTP unachieved savings variance £9.4m
- CHC growth and price pressures & Prescribing price growth - £18m
- Covid legacy service costs - £7.4m
- Medical and Nursing workforce and non-pay operational pressures - £19m
- Off-set by reserves supporting the financial position and other benefits e.g. energy – (£11.6m) (f)
- Further Executive scrutiny and updated mitigation plans (£9m) (f)
- **Total forecast as at month 7 - £57.6m**

Work will continue to mitigate this position for this year and for future years. When considering this, the Health Board feels a **range of best case £52m to worst case £62m** is reflective of the remaining opportunities and risks. The best case incorporates opportunities that were not supported by the Clinical Advisory Group but are being revisited due to the financial position. The worst case takes account of a risk to certain Board allocations and assumptions, the worsening of variable pay agency, and prescribing price growth.

The forecast of £57m deficit, is in line with the CEO accountability letter forwarded to the Director General for NHS Wales on 16th October 2023 less the assumed funding stated in the WG letter dated 20th October 2023.

The revised forecast position is still subject to delivery risk since it relies on savings achievement and other mitigating actions across a wide range of services, some of which remain 'Amber' and need more detailed implementation plans. These actions remain a key standing item on Executive Committee meetings as well as the focus of the ABUHB Value and Sustainability group.

Cefndir / Background

Key points to note for month 7 include:

- A reported year to date position of **£41.9m deficit.** The March IMTP planned profile variance of **£68.8m deficit**, (note this is not comparable due to funding).
- The reported forecast has been revised to a **£57.6m deficit,** given WG funding confirmed of £78.9m and anticipated funding of £9.5m, however, there remain risks to achievement given the level of savings and actions required.
- Income –includes funding for the 2023/24 A4C pay award (£26.5m), anticipated income for the 2023/24 medical pay award (£6.4m) and estimated revenue charges related to Capital accounting.
- Pay Spend (excluding the notional pension adjustment from March 2023) – has increased compared to month 6 by c.£4m. The main reasons are:
    - Back-dated medical pay award of £3.8m
    - Substantive enhancement increase of £0.2m
    - WLI, additional sessions increase of £0.2m
    - Reduction in bank / agency usage of £0.2m
- Non–Pay Spend (excluding capital adjustments) - has increased by c.£4.4m, due to increased dental contract costs, drugs/vaccines costs, funded RIF and 6 goals scheme costs and EASC.
- Savings – overall forecast achievement is £42.1m, against the IMTP savings plan of £51.5m
    - Year to date achievement of £18.4m against year-to-date plan of £28.4m.
    - All additional schemes likely to be achieved have been included which in some cases have replaced original IMTP savings schemes which are no longer expected to be achieved. All opportunities from the executive led exercise are included in the forecast, delivery of these new schemes will be reported as part of established savings reporting arrangements.

As at Month 07, ABUHB is reporting a deficit of **£41.9m** with a revised forecast deficit of **£57.6m**.

There remain risks associated with maintaining this forecast position, particularly the full receipt of all anticipated income, identification and achievement of mitigation savings plans, prescribing cost growth, CHC cost growth and workforce pressures. Further detail is provided in this report however, the risk lies between a **£52m** and **£62m** deficit.

As at month 7 the reported capital position is break-even with a balanced forecast, however there is currently a deficit risk of £0.2m which is expected to be manged by year end.

Asesiad / Assessment

- **Revenue Performance**

The month 7 position is reported as a **£41.9m deficit**, the planned year end deficit agreed by the Board as part of the Annual Plan was £112.8m. This has now been revised to a forecast deficit position of **£57.6m.** This is derived from the month 6 forecast of £145.7m deficit as agreed by the Board on the 11th October less funding assumed of £88.4m following WG correspondence on the 20th October.

A summary of the financial performance is provided in the following table, by delegated area. The month 7 year to date position has reflected a pro-rata 7/12ths of the new WG allocation funding, hence showing a significant improvement compared with the prior month 6.

Summary Reported position - October 2023 (M07)	Full Year Budget £000s	YTD Reported Variance £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	285,668	800	1,356	(556)
Prescribing	111,133	6,373	5,796	577
Community CHC & FNC	73,677	(620)	(78)	(541)
Mental Health	127,700	8,495	7,447	1,048
Total Primary Care, Community and Mental Health	**598,177**	**15,048**	**14,520**	**527**
Scheduled Care	197,181	5,841	4,982	859
Clinical Support Services	62,572	(977)	(816)	(161)
Medicine	148,725	10,394	8,877	1,517
Urgent Care	35,024	3,041	2,781	260
Family & Therapies	132,869	1,860	1,639	222
Estates and Facilities	87,170	3,961	2,944	1,017
Director of Operations	8,283	441	307	134
Total Director of Operations	**671,823**	**24,560**	**20,713**	**3,847**
Total Operational Divisions (Chief Operating Officer)	**1,270,000**	**39,608**	**35,233**	**4,374**
Corporate Divisions	121,923	(2,418)	(2,807)	389
Specialist Services	183,299	(1,692)	(1,450)	(242)
External Contracts	88,576	(157)	(149)	(8)
Capital Charges	54,118	347	321	27
Total Delegated Position	**1,717,915**	**35,688**	**31,147**	**4,541**
Total Reserves	6,572	6,176	50,999	(44,823)
Total Income	(1,724,488)	(0)	(0)	(0)
Total Reported Position	**0**	**41,864**	**82,146**	**(40,283)**

Summary of key operational pressures for Month 7

- During October 2023, pay expenditure (excluding the effect of the notional pension adjustment from March 2023) increased by c.£4m compared with September.
    - Backdated 2023/24 medical pay award costs (£3.8m) were incurred in-month.
    - Enhancement costs were higher (£0.2m) which is an expected result of the payroll profiles,
    - Other WLI, additional sessional costs increased by c.£0.2m compared with September,
    - Overall variable pay costs remain significant (£7.4m in month 7, YTD value £57.6m) but decreased by £0.2m compared with September. The cessation of flexible reward payments continues to reduce the overall variable pay monthly average and in addition registered nursing agency costs decreased by £0.2m compared with September,
    - HCSW costs in estates and facilities remain high linked to the continuation of enhanced cleaning standards and other Covid legacy related costs.
- Non–Pay Spend (excluding capital adjustments) - has increased by c.£4.4m. Key movements from month 6 include;
    - Dental contract costs increased by £1.4m this is a result of the clawback reducing the spend in September,
    - RIF funded scheme and 6 goals increased costs (£1.1m increase) matched by budget,
    - Homecare drug and vaccine increases linked to timing of prescriptions, pharmacy system and school vaccinations. (£1.3m increase)
    - EASC, WHSSC, Out of Area Treatment, IPTR, and other costs (c.£0.6m increase).
- Demand pressures for elective and urgent care across all services, including primary care, mental health, acute and community hospitals remains above the pre pandemic levels. There are 281 inpatients who are fit for discharge as at the end of October; approximately 26% of the blocked bed days are health related, 45% are social care and package of care related with the remaining 29% relating to other reasons e.g., patient/family related, nursing homes, etc.
- The estimated cost for the year of continued blocked bed days for all reasons is c.£21.3m using a £200 cost per bed day. The challenges in terms of demand and flow across the UHB drive surge bed capacity requirements which result in high-cost temporary staff demand and overspends across the UHB. The delays need to reduce to avoid the requirement for this capacity and to achieve a safe and sustainable aligned service, workforce, and financial plan for the UHB. There is an invigorated focus on optimising appropriate bed capacity to support financial

sustainability for 2023/24 and the future, through the discharge and bed reduction saving programme.

- For October other issues include: -
    - Prescribing spend remains significant at £9.8m in-month (£71.2m year to date). The August PAR average cost per item was 1p lower than July. The 2023/24 forecast PAR price per item has reduced from £7.53 to £7.52 due to a reduction in NCSO concessions from October.
    - CHC cost and growth pressures in Mental Health and Learning Disabilities (Mental Health year to date deficit variance of c.£4.4m, forecast £6.4m deficit),
    - An additional 4 out of county paediatric CHC packages (23 as at October, 6 of which are classified as high value), total year to date expenditure on external packages is currently £1.3m,
    - On-going use of variable pay above budget within mental health wards for acuity as well as sickness and vacancy cover, (nursing variable pay within the Division of £4.6m year to date with over 40% linked to enhanced care,)
    - Enhanced cleaning, additional security and other Covid-19 legacy costs (£4.4m expenditure for year to date), and
    - Increased non-pay costs across a number of areas including homecare drugs, respiratory equipment, diabetes pumps/consumables and hearing aids. Diabetes pumps and associated consumable costs are now forecast to be c.£1.6m above funded levels across both adult and paediatric services.
    - Additional income from HEIW for training grade post changes for the year 2023/24 hence the back-dated element provides an in-month benefit.

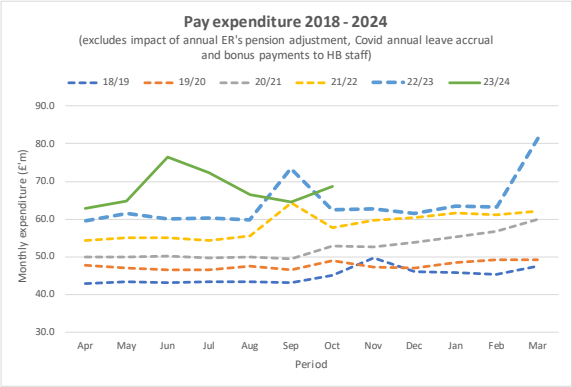
Key areas of focus for mitigating actions for the Health Board remain:

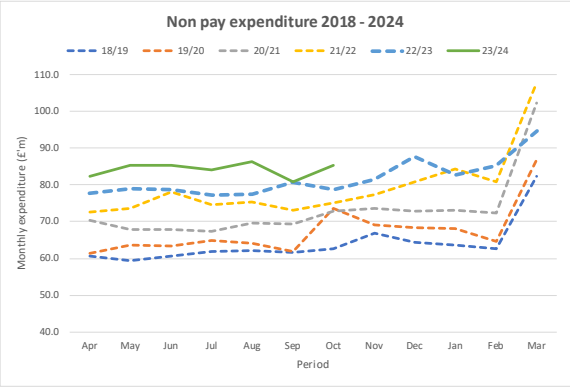
- System level working & redesign – reducing DTOCs and additional bed capacity requirements
- Elective care, Theatre and operational efficiency improvement,
- Urgent care pathways re-design,
- Demand and flow management,
- Workforce efficiency, reducing variable pay in particular agency and medical temporary pay costs,
- Driving Medicines management opportunities,
- Review of CHC pathways within Mental Health and Complex Care,
- Review of savings plans, current investments made and service options across Divisions,

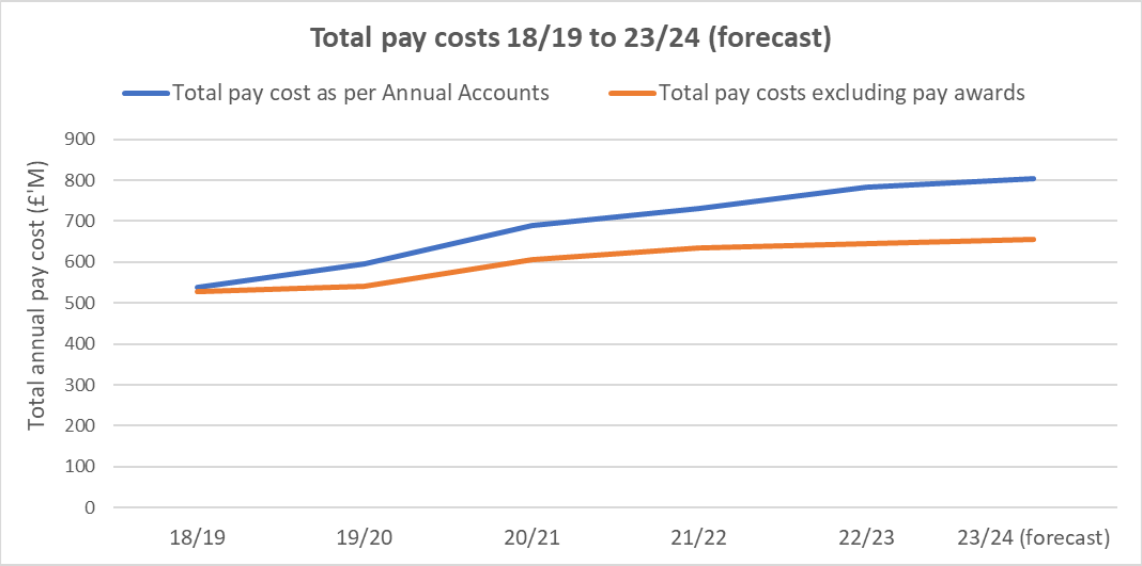
- Other actions to improve the financial position e.g. review of income and non-pay expenditure.
- Consideration of longer-term benefits of prevention services
- Optimising Digital solutions.
- Recruitment to vacant posts will go through a weekly scrutiny panel process to enable recruitment to progress
- There will be a freeze on all agency and consultancy for administrative work
- Internal conferences not to be held at external venues
- IT equipment will be subject to IT department approval and refurbished or reallocated equipment will be used as the first call for requests for kit.
- A freeze on purchasing all office equipment and furniture

Expenditure run-rates

Pay and Non-Pay expenditure run-rates for the last four financial years are shown below, along with a chart showing annual total pay and the impact of pay awards;







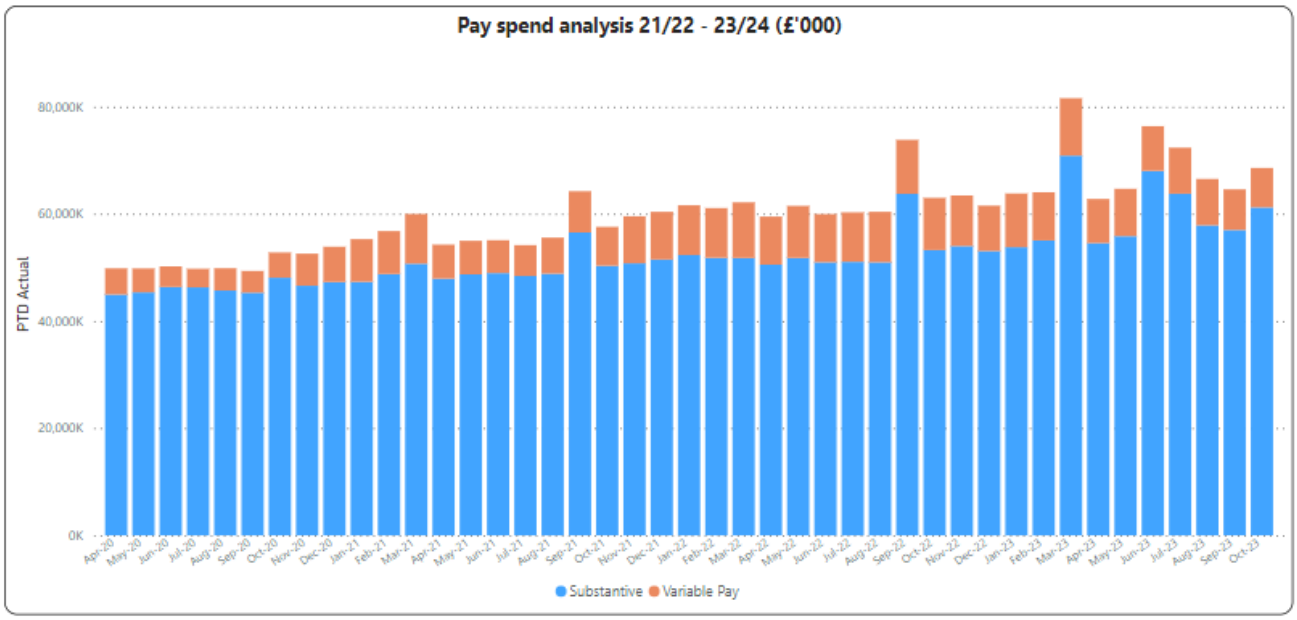
The expenditure run-rates need to reduce substantially in the remaining five months of the financial year in order to meet the revised forecast for the Health Board.

The run rate drives an overspend of £6m per month - this needs to move to an average of £3.2m per month for months 8 to 12 to achieve the forecast £57m, this is a £2.8m reduction per month.

Workforce

The Health Board spent £68.6m on workforce in month 7 23/24, an increase of £4m compared with month 6 (22/23 monthly average of £64.1m) driven by the backdated medical pay award, monthly average year to date for 23/24 of £68m per month.

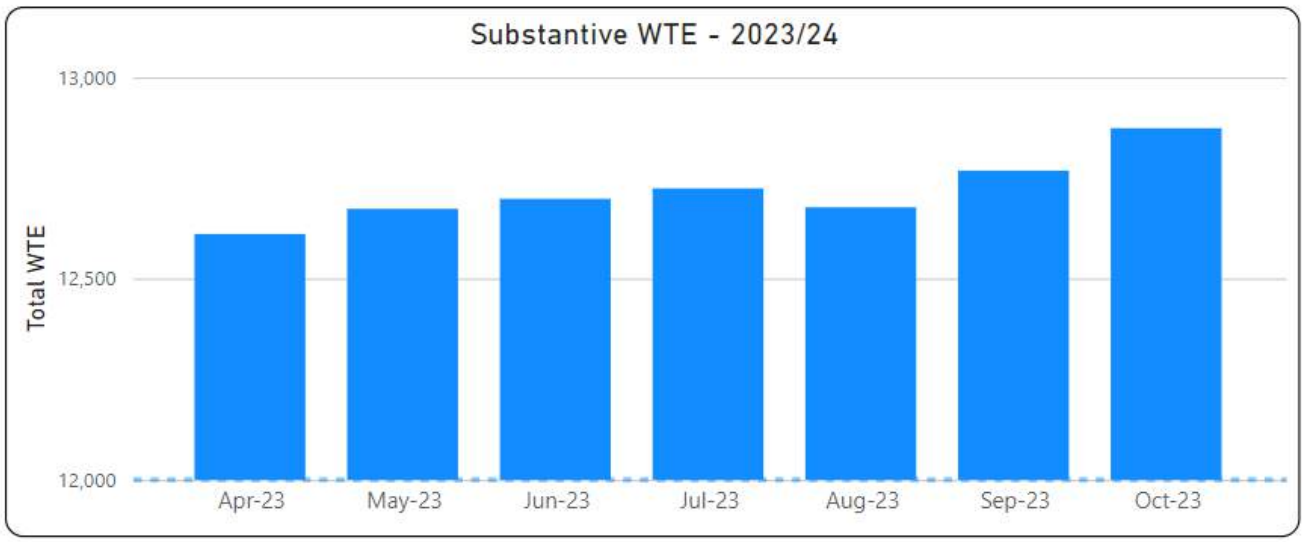
Workforce expenditure is shown below differentiating between substantive and variable pay[1]:



Substantive staff

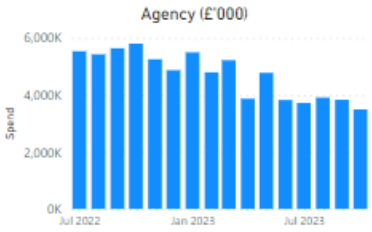
Substantive pay was £61.2m in October, costs increased by £4.2m compared with September due to the backdated medical pay award of c.£3.8m. A higher number of enhancements were paid in October (c.£0.2m) as well as increased additional consultant sessional/WLI costs (£0.2m). Month 7 includes 12,873 wte employed, an increase of 105 wte over the prior month.

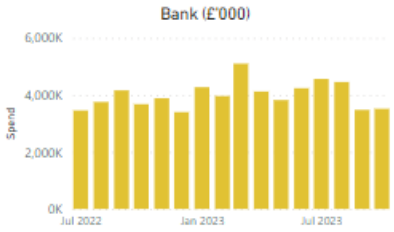
[1] *To enable useful comparisons and trends all references to 22/23 pay expenditure exclude the month 12 expenditure for additional employer pension contributions (6.3%/£27.5m).*

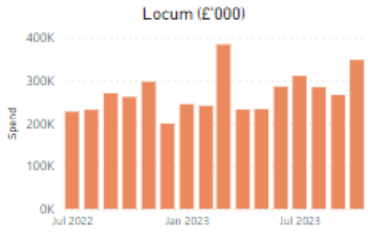


Variable pay

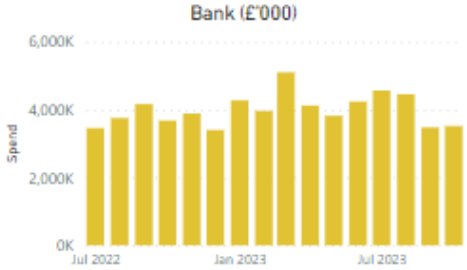
Variable pay (agency, bank and locum) was £7.4m in October. The monthly average variable pay is currently running at £8.2m for 2023/24 (£9.2m average 22/23). Vacancy cover along with sickness and enhanced care continue to drive a financial pressure as well as pressure on staff. Mental Health, in particular, remains an area with a sustained increase in acuity which subsequently impacts on variable pay. Nursing agency expenditure decreased in-month alongside continued reduced bank costs. Costs relating to vacancy cover have decreased which is likely to be linked to the increase in substantive staff in October shown above.







Bank staff



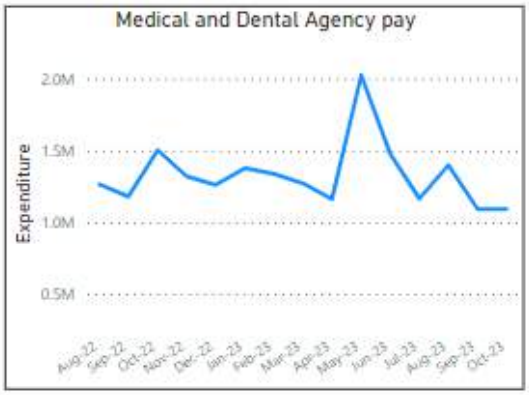
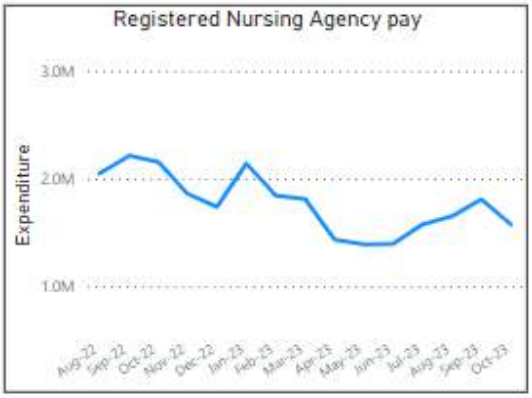
In-month spend of £3.5m, a similar level compared with September, but reduced compared to the average spend April-August (£4.2m per month).

- **Flexible rewards ceased end of August 23. Flexible rewards costs were £0.6m in August, with no new costs incurred in September or October (£2.7m year to date).**
- Continued pressures in Medicine wards, GUH Acute Medicine and GUH ED but generally reduced usage.
- Enhanced care / observation shifts particularly linked to Mental Health.
- Continued expenditure in Critical Care, General Surgery and Trauma & Orthopaedics for operational pressures / elective activity.
- £0.27m expenditure within medicine wards in YYF.

	○ Average bank spend in 2022/23 of £3.8m per month

Agency

Total agency spend in October was £3.5m compared with £3.8m in September.

	• In-month spend of £1.1m, a similar level compared with September. ○ Decreased expenditure in Managed Practices, specialist Mental Health and Community Hospitals linked to review of previous shifts worked in 2023/24. ○ Continued pressures in Medicine wards, pathology and GUH ED to cover operational pressures. ○ COTE expenditure (c.£0.2m) for operational pressures. ○ Trauma & Orthopaedics costs (c.£0.17m) for junior rota (vacancies) and orthogeriatric cover that was implemented post GUH. • Medical agency spend averaged c.£1.3m per month in 2022/23.
	In-month spend of £1.6m decrease of £0.2m compared with September. Average spend per month, year to date, is £1.5m per month. • Reasons for use of registered nurse agency include: ○ Vacancy cover ○ Additional service demand, ○ Enhanced care and increased acuity of patients across all sites, and ○ On-going sickness and international recruitment costs, • On-going significant costs in GUH Emergency Department (c.£0.2m) and medicine wards (c.£0.7m) linked to enhanced care, sickness pressures as well as vacancy cover. Mental Health agency costs increased by c.£0.2m in-month linked to enhanced care cover. • Registered Nursing agency spend averaged c.£1.8m per month in 2022/23.

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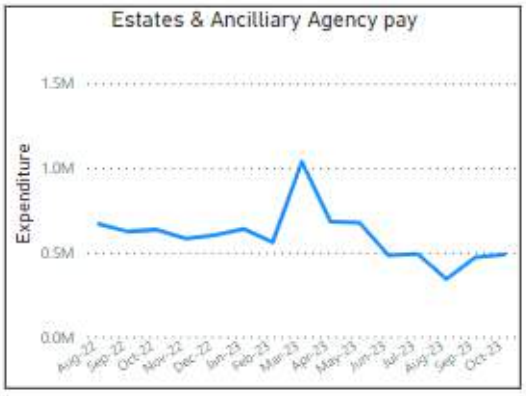
<td> 
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In month spend of £0.49m on Estates & Ancillary agency, a similar level compared with September.
Reasons for use of agency include:

Meeting enhanced cleaning standards,
Other additional surge capacity,
Sickness,
Vacancies and
Supporting National Covid-19 programmes (Mass Vaccination).

Estates and Ancillary agency spend averaged c.£0.65m per month 2022/23.

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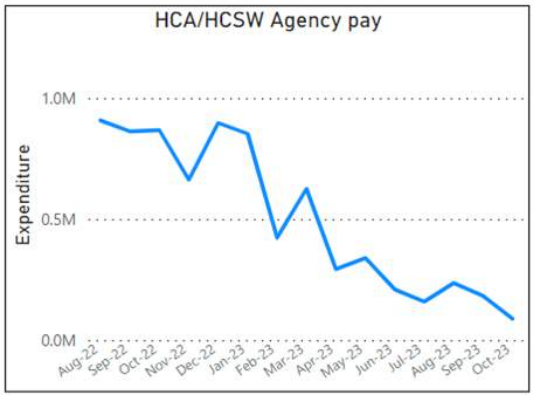
<td> 
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In month spend of £89k on HCSW agency, this has significantly reduced from £0.88m average spend per month in 2022/23.
Areas where spend remains are:

F&T £10k in CAMHS / complex needs
MH&LD £39k including: £9.6k in LD, specifically LGH Ty Lyfant unit, £21.6k in Adult MH services including 5k in Talygarn I/P and 14k in the Psychiatric ICU unit, and £8K in Older Adult MH across 4 wards
PCCS £27k across the wards including: 4k in County, £7k in YAB, £8k in STW, £3k in Cas Gwent & £5k in Monnow Vale Trefynwy ward.
Medicine £11k across the wards including: £6k NHH, £2.6k GUH & £2.6k RGH

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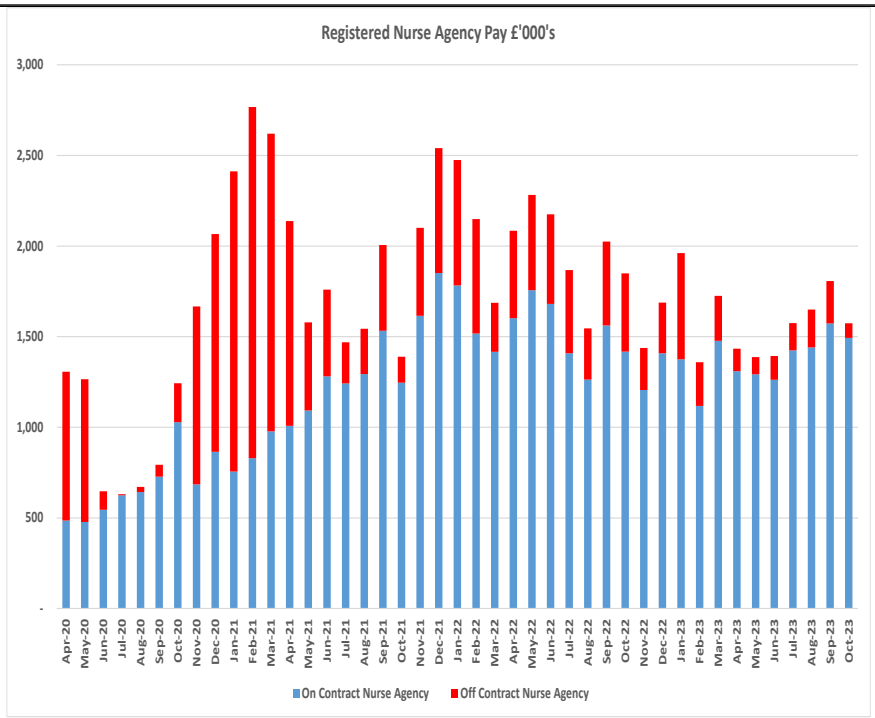
Registered Nurse Agency

Health Board spend in October 2023 is £1.6m which is a decrease of £0.23m compared with September. The effect of the removal of the flexi rewards for Bank staff may now be reduced but this needs to be monitored. The increase in substantive wte suggests that a combination of these various actions have reduced in-month expenditure. It is forecast that decreases in bed capacity should continue to directly reduce agency costs.

Current indications are that 23/24 agency costs could be circa £18.5m.

Registered nurse agency spend totalled £22m in 2022/23, £22.8m in 2021/22, £18.1m in 2020/21 and £10.2m in 2019/20.

The use of "off-contract" agency i.e. not via a supplier on an approved procurement framework usually incurs higher rates of pay, is decreasing but remains a pressure.



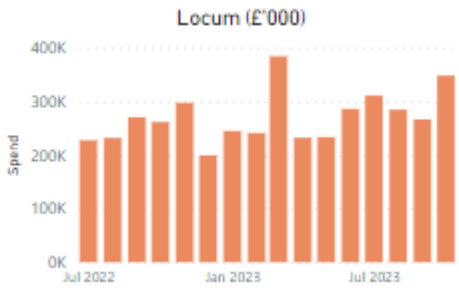
The Health Board spent £0.1m on **"off" contract** RN agency in October. These costs reflect the on-going vacancy cover as well as smaller usage for other operational pressures such as:

- Enhanced care,
- Additional capacity,
- Nursing vacancies,
- Patient safety, and
- Increased sickness and cover for staff in isolation.

Implications of Nursing Shift 'Fill Rate'

It should be noted that there remain high levels of unfilled shifts. Whilst filling these shifts may improve workforce and service provision, there would be an increased cost. In October there were approximately 200 unfilled registered nursing shifts and 450 unfilled HCSW shifts, which could in total result in a further c.£0.25m if these shifts were filled.

Medical locum staff



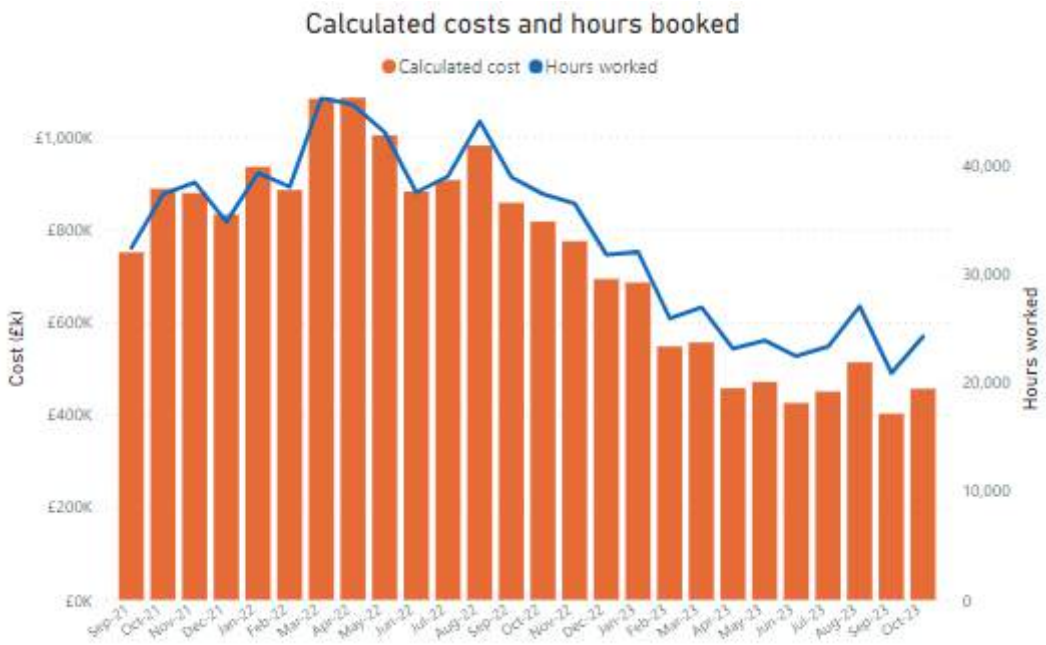
- Total locums spend of £0.3m, a £0.1m increase compared with September.
    - Medical pay award costs of c.£0.06m
    - Radiology, COTE, AMU NHH, and GUH ED are the specialties with the greatest in-month expenditure.
    - Expenditure incurred in relation to vacancies, elective recovery alongside other operational pressures.

Enhanced Care

Enhanced Care, also known as 'specialling', can be provided for a variety of reasons ranging from the provision of assistance to help a patient mobilise or avoid falls through to one-to-one patient monitoring. Enhanced care is designed to ensure an appropriate level of safety and supervision for patients with additional care needs.

The following graph highlights the hours attributed to enhanced care for the period September 2021 to October 2023 using bank and agency registered nurses and health care support workers. The trend suggests that targeted actions may be having a positive impact on enhanced care usage. This reduction needs to be considered in conjunction with trends for other reasons for variable pay usage.

Enhanced Care bank and agency calculated costs and hours booked.



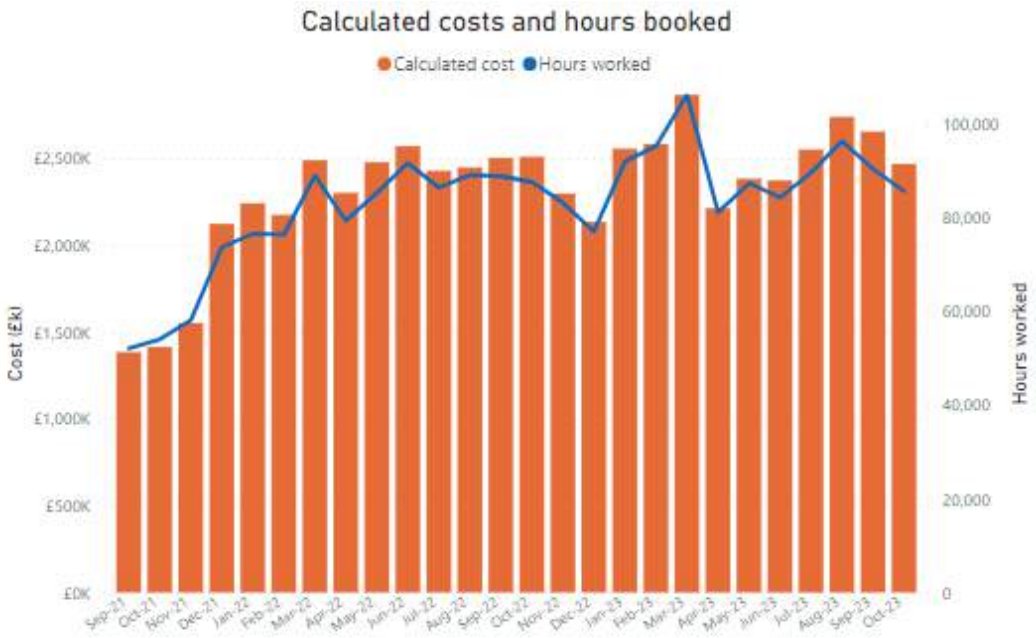
The level of the provision of enhanced care for patients within the Medicine Division for April to October 2023 shows a decrease in September significantly within YYF as well a decrease within RGH.

Enhanced Care by Hospital Site as a percentage of total bed capacity	M1	M2	M3	M4	M5	M6	M7
RGH							
Total no of Medicine beds	192	192	192	192	192	192	192
Monthly average enh care patients	46	38	32	31	42	37	22
%age of beds in receipt of enh care	24%	20%	17%	16%	22%	19%	12%
NHH							
Total no of Medicine beds	164	164	164	164	164	164	164
monthly average enh care patients	17	17	23	23	24	25	23.2
%age of beds in receipt of enh care	10%	10%	14%	14%	15%	15%	14%
GUH							
Total no of Medicine beds	91	91	91	91	91	91	91
monthly average enh care patients	14	12	12	11	10	9	11.87
%age of beds in receipt of enh care	15%	13%	13%	12%	11%	10%	13%
YYF							
Total no of Medicine beds	148	148	148	148	148	148	148
monthly average enh care patients	33	35	30	27	28	18	14
%age of beds in receipt of enh care	22%	23%	20%	18%	19%	12%	9%
Total							
Total no of beds	**595**	**595**	**595**	**595**	**595**	**595**	**595**
Total monthly average enh care patients	**110**	**102**	**97**	**92**	**104**	**89**	**71**
	18%	**17%**	**16%**	**15%**	**17%**	**15%**	**12%**

Nursing vacancy cover

The graph below presents the bank and agency hours and costs relating to those shifts booked to cover vacancies. The graph highlights that in October 2023 variable pay relating to vacancies remains significant and is c.£2.5m of 'notional calculated' expenditure.

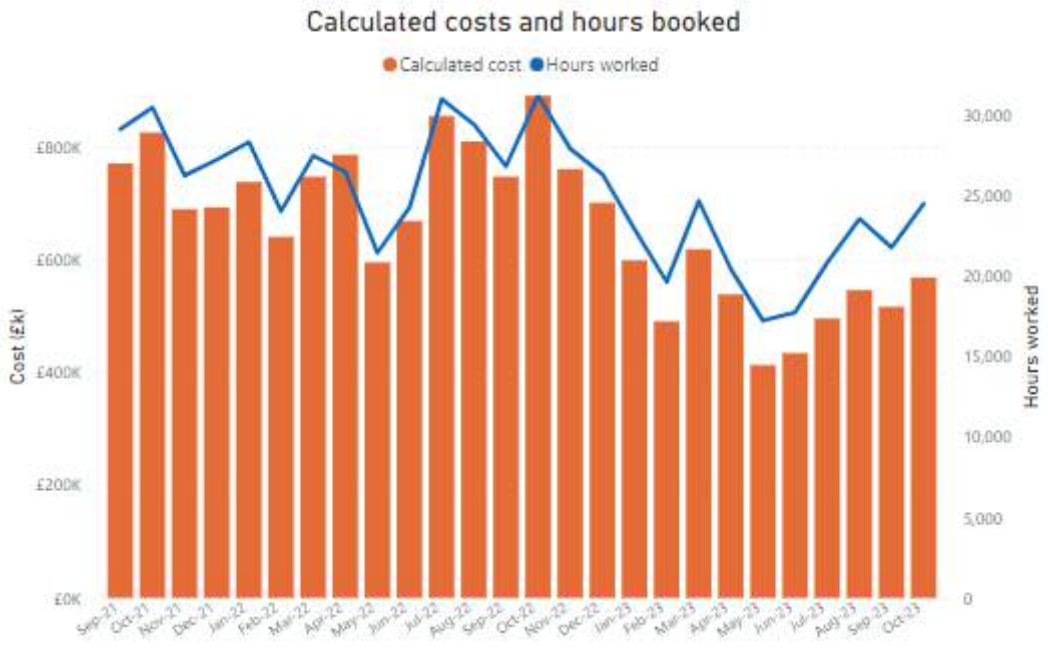
Calculated bank and agency costs / hours booked to cover shifts resulting from vacancies.



Nursing sickness cover

The graph below presents the bank and agency hours and costs relating to those shifts booked to cover sickness as input onto the e-roster system. The graph highlights that in October 2023 variable pay relating to sickness is significant (c.£0.6m) of 'notional calculated' expenditure.

Calculated bank and agency costs / hours booked to cover shifts resulting from sickness.

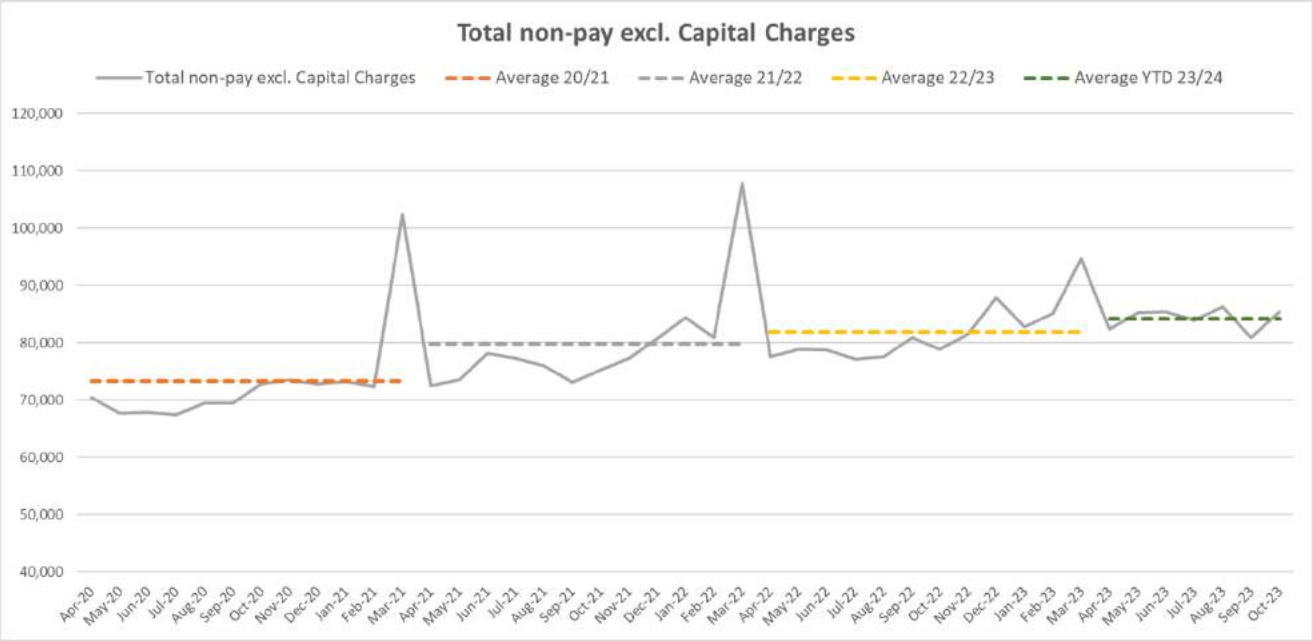


Non-Pay

Spend (excluding capital) was £85.4m in October, which is a £4.4m increase when compared with September. Key reasons include: -

- Dental contract costs increased by £1.4m, note contract underperformance was recovered in September accounts,
- EASC and WHSSC increased by c.£0.3m in line with funding received,
- RIF funded scheme and 6 goals increased costs (£1.1m increase) matched by budget,
- Homecare drug and vaccine increases linked to timing of prescriptions, pharmacy system and school vaccinations. (£1.3m increase)
- Out of Area Treatment, IPTR and other costs (c.£0.3m increase).

The graph below presents non-pay expenditure since April 2020 (it should be noted that the peaks are year-end adjustments and Month 12 items): -



Energy

Energy costs remain a volatile cost pressure, additional non-recurrent funding received in 2022/23 was c.£13.7m with total expenditure of c.£22.2m. 2023/24 forecasts will continue to be updated in line with the latest data and advice received from NWSSP and internally for those energy costs outside of this arrangement, an updated national contract forecast was not available for month 7 so the forecast remains based on month 6 intelligence.

Forecast expenditure for 2023/24 as at month 7 is £18.1m, compared with c.£29m IMTP estimates and the baseline 2022/23 costs of £22.2m.

Element	2022/23 costs (baseline) £'000	2023/24 forecast (£'000)	Variance (£'000)
Total Shared Service Energy Cost	20,620	16,659	(3,961)
Total Other Energy costs	571	849	278
NWSSP (Greenvale Laundry)	992	628	(364)
Total	**22,183**	**18,137**	**(4,046)**

Note 2022/23 experienced a significant energy cost increase over 21/22 of £13.7m.

CHC

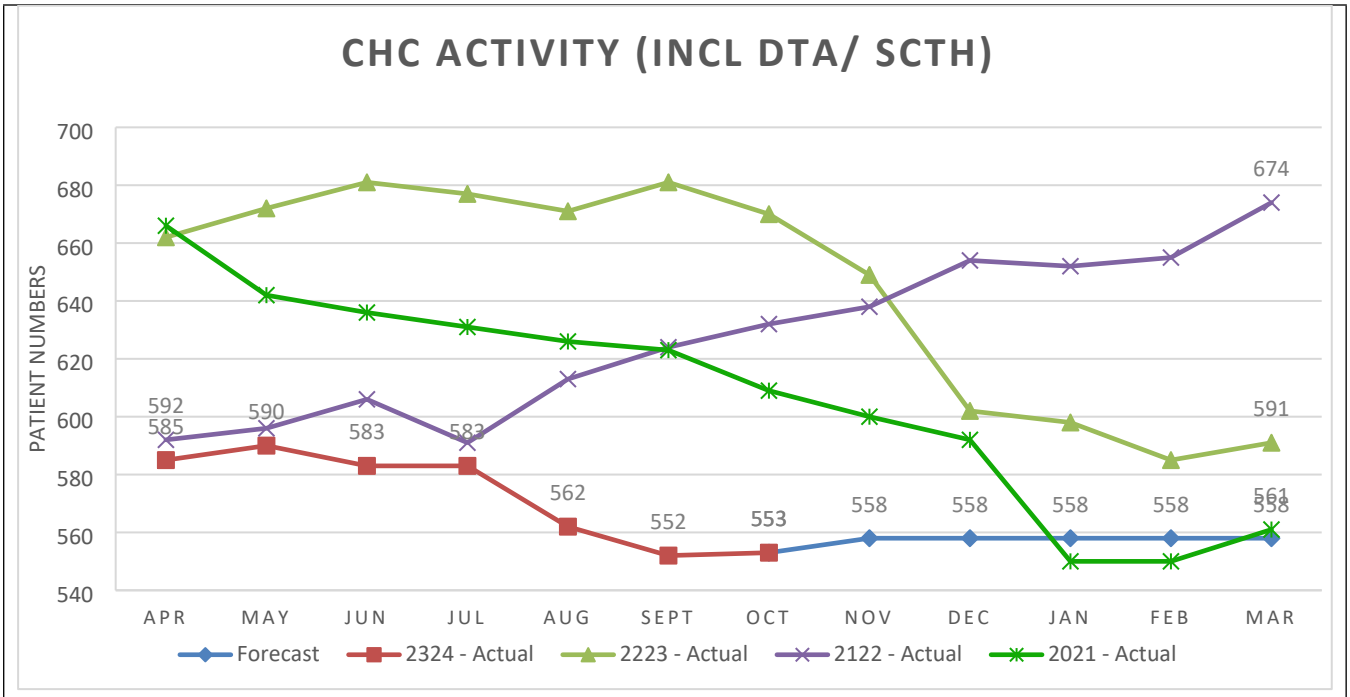
- CHC Mental Health – the patient numbers at the end of October were 426 at a cost of £4.5m (419 patients at a cost of £4.4m in September).
- CHC Adult / Complex Care - 553 total active placements on 31st of October at a cost of £4.8m in-month (increase of 1 from previous month). There was a decrease of 6 D2A patients and a decrease of 1 placement on the 'Step Closer to Home' pathway in October. The table below summarises the current position (patients and forecast costs):

Activity	Oct 2023	Sept 2023	Movement
D2A	10	16	-6
Step Closer to Home	6	7	-1
All Other CHC	537	529	+8
Total	553	552	+1

£'000	M07 Forecast	M06 Forecast	M05 Forecast
D2A	1,948	2,273	2,541
Step closer to home	532	524	563
All other CHC	40,991	41,101	41,542
Total	43,472	43,897	44,646

- FNC - currently 1,063 active placements, which is an increase of 40 from the number of placements in September (expenditure of £0.94m in October).

Adult Complex Care CHC activity over the last four financial years is summarised in the chart below: -

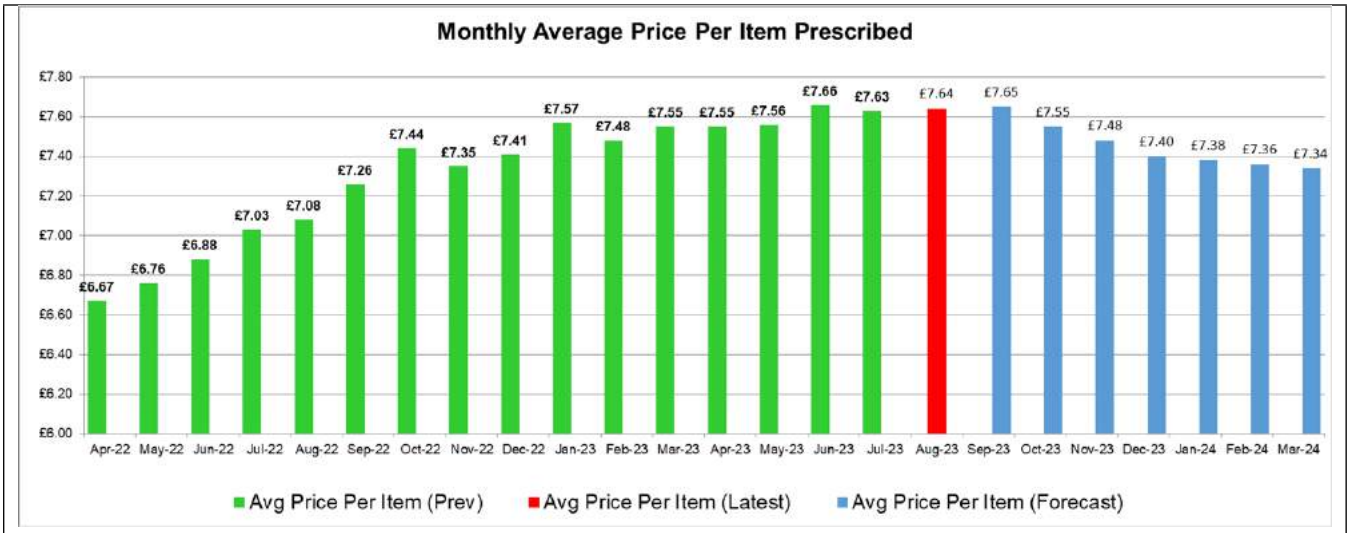


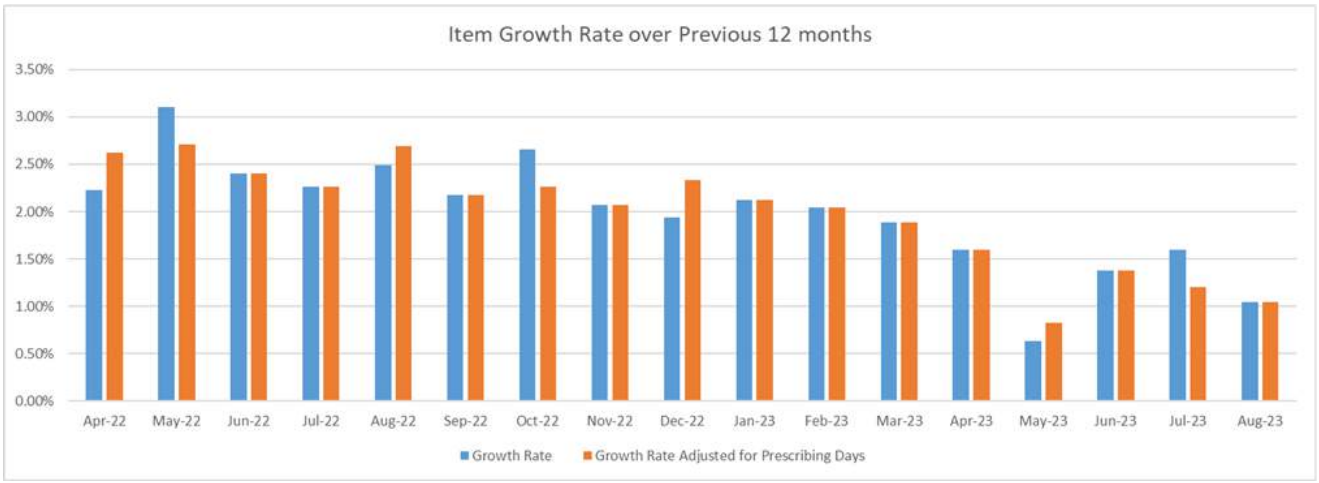
- CHC Paediatric – currently 23 Out of County patients (2023/24 year to date cost of £1.3m) and 15 internal packages (12 patients). There are 6 external and 4 internal high-cost packages which continue to be a cost pressure against budget levels.

Prescribing

- Primary Care prescribing – the expenditure year to date is £71.2m. The October 2023 costs are based on August PAR data: -
    - Item growth rate for 2023/24 of 0.8% (forecast volume of items based on the number of prescriptions for 23/24 is c.16.8m)
    - IMTP average cost per item was £7.20.
    - Average actual cost per item for 2022/23 was £7.21.
    - Average cost per item price forecast for 2023/24 (April-March) is £7.52. This has decreased slightly in month 7 by £0.01 due to a reduction in NCSO concessions from October.
    - A revised home oxygen contract and drug rebates have improved the forecast position by c.£0.2m.

The graphs below show the monthly average price per item and item growth: -



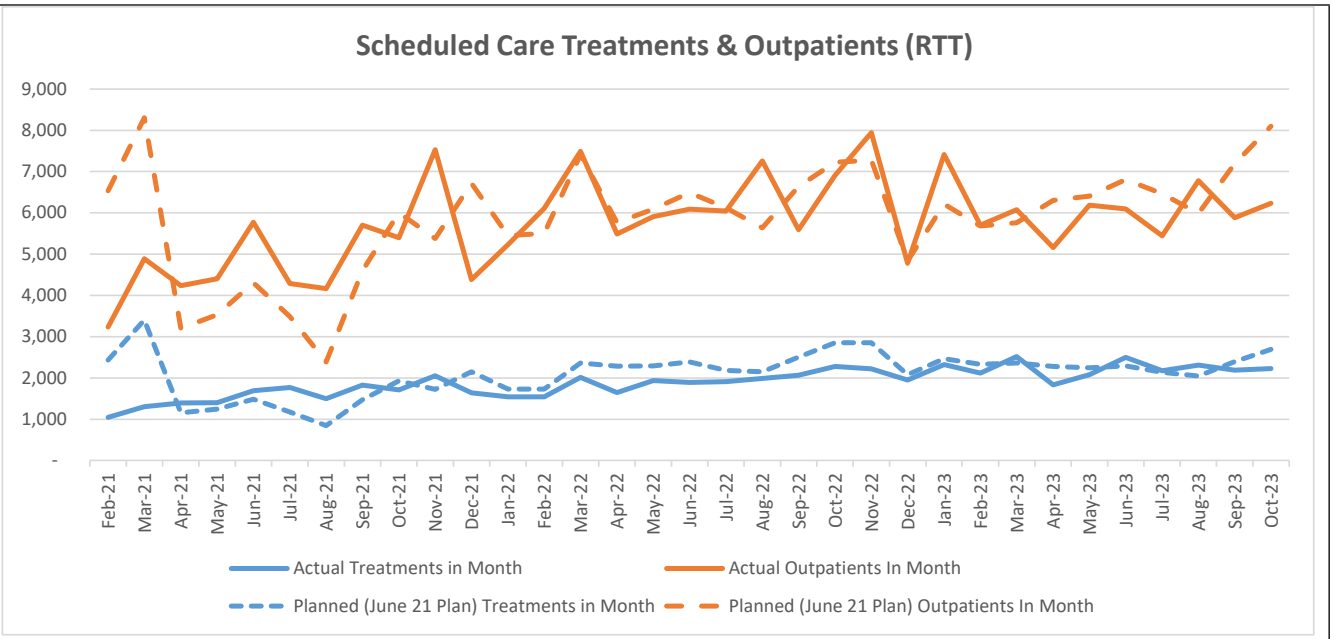


Scheduled Care treatments and outpatients

Elective Treatments for October '23 were 2,226 (September '23 was 2,187). Elective Activity in October has increased by 39 treatments compared with September (2% increase). The number of in month treatments are 464 below plan for October, resulting in a cumulative deficit against plan of 772 treatments.

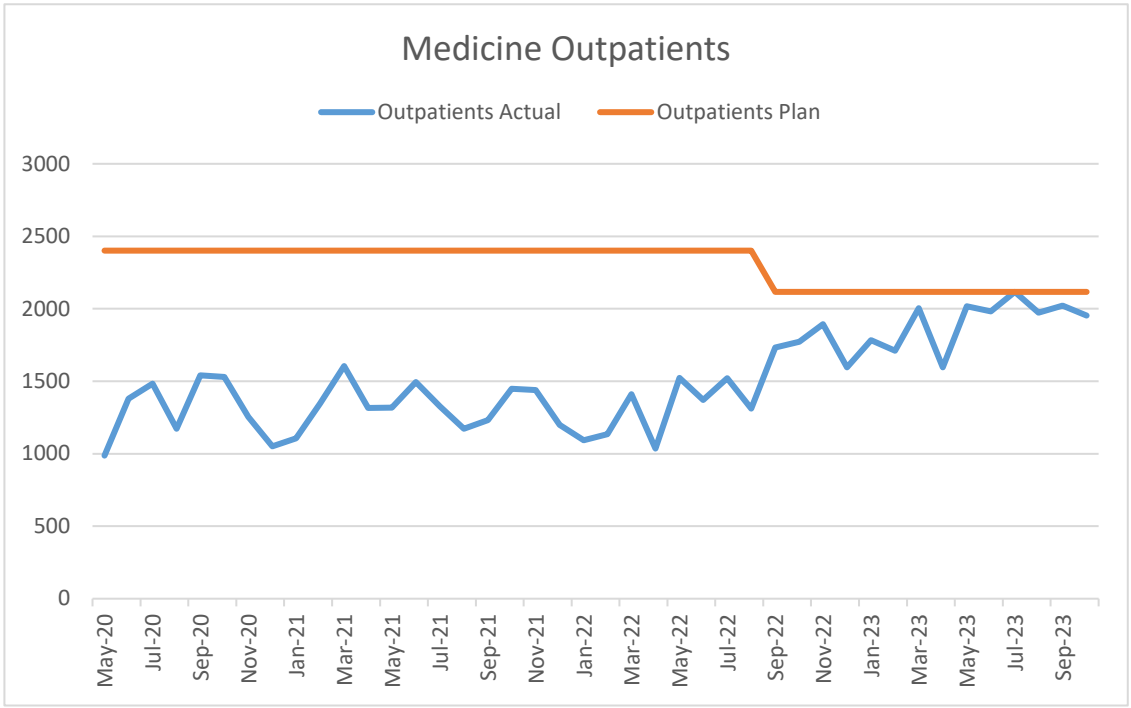
Outpatient activity for October '23 was 6,229 (September '23 was 5,885). Outpatient activity has increased in comparison with the level achieved in September (increase of 344 attendances, 6%) but remains significantly below the planned levels on a year-to-date basis (5,473 cases).

There remain significant efficiency opportunities in the delivery of elective care which need to be progressed as part of the Planned Care programme. The graph below presents performance compared with plan.



Medicine Outpatient Activity

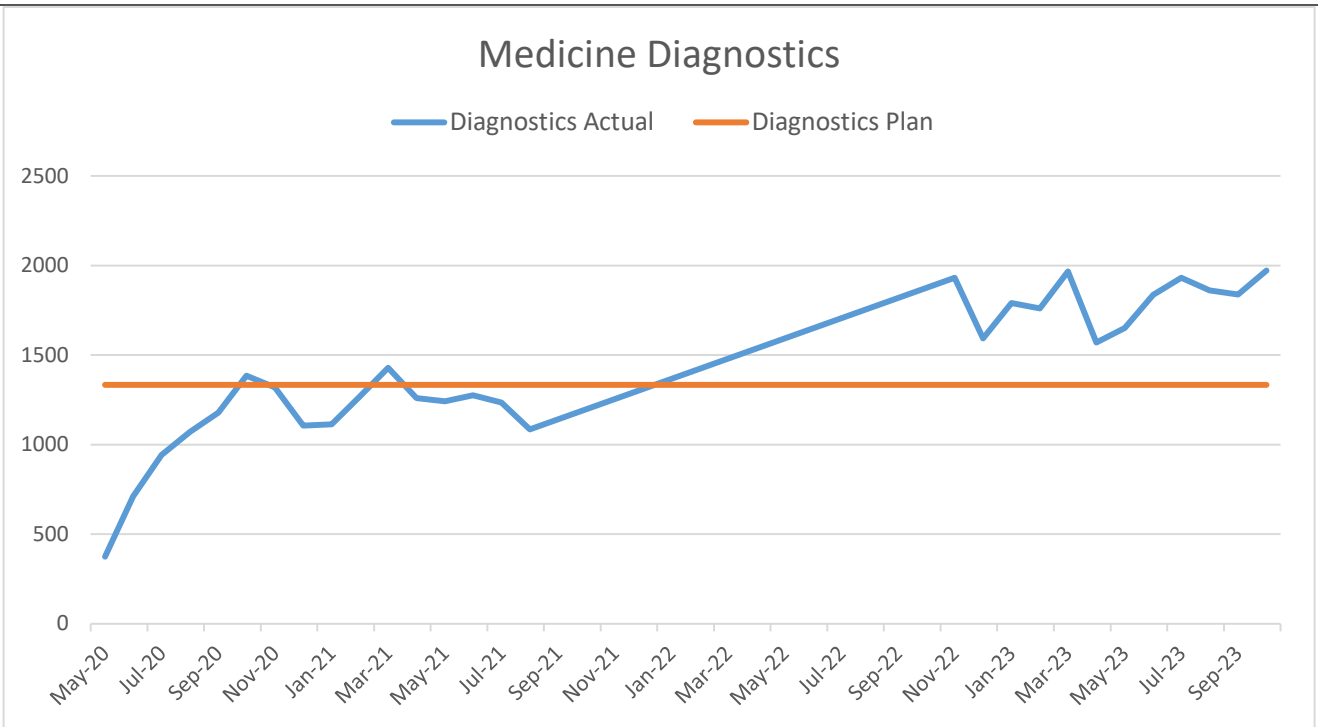
Medicine Outpatient activity for October '23 was 1,954 attendances (September '23 was 2,023 attendances) the activity is presented below:



Medicine Diagnostics (Endoscopy) Activity

Medicine endoscopy activity for October '23 was 1,937 procedures which is 639 cases more than plan (September '23 activity was 1,838). Additional services have been commissioned.

The activity undertaken since May '20 is shown below.



Divisional analysis

Summaries of the Divisional forecast positions are included in the appendices. These include expenditure and budget profiles along with a list of savings schemes and their current progress.

The table below identifies operational divisional forecasts at month 7, these forecasts will be updated once clarity on bed reduction plans are applied to divisions at ward level.

Summary Reported position - October 2023 (M07)	Annual Year Budget £000s	Full-year forecast at M07 £000s	Full-year forecast at M06 £000s	Movement £000s
Operational Divisions:-				
Primary Care and Community	285,668	2,701	3,459	(757)
Prescribing	111,133	10,253	10,461	(208)
Community CHC & FNC	73,677	(3,549)	(2,732)	(817)
Mental Health	127,700	12,681	12,914	(233)
Scheduled Care	197,181	8,980	8,574	406
Clinical Support Services	62,572	(512)	(432)	(80)
Medicine	148,725	16,264	16,918	(653)
Urgent Care	35,024	5,053	5,138	(85)
Family & Therapies	132,869	3,058	2,703	356
Estates and Facilities	87,170	6,138	5,988	150

In line with the ABUHB performance escalation framework, Divisions with a forecast overspend attended escalation 'special budgetary financial review' meetings to establish further plans to achieve an improved financial forecast, ensure control and governance procedures are maintained and identify any areas requiring support.

Divisional forecast movement summaries are as follows (f=favourable, a=adverse): -

- Primary Care and Community £0.757m (f) – due to COTE funding (£0.6m) received from Medicine and reduced GMS fees.
- Prescribing £0.208m (f) – due to revised home oxygen contracts and additional drug rebates.
- Community CHC & FNC £0.818m (f) – reduced forecast numbers for the Discharge to Assess and CHC pathways. Additional RIF funding of c.£0.3m for Step Closer to Home.
- Mental Health £0.233m (f) – reduced forecast due to HEIW income (c£0.05m) and lower nursing variable pay costs particularly in relation to HCSW agency.
- Scheduled Care £0.406m (a) – increased forecast linked to additional medical agency costs (£0.4m) despite c.£0.3m of HEIW income alongside non-pay implant and hearing aid costs.
- Clinical Support Services £0.08m (f) – reduction due to radiographer vacancies, HEIW income of c.£0.04m and reduced overtime forecast costs.
- Medicine £0.653m (f) – reduction due to RIF funding received for YYF SDEC (£0.6m), Cardiology insourcing (£1.1m) and HEIW income (c.£0.2m) off-set by funding transferred to PCCS (£0.6m) and increased forecast costs for acute drugs (£0.5m) respiratory equipment (£0.2m).
- Urgent Care £0.09m (f) – reduction due to reduced middle grade agency costs in ED, HEIW income of c.£0.05m and increased RTA income.
- Family & Therapies £0.356m (a) – increase due to CHC forecast costs (£0.2m) and increased Diabetes pumps/consumable costs (£0.2m).
- Estates & Facilities £0.15m (a) – increased forecast due to removal of the security savings plan within GUH, in line with the special budgetary review meeting.

Covid-19 – 2023/24 Revenue Financial Assessment

Covid-19 funding of £16.3m (£5.9m received, £10.4m anticipated) is only for specific schemes in 2023/24 which are:

- Nosocomial investigation- £0.753m
- PPE (quarters 1 and 2) - £0.603m
- Health Protection (quarters 1 and 2) - £2.446m
- Immunisation/Mass Vaccination (quarters 1 and 2) - £2.076m

Anticipated funding

- *Immunisation (Mass Vaccination) (quarters 3-4) - £6.024m*
- *Surveillance (TTP) (quarters 3-4) - £2.354m*
- *Adferiad (Long Covid) - £1.216m*
- *PPE (quarters 3-4) - £0.797m*

Spend will continue to be reviewed as detailed service delivery plans and models are approved, however, the UHB's financial plan and forecast depends on the receipt and retention of the full levels of funding anticipated.

The Health Board continues to incur additional costs related to Covid-19 for enhanced cleaning standards, security and rental costs. These costs result in an on-going financial pressure for the Health Board.

The Health Board continues to assume full receipt of all the funding mentioned along with the retention of any slippage.

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 or they are earmarked to support the financial position.

A number of items in reserves have been re-allocated to specifically indicate that they are supporting the financial position. A summary of all Health Board reserves on 31st October, along with details of amounts approved for delegation by the CEO in Month 7 can be found in the appendices.

Long Term Agreements (LTA's)

ABUHB has signed LTA documentation with all organisations apart from Cwm Taf.

ABUHB have fully reflected the Cwm Taf arbitration outcome in the Month 7 reported position. ABUHB were successful in reducing the contract by c.£2m for 2023/24.

Meetings have commenced with CTMUHB to establish a revised LTA contract for 2023-24 and 2024-25.

Underlying Financial Position (ULP)

The Underlying (U/L) forecast position was a brought forward value of £89.6m. The current revised carry forward position into the 2024/25 financial year is assessed to be aligned with the revised 2023/24 £145m forecast deficit reduced by anticipated funding. This forecast will undergo further review during 2023/24 as part of the 2024/25 annual plan process.

The analysis of the c/f underlying deficit is as follows: -

- Forecast 2023/24 deficit - £112.8m
- Non-Recurrent Savings - £11.5m
- FYE Cost Pressures as at IMTP - £5.5m
- Sub-total £129.8m

- Estimated FYE Pressures in 2023/24 (Prescribing, CHC, Covid legacy) - £15.9m
- Sub-Total - £145.7m
- WG recurrent funding – (£64.5m)
- Total recurrent deficit - £81.2m

It is noted that this assumes Health Board savings and mitigating actions for 2023/24 are implemented in line with the plan. Financial sustainability is an on-going priority and focus for the Health Board & will form the basis upon which the 2024/25 Annual Plan is developed.

It should be noted that although the £64.5m allocations are recurrent in principle they are conditional on HB's making progress to delivering the WG target control totals, £13m deficit for ABUHB.

Savings delivery

As part of the IMTP submitted by the Board to Welsh Government, the financial plan for 2023/24 identified an ambitious savings requirement of £51.5m. As at Month 7 the forecast achievement in 23/24 of green and amber schemes is reported as £42.1m. This includes the additional options considered and approved by the Board on the 11th October.

Of the expected £42.1m savings delivery, actual savings delivered to October amount to £18.4m.

As part of revised escalation arrangements, the Board has established a Value and Sustainability Board in order to progress savings, mitigations delivery, Executive leads have been allocated to the following themes: -

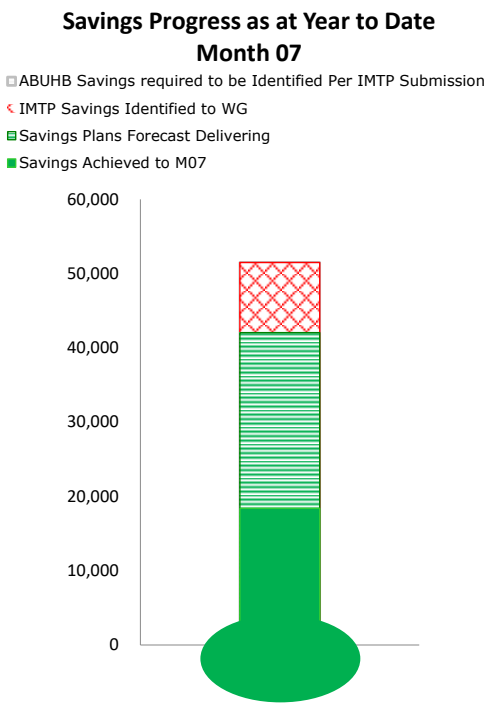
- CHC
- Medicines Management
- Non-pay
- Workforce
- Service reconfiguration
- Prevention
- Digital

The challenge for ABUHB is significant and the reported forecast deficit at month 7 is based on mitigations considered by the Board on the 11th October and at previous sessions.

The table below presents the month 7 updated forecast savings profile:

	£m						
RAG Rating	IMTP	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
Green	24.0	13.7	15.4	19.3	24.7	29.0	29.2
Additional Green ideas					3.3	5.6	6.4
Amber	8.0	7.8	7.5	2.4	2.2	7.9	6.5
Red savings variance	19.5	30.0	28.7	29.8	21.3	9.0	9.4
Sub-total	**51.5**	**51.5**	**51.5**	**51.5**	**51.5**	**51.5**	**51.5**

The year-to-date savings delivery is £18.4m.



Month 7 Forecast Savings Plans

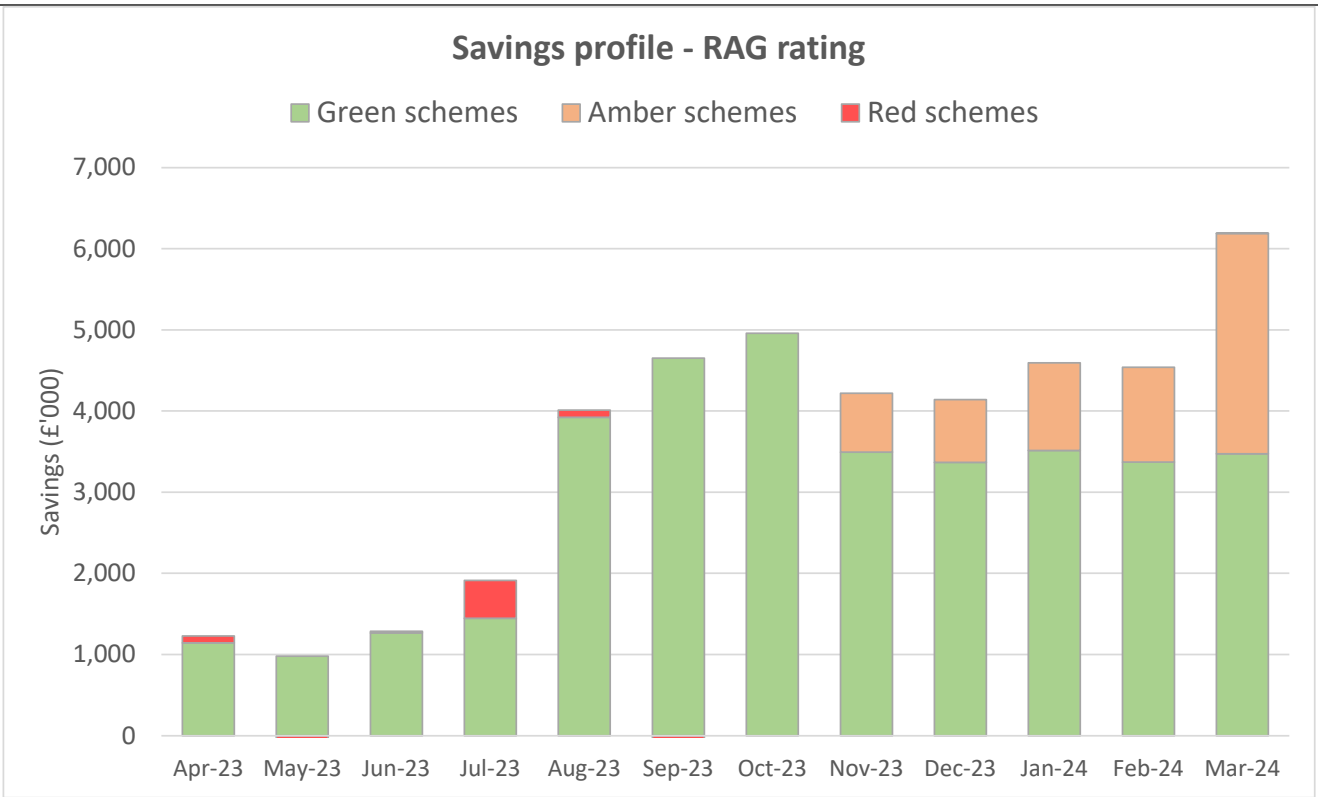
	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
CHC and Funded Nursing Care	6,038	580	5,458	7,305
Commissioned Services	5,664	3,195	2,469	2,469
Medicines Management (Primary and Secondary Care)	5,137	21	5,116	6,892
Pay	13,205	1,786	11,419	12,099
Non Pay	12,014	8,398	3,616	3,915
Total	**42,057**	**13,980**	**28,078**	**32,681**

Month 7 Forecast Savings Plans – Green

Green Savings schemes	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
CHC and Funded Nursing Care	**5,618**	**580**	**5,038**	**6,277**
Commissioned Services	**5,664**	**3,195**	**2,469**	**2,469**
Medicines Management (Primary and Secondary Care)	**5,137**	**21**	**5,116**	**6,892**
Pay	**9,165**	**1,030**	**8,135**	**8,795**
Non Pay	**10,005**	**6,807**	**3,198**	**3,307**
Total	**35,588**	**11,632**	**23,955**	**27,740**

To achieve the revised forecast the Health Board needs to ensure that savings plans are successfully implemented and that potential risks are offset by mitigation either through additional savings plans or other solutions.

The graph below describes the current profile of green and amber savings (£42.1m), noting that the delivery of other mitigating actions not reflected in the savings graph will be essential to support achievement of the £57.6m deficit target.



Savings Plans progress to Note

- Within the savings schemes is £2.25m for closure of beds across all sites. Within Community Division there are discussions to move 3 wards from St Woolos to 2 wards in RGH, the plan and timeline for this is not clear and delays could impact the achievement of the savings scheme.
- Despite investment in the support of the inter-site transport management the savings target will not be achieved and in fact spend has increased by £150k in October.
- Medicine reduced Cardiology evening sessions from 4 to 2, however, this is impacting the waiting lists and may need to be reconsidered.
- Urgent Care are reviewing the use of Discharge Lounges, this needs to be considered alongside discharge improvement plans.
- Good progress is now being made with CHC package reviews.

It is vitally important that all budget holders continue to pursue savings plans to meet the ABUHB financial target and mitigate operational pressures.

2023/24 IMTP revenue plan profile

The in-month variance profile submitted as part of the IMTP for 2023/24 is presented below:

£m Deficit (Surplus)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position
Revised forecast position	12.27	12.27	8.75	8.90	8.90	8.75	8.90	8.90	8.90	8.90	8.90	8.48	**112.85**

The revised profile for 2023/24 with the updated forecast, current savings assessment and updated for new funding, noting the month 7 position is described as follows: -

£m Deficit (Surplus)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position
Revised forecast position	13.49	15.98	14.52	13.11	14.32	10.74	(40.28)	4.08	3.24	3.62	2.71	2.12	**57.627**

The Health Board is reporting a £26.9m favourable variance compared to the Annual Plan for the year-to-date position, as a result of the new funding received from WG.

Risks & Opportunities (2023/24)

There are significant challenges to achieving the financial forecast for 2023/24, which include: -

Risks:

- Full / part delivery of the savings plans identified,
- Managing variable pay,
- Identifying savings to mitigate any further financial pressures identified outside of the IMTP,
- Full receipt and retention of all anticipated allocations,
- Workforce absence / vacancies, availability of staff for priority areas,
- Delayed transfers of care due to LA service challenges,
- Funding for any wage award and changes in terms and conditions,
- Prescribing growth in items and average cost per item,
- Further CHC fee uplifts above forecast levels and potential challenges/disputes with Councils,
- Establishment increases relating to patient safety & quality issues,
- Covid legacy costs to adhere to specific guidelines, e.g. enhanced cleaning costs, ED screening and testing unit,
- Inflationary impacts including provisions and supplies,
- Additional costs (including national programme/legal/penalty costs) in relation to LINC,

- RISP risk with regards to capital funding letters received exclusive of VAT however the VAT reclaimable is not definitively confirmed,
- WCCIS in relation to the cessation of WG supporting the use of the platform required to run it, ABUHB has invested in staff to undertake work related to phases 2 & 3. If it is decided to cease this work then the costs of these staff will no longer be eligible for Capital funding and will transfer to revenue,
- Health Protection, the HB's Annual plan delivery has always been reliant on slippage relating to HP funding. WG's recent letter stated that this funding would be based on actual costs only, therefore, the slippage is a risk to the delivery of the HB's plan.
- The new funding indicated in WG's letter was apportioned based on Commissioner shares, there is a risk that the HB will be directed to pass some of the funding through to the Providers of ABUHB's LTA services.
- IFRS 16 for PFI schemes. HM treasury has issued guidance related to the accounting / recording of the index linked payments in accordance with IFRS 16 from 2023/24. This could mean additional charges to revenue; this is being taken forward by WG colleagues.
- Specific economic factors/Ukraine conflict issues such as energy costs, supply chain issues and non-pay inflation including travel expense costs, and
- Additional national IMTP programme costs.

Opportunities

- Potential energy cost reduction through new national contract,
- A share of 6 Goals funding slippage, to be confirmed with the All Wales lead,
- VAT rebates (MS Office & Oxygen),
- Velindre NICE cancer drug costs,
- Re-review of 'discounted' savings ideas,
- Driving efficiency opportunities,
- Service reconfiguration, consolidation, centralisation, and
- Maximising the opportunity to change services resulting in improved health outcomes for the population.

Capital

The approved Capital Resource Limit (CRL) as at Month 7 totalled £51.944m. In addition, Charitable funds donations totalling £0.150m and disposals proceeds of £0.427m have been confirmed. The forecast outturn at Month 7, after accounting for anticipated inflation funding of £0.020m in relation to the YYF Breast Unit, is an overspend of £163k. The overspend relates to the fees and enabling works approved in relation to the GUH Emergency Department extension scheme. These costs will be reimbursed if the business case is approved by Welsh Government (WG). This

overspend risk will be managed through the capital programme to ensure financial balance.

The Health Board confirmed the CRL requirements for all All-Wales Capital Programme (AWCP) schemes at the end of October. The revised budget allocations are included in the reported month 7 position and are now fixed. **Any future slippage will need to be managed by the Health Board through brokerage with the Discretionary Capital Programme.**

Additional funding of £3.056m has been received in relation to the GUH remaining works scheme. The additional funding allows the anticipated VAT reclaim amount to be slipped to 2024/25 in line with the expected finalisation of the claim with HMRC.

The Tredegar Health and Well-being Centre scheme is forecasting an overspend of £0.478m in 2023/24 which is being funded by the Discretionary Capital programme (DCP). The total forecast overspend for the scheme is £0.758m with the balance of this amount falling into 2024/25. The handover date for phase one has been delayed to January 2024 due to delayed electricity, water and gas connections. Any additional costs accepted as part of the delay will increase the overspend that is being funded from DCP. A meeting with NWSSP took place in October to discuss the £1.137m ex VAT of unfunded costs in relation to inflation allowances on works and fees, EV charging and other required changes that are intended to be submitted as an additional funding request to WG. Conversely, further risks are identified in relation to five unresolved compensation events which total £2.006m plus VAT (including re-design of the foundations (£0.753m plus VAT), costs associated with the cancellation of the brick supply (£0.644m plus VAT) and the delay associated with the remedial works to the heart floor slab (£0.367m plus VAT)) which are not currently built into the forecast outturn. If these claims are found to be valid, they will significantly increase the reported overspend position.

The works to NHH Satellite Radiotherapy Centre Scheme are progressing. A 10-week delay has been confirmed due to the adverse ground conditions under the now demolished Ante Natal Clinic. This has resulted in a compensation event being awarded to the contractor of £0.468m plus VAT. The revised completion date is now February 2025. The 2023/24 CRL allocation has been reduced in October by £0.975m in line with the contractor's current cash flow forecast. The overall scheme remains within budget.

Works at the YYF Breast Centralisation Unit are on schedule to complete by December 2023. The building will then be commissioned by January 2024. The scheme is currently forecasting an overspend against the approved CRL of £0.020m, however, inflation funding is available within the unapproved section of the CRL to offset this amount once it has been confirmed.

WG have agreed a CRL reduction of £0.607m for the Newport East H&WBC scheme because of slippage into 2024/25. The revised outturn is based on the works currently progressing at around 15 weeks behind original programme. There is a forecast overspend of £0.387m on the project overall which will impact on the

2024/25 DCP unless mitigated by additional funding and / or value engineering savings.

RGH Endoscopy unit was opened on the 6th November. WG have approved for the Health Board to retain the expected VAT savings (£232k) to enable the purchase of additional scope guides and scopes in relation to Bowel Screening patients.

The RGH Blocks 1 & 2 Demolitions and Car Park scheme is forecasting an overspend of £0.106m due to higher than anticipated asbestos removal costs and the requirement to board up the building whilst the scheme is delayed due to nesting birds. The building has now been demolished. A further potential risk in relation to asbestos is being costed by the Facilities Division and will be reported in the Month 8 position. This overspend is being offset by the DCP.

Slippage of £0.196m has been agreed in relation to the EFAB allocations. Slippage on the allocations agreed for the Glan Usk roof replacement and Cordell Centre infrastructure upgrades have been partially offset through the acceleration of the replacement RGH Fire Alarm scheme.

The Outline Business Case for the Mental Health SISU has been submitted to WG for approval. The scrutiny process is on-going. The CRL allocation has been reduced by £ £0.126m in month in line with the underspend achieved against the OBC stage.

Slippage of £0.227m has been agreed against the CAMHS Sanctuary Hub scheme. The Stage 4 design is now complete with the works expected to gout to tender mid-November.

The Health Board Discretionary Capital Programme (DCP) funding available for 2023/24 is £7.041m made up of:

- 2023/24 DCP Funding - £9.521m (a reduction of 12% compared to 2021/22)
- Less 30% EFAB contribution – (£0.629m)
- Less 2022/23 AWCP scheme brokerage – (£2.278m)
- NBV of Assets Disposed (E Block disposals) - £0.427m

The opening DCP for 2023/24 was approved at the January 2023 Board meeting. The current forecast spend for approved DCP schemes is £6.588m generating an underspend against DCP of £0.453m. This saving is being used to partially offset overspends on AWCP schemes (mainly Tredegar H&WBC £0.478m and RGH Blocks 1&2 £0.106m). The programme contains two large schemes (GUH ED Extension fees (£0.893m) and Phase one NHH RAAC Urgent Works (£0.250m)) which will be submitted to WG for approval with the intention of being reimbursed in the current financial year. The Business Justification Case for the GUH ED extension was submitted to WG for approval in October.

There are also further significant requirements that are not currently included in the approved DCP funding total including capital works associated with the lease at Ty Gwent (£1.3m), costs associated with phase two remedial works required in relation to RAAC at NHH (costs TBC) and the RGH Pharmacy robot replacement (£710k).

These risks are in addition to the high number of bids submitted by divisions for essential works and end of life IT and equipment replacements.

Potential additional funding sources are available to offset some of the pressures. These include the additional funding bid in relation to Tredegar H&WBC unfunded inflation and costs outside of the FBC approval and the potential reimbursement of fees (previously funded from DCP) in relation to the GUH ED Extension (£1.003m) and RGH Decontamination (£0.114m) schemes. These reimbursements are dependent on the business cases for these schemes being approved within the current financial year.

Cash

The cash balance on the 31st of October is £4.502m, which is below the advisory figure set by Welsh Government of £6m.

As part of the mid-year financial review the Board has given approval for the executive to submit a request for the necessary strategic cash support for 2023/24 as a result of the deficit position.

Public Sector Payment Policy (PSPP)

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods in October and cumulatively (97.1% year to date). There has been an increase in the number & value of NHS invoices paid within 30 days this month & cumulatively. We are continuing to work with those departments where invoices are being processed outside of the 30-day payment terms and at the NHS payment rate.

Argymhelliad / Recommendation

The Board is asked to note for assurance:

- The financial performance at the end of October 2023 and forecast position against the statutory revenue and capital resource limits,
- The savings position for 2023/24,
- The revenue reserve position on the 31st of October 2023,
- The Health Board's underlying financial position, and
- The capital position.

Note the appendices attached providing further information.

Appendices:

As attached.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	7. Staff and Resources Governance, Leadership & Accountability All Health & Care Standards Apply Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Finance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	ABUHB efficiency compendium
Rhestr Termau: Glossary of Terms:	A&C – Administration & Clerical A&E – Accident & Emergency A4C - Agenda for Change AME – (WG) Annually Managed Expenditure AQF – Annual Quality Framework AWCP – All Wales Capital Programme AP – Accounts Payable AOF – Annual Operating Framework ATMP – Advanced Therapeutic Medicinal Products B/F – Brought Forward BH – Bank Holiday C&V – Cardiff and Vale CAMHS – Child & Adolescent Mental Health Services C/F – Carried Forward CHC – Continuing Health Care

	Commissioned Services – Services purchased external to ABUHB both within and outside Wales COTE – Care of the Elderly CRL – Capital Resource Limit Category M – category of drugs CEO – Chief Executive Officer CEAU – Children's Emergency Assessment Unit CTM – Cwm Taf Morgannwg D&C – Demand & Capacity DCP – Discretionary Capital Programme DHR – Digital Health Record DNA – Did Not Attend DOSA – Day of Surgery Admission D2A – Discharge to Assess DoLS - Deprivation of Liberty Safeguards DoF – Director(s) of Finance DTOC – Delayed Transfer of Care EASC – Emergency Ambulance Services Committee ED – Emergency Department EDCIMS – Emergency Department Clinical Information Management System eLGH – Enhanced Local general Hospital EFAB – Estates Funding Advisory Board ENT – Ear, Nose and Throat specialty EoY – End of Year ETTF – Enabling Through Technology Fund F&T – Family & Therapies (Division) FBC – Full Business Case FNC – Funded Nursing Care GDS – General Dental Services GMS – General Medical Services GP – General Practitioner GWICES – Gwent Wide Integrated Community Equipment Service GUH – Grange University Hospital GIRFT – Getting it Right First Time HCHS – Health Care & Hospital Services HCSW – Health Care Support Worker HIV – Human Immunodeficiency Virus HSDU – Hospital Sterilisation and Disinfection Unit H&WBC – Health and Well-Being Centre IMTP – Integrated Medium-Term Plan INNU – Interventions not normally undertaken IPTR – Individual Patient Treatment Referral I&E – Income & Expenditure ICF – Integrated Care Fund

	LoS – Length of Stay LTA – Long Term Agreement LD – Learning Disabilities MH – Mental Health MSK - Musculoskeletal Med – Medicine (Division) MCA – Mental Capacity Act MDT – Multi-disciplinary Team MMR – Welsh Government Monthly Monitoring Return NCA – Non-contractual agreements NCN – Neighbourhood Care Network NCSO – No Cheaper Stock Obtainable NI – National Insurance NICE – National Institute for Clinical Excellence NHH – Neville Hall Hospital NWSSP – NHS Wales Shared Services Partnership ODTC – Optometric Diagnostic and Treatment Centre OD – Organisation Development PAR – Prescribing Audit Report PCN – Primary Care Networks (Primary Care Division) ☐ PER – Prescribing Incentive Scheme PICU – Psychiatric Intensive Care Unit PrEP – Pre-exposure prophylaxis PSNC –Pharmaceutical Services Negotiating Committee PSPP – Public Sector Payment Policy PCR – Patient Charges Revenue PPE – Personal Protective Equipment PFI – Private Finance Initiative RGH – Royal Gwent Hospital RN – Registered Nursing RRL – Revenue Resource Limit RTT – Referral to Treatment RPB – Regional Partnership Board RIF – Regional Integration Fund SCCC – Specialist Critical Care Centre SCH – Scheduled Care Division SCP – Service Change Plan (reference IMTP) SLF – Straight Line Forecast SpR – Specialist Registrar STW – St.Woolos Hospital TCS – Transforming Cancer Services (Velindre programme) ☐ T&O – Trauma & Orthopaedics TAG – Technical Accounting Group

	UHB / HB – University Health Board / Health Board USC – Unscheduled Care (Division) UC – Urgent Care (Division) ULP – Underlying Financial Position VCCC – Velindre Cancer Care Centre VERS – Voluntary Early Release Scheme WET AMD – Wet age-related macular degeneration WG – Welsh Government WHC – Welsh Health Circular WHSSC – Welsh Health Specialised Services Committee WLI – Waiting List Initiative WLIMS – Welsh Laboratory Information Management System WRP – Welsh Risk Pool YAB – Ysbyty Aneurin Bevan YTD – Year to date YYF – Ysbyty Ystrad Fawr
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Finance & Performance Committee

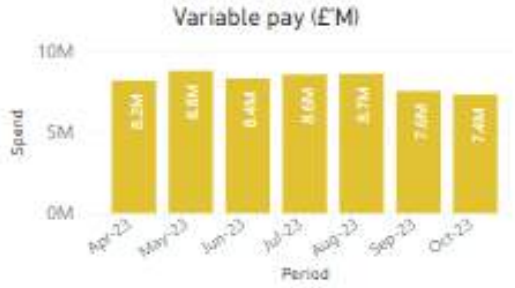
Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan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

Aneurin Bevan University Health Board

Finance Report – October (Month 7) 2023/24

Appendices

Pay Summary (1) (subject to change excluding annual leave effect Pension employer costs):



Substantive (£'000)

Pay category	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Change	%	Avg 22/23
ADD PROF SCIENTIFIC AND TECHNICAL	1,975	1,989	2,427	2,429	2,163	2,150	2,139	-10	-0.5%	2,027
ADDITIONAL CLINICAL SERVICES	7,299	7,742	10,215	9,152	8,071	7,755	7,816	61	0.8%	7,113
ADMINISTRATIVE & CLERICAL	9,660	9,674	12,471	11,514	10,101	9,893	10,076	183	1.9%	9,427
ALLIED HEALTH PROFESSIONALS	3,773	3,817	4,803	4,508	4,000	4,009	4,035	26	0.6%	3,839
ESTATES AND ANCILLIARY	2,735	2,875	3,777	3,342	2,974	2,875	2,868	-7	-0.3%	2,781
HEALTHCARE SCIENTISTS	1,055	1,071	1,334	1,238	1,118	1,111	1,112	1	0.1%	1,039
MEDICAL AND DENTAL	12,849	12,877	13,153	13,297	13,297	13,213	16,884	3,671	27.8%	13,085
NURSING AND MIDWIFERY REGISTERED	15,206	15,802	19,843	18,278	16,143	15,996	16,281	286	1.8%	15,604
STUDENTS	4	4	6	5	4	4	2	-3	-63.6%	9
Total	**54,556**	**55,849**	**68,028**	**63,763**	**57,871**	**57,006**	**61,213**	**4,207**	**7.4%**	**54,923**

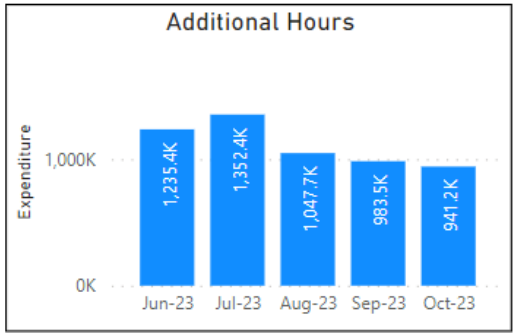
Variable pay (£'000)

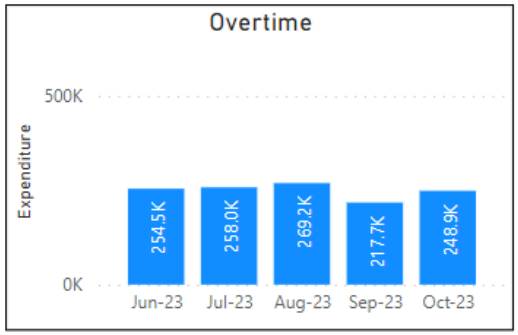
Pay category	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Change	%	Avg 22/23
Bank	4,125	3,823	4,242	4,568	4,460	3,480	3,519	-338	-8.8%	5,074
Agency	3,873	4,781	3,827	3,724	3,913	3,835	3,497	39	1.1%	3,831
Locum	233	234	286	311	285	267	349	82	30.6%	260
Total	**8,230**	**8,838**	**8,355**	**8,603**	**8,658**	**7,582**	**7,365**	**-217**	**-2.9%**	**9,165**

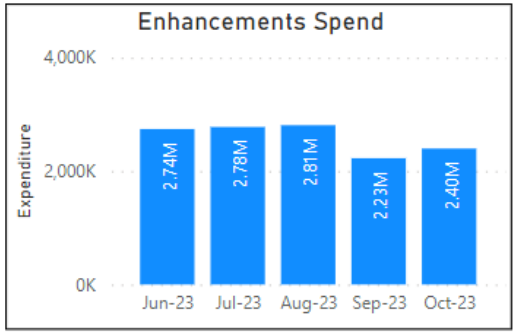
Total pay (£'000)

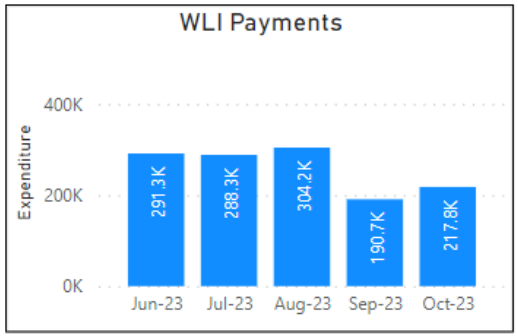
Pay category	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Change	%	Avg 22/23
Pay	62,786	64,687	76,383	72,366	66,529	64,588	68,578	3,990	6.2%	64,089

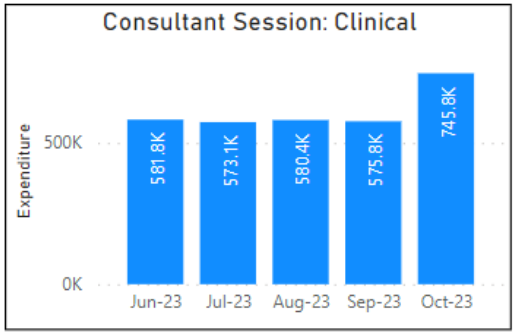
Pay Summary (2): Substantive Pay

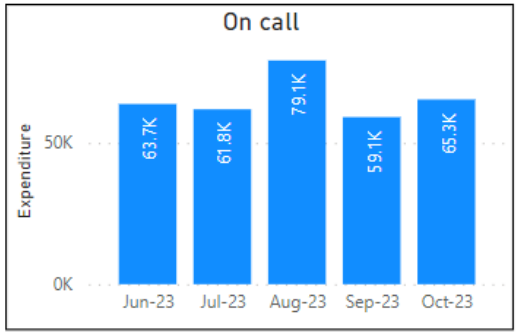










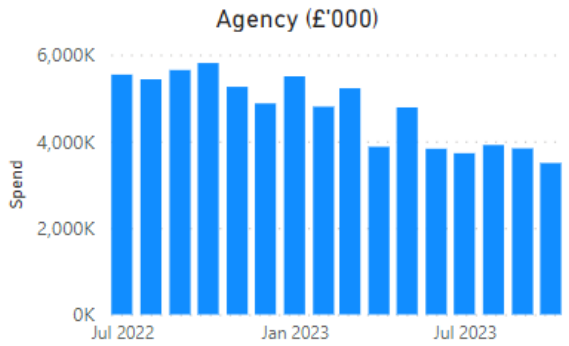


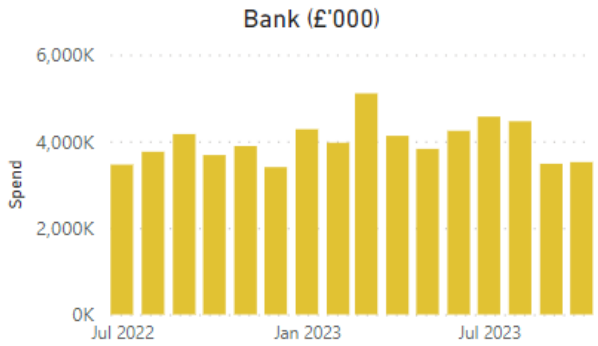
Analysis type by Division

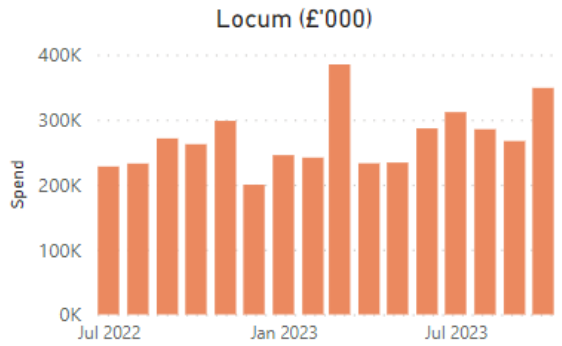
Analysis type	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Total
⊟ **Enhancements**						
⊞ Medicine	493	513	532	410	434	**2,381**
⊞ Scheduled Care	402	415	434	337	366	**1,954**
⊞ Estates and Facilities Division	371	392	394	346	340	**1,843**
⊞ Primary Care and Community	430	386	335	257	324	**1,732**
⊞ Family and Therapies	323	330	352	279	299	**1,583**
⊞ Mental Health and LD	253	261	266	205	212	**1,198**
⊞ Urgent Care	212	213	220	177	186	**1,008**
⊞ CHC and FNC	109	113	119	93	101	**535**
⊞ Clinical Support Services	106	113	118	95	99	**532**
⊞ Corporate	43	40	35	27	36	**180**
Total	**2,740**	**2,776**	**2,807**	**2,226**	**2,396**	**12,945**
⊞ **ADDITIONAL HOURS**	**1,235**	**1,352**	**1,048**	**984**	**941**	**5,560**
⊞ **CONSULTANTS SESSION: CLINICAL**	**582**	**573**	**580**	**576**	**746**	**3,057**
⊟ **WAITING LIST PAYMENTS: CONSULTANTS**						
⊞ Clinical Support Services	157	131	137	104	130	**658**
⊞ Medicine	95	102	92	78	70	**436**
⊞ Scheduled Care	43	51	77	3	8	**182**
⊞ Family and Therapies	-3	3		4	6	**10**
⊞ Primary Care and Community				2	3	**6**
Total	**291**	**287**	**306**	**191**	**218**	**1,292**
⊞ **Overtime**	**255**	**258**	**269**	**218**	**249**	**1,248**
⊞ **ON CALL**	**64**	**62**	**79**	**59**	**65**	**329**
Total	**5,167**	**5,308**	**5,089**	**4,253**	**4,615**	**24,432**

Pay Summary (3): Variable Pay (£'k)

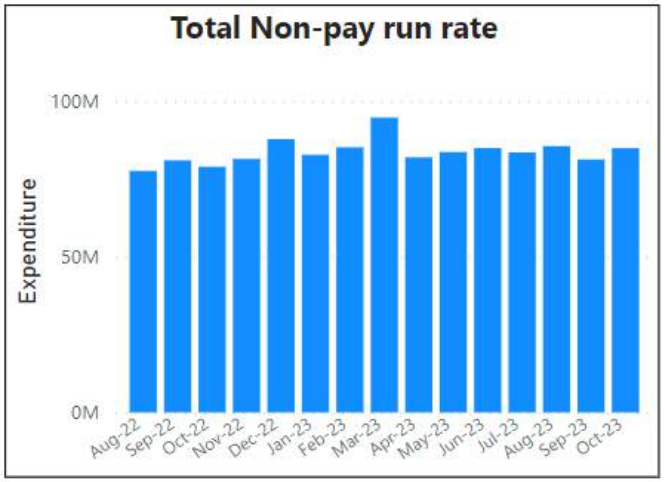
Pay category	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Change	%
Agency																		
Admin & Clerical Agency	204	126	118	85	124	152	79	10	147	72	64	77	49	41	39	86	46	117.1%
Allied Health Prof Agency	155	97	319	187	279	108	232	188	165	171	219	147	196	196	192	123	-69	-36.0%
Estates & Ancilliary Agency	663	669	623	635	583	602	639	560	1,036	683	675	483	490	341	471	489	18	3.9%
Medical Agency	1,439	1,265	1,179	1,503	1,321	1,261	1,377	1,336	1,271	1,162	2,025	1,474	1,165	1,399	1,093	1,091	-2	-0.2%
Nurse HCA/HCSW Agency	1,122	1,080	1,092	1,135	975	977	980	798	690	293	339	209	160	236	183	89	-95	-51.6%
Other Agency	88	146	100	105	116	37	53	64	105	58	70	43	90	49	50	46	-4	-8.6%
Registered Nurse Agency	1,867	2,048	2,213	2,155	1,859	1,737	2,139	1,842	1,810	1,434	1,387	1,394	1,575	1,650	1,807	1,574	-233	-12.9%
Total	**5,538**	**5,430**	**5,644**	**5,806**	**5,256**	**4,873**	**5,500**	**4,798**	**5,224**	**3,873**	**4,781**	**3,827**	**3,724**	**3,913**	**3,835**	**3,497**	**-338**	**-8.8%**
Bank																		
Admin & Clerical Bank	101	105	136	104	108	80	109	88	123	94	86	108	114	92	92	82	-9	-10.2%
Estates & Ancilliary Bank	181	192	217	169	151	155	156	158	204	138	142	166	216	201	215	216	2	0.8%
Nurse HCA/HCSW Bank	1,243	1,408	1,660	1,378	1,455	1,249	1,614	1,452	1,765	1,598	1,485	1,635	1,811	1,816	1,438	1,520	82	5.7%
Other Bank	0	0	0	0	0	0	0	0	0	0	0	0	1	-1	0	2	2	-6007.0%
Registered Nurse Bank	1,934	2,052	2,154	2,031	2,175	1,918	2,397	2,268	3,014	2,295	2,110	2,332	2,425	2,352	1,736	1,699	-37	-2.1%
Total	**3,460**	**3,757**	**4,166**	**3,681**	**3,889**	**3,402**	**4,277**	**3,966**	**5,105**	**4,125**	**3,823**	**4,242**	**4,568**	**4,460**	**3,480**	**3,519**	**39**	**1.1%**
Locum																		
Medical Locum	228	232	271	262	298	200	245	241	385	233	234	286	311	285	267	349	82	30.6%
Total	**228**	**232**	**271**	**262**	**298**	**200**	**245**	**241**	**385**	**233**	**234**	**286**	**311**	**285**	**267**	**349**	**82**	**30.6%**
Total	**9,226**	**9,420**	**10,082**	**9,749**	**9,443**	**8,475**	**10,022**	**9,006**	**10,713**	**8,230**	**8,838**	**8,355**	**8,603**	**8,658**	**7,582**	**7,365**	**-217**	**-2.9%**

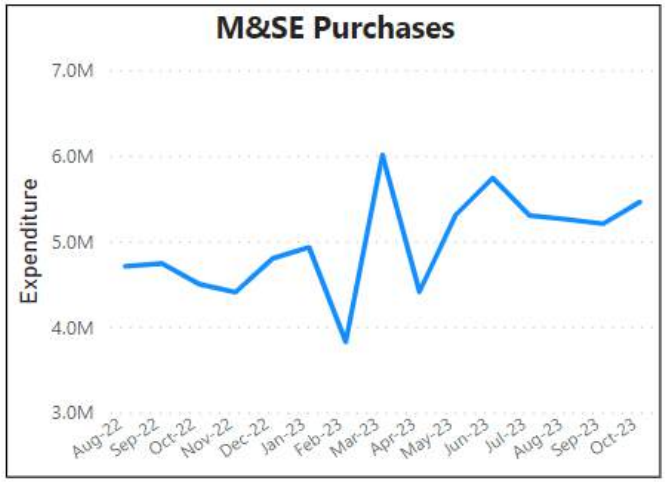


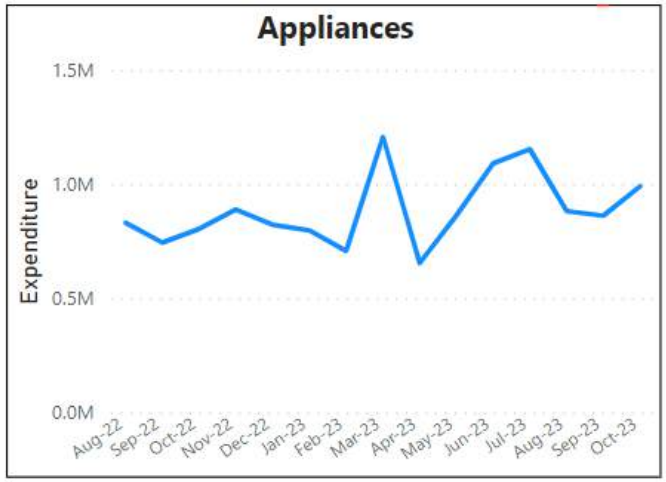


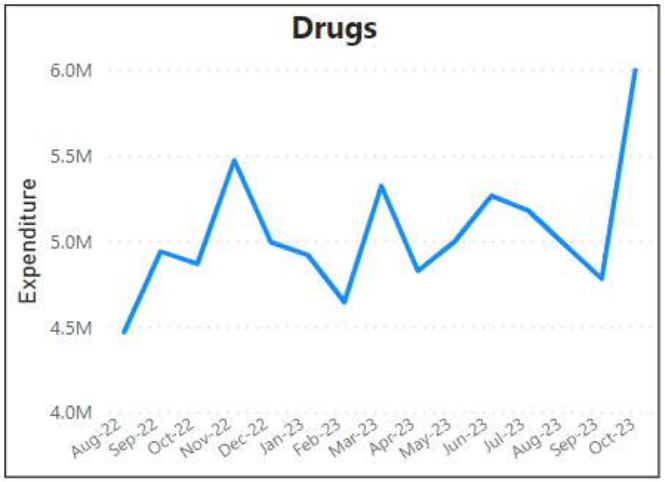


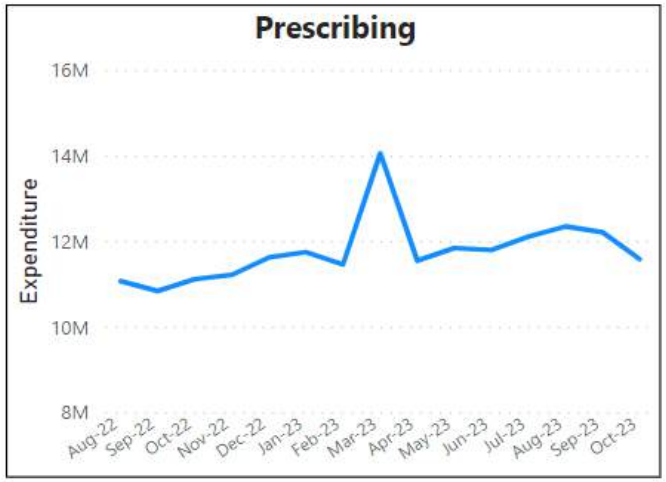
Non-Pay Summary:

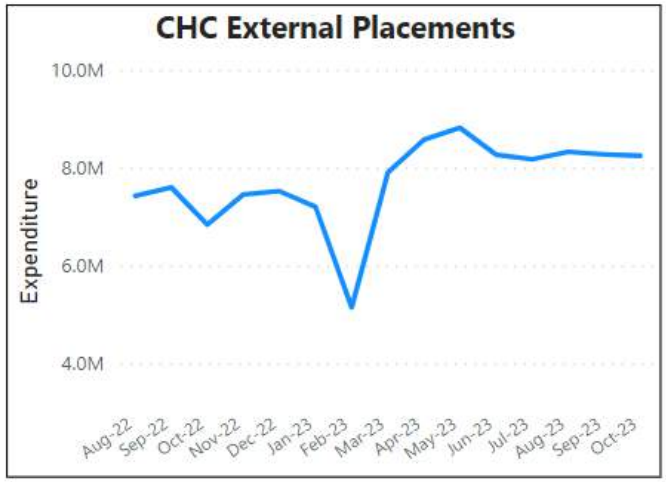












Referral to Treatment (RTT):

Elective activity has significantly reduced as part of the Health Board's Covid-19 planned response. Whilst routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

- Elective Treatments for October '23 was 2,226 (September '23: 2,187, 2022/23 total: 22,327, 2019/20 total: 28,004)

Planned Treatments (M07)					
Treatment	Core	Backfill	WLI	Other	Total
N107-Dermatology	261	0		0	261
N147-ENT	156	0		0	156
N105-General Surgery	308	56		0	364
N146-Oral Surgery	172	12		0	184
N148-Ophthalmology	393	0		0	393
N108-Rheumatology	0	0		0	0
N115-Trauma & Orthopaedics	655	138		0	793
N106-Urology	539	0		0	539
	2,484	206	0	0	2,690

Actual Treatments (M07)					
Treatment	Core	Backfill	WLI	Other	Total
N107-Dermatology	200	26	0	0	226
N147-ENT	134	0	0	0	134
N105-General Surgery	349	38	0	0	387
N146-Oral Surgery	217	0	0	0	217
N148-Ophthalmology	231	0	0	0	231
N108-Rheumatology	0	0	0	0	0
N115-Trauma & Orthopaedics	500	0	0	0	500
N106-Urology	525	6	0	0	531
	2,156	70	0	0	2,226

Treatment Variance (M07)					
Treatment	Core	Backfill	WLI	Other	Total
Derm	(61)	26	0	0	(35)
ENT	(22)	0	0	0	(22)
GS	41	(18)	0	0	23
Max Fax	45	(12)	0	0	33
Ophth	(162)	0	0	0	(162)
Rheum	0	0	0	0	0
T&O	(155)	(138)	0	0	(293)
Urology	(14)	6	0	0	(8)
	(328)	(136)	0	0	(464)

- Outpatient activity for October '23 was 6,229 (September '23: 5,819, 2022/23 total: 65,873, 2019/20 total: 75,707)

Planned Outpatients (M07)					
Outpatient	Core	Backfill	WLI	Other	Total
N107-Dermatology	1,501	0		0	1,501
N147-ENT	716	0		0	716
N105-General Surgery	1,916	0		0	1,916
N146-Oral Surgery	369	40		0	409
N148-Ophthalmology	797	0		0	797
N108-Rheumatology	194	0		0	194
N115-Trauma & Orthopaedics	1,722	307		0	2,029
N106-Urology	518	18		0	536
	7,733	365	0	0	8,098

Actual Outpatients (M07)					
Outpatient	Core	Backfill	WLI	Other	Total
N107-Dermatology	963	0	0	0	963
N147-ENT	573	0	0	0	573
N105-General Surgery	1,639	174	21	0	1,834
N146-Oral Surgery	439	0	3	0	442
N148-Ophthalmology	561	15	0	0	576
N108-Rheumatology	211	0	0	0	211
N115-Trauma & Orthopaedics	1,046	66	0	0	1,112
N106-Urology	491	0	27	0	518
	5,923	255	51	0	6,229

Outpatient Variance (M07)					
Outpatient	Core	Backfill	WLI	Other	Total
Derm	(538)	0	0	0	(538)
ENT	(143)	0	0	0	(143)
GS	(277)	174	21	0	(82)
Max Fax	70	(40)	3	0	33
Ophth	(236)	15	0	0	(221)
Rheum	17	0	0	0	17
T&O	(676)	(241)	0	0	(917)
Urology	(27)	(18)	27	0	(18)
	(1,810)	(110)	51	0	(1,869)

Medicine Outpatients activity for October ’23 was 1,954 (September ’23: 2,023, 2022/23: 19,258):

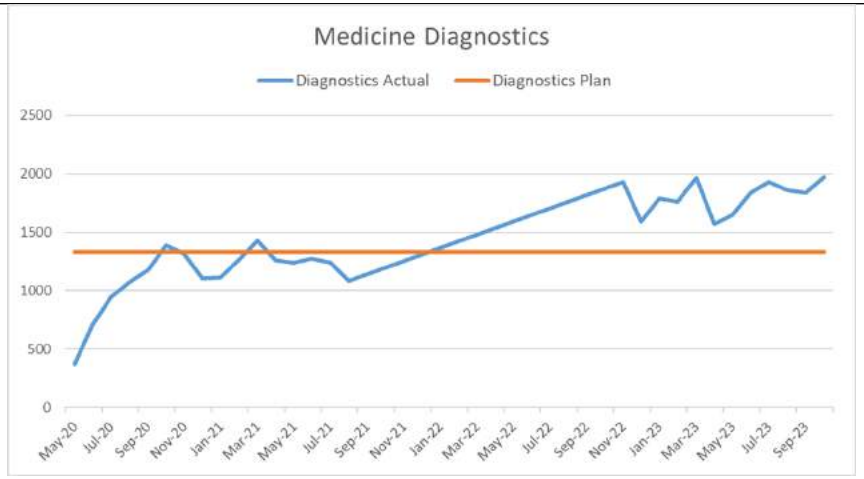
Oct-23

	Assumed monthly activity	Actual activity	Variance
Gastroenterology	475	373	-102
Cardiology	430	466	36
Respiratory (inc Sleep)	455	411	-44
Neurology	257	341	84
Endocrinology	186	143	-43
Geriatric Medicine	313	220	-93
Total	**2116**	**1954**	**-162**

Oct-23

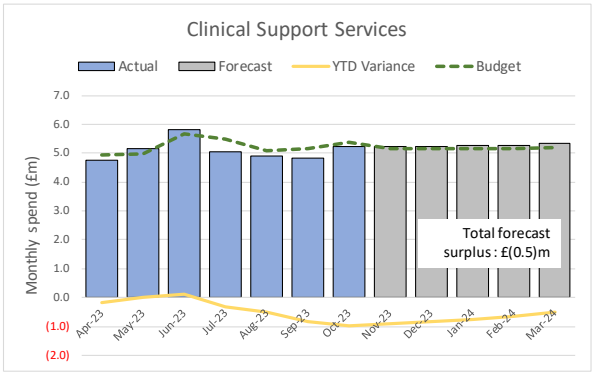
YTD Oct-23	YTD Plan	YTD Actual	Variance
Gastroenterology	3325	2764	-561
Cardiology	3010	3023	13
Respiratory (inc Sleep)	3185	3275	90
Neurology	1799	1969	170
Endocrinology	1302	1168	-134
Geriatric Medicine	2191	1464	-727
Total	**14812**	**13663**	**-1149**

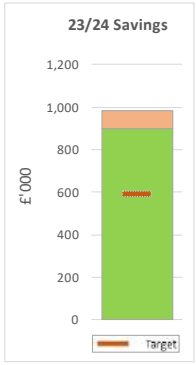
Medicine Diagnostics activity for October ’23 was 1,973 (September ’23: 1,838, 2022/23: 36,246):



YTD October 23	YTD Plan	YTD Actual	Variance	Variance
Endoscopy	9338	12664	3326	-36%
Total	**9338**	**12664**	**3326**	**-36%**

Divisional analysis – Clinical Support Services



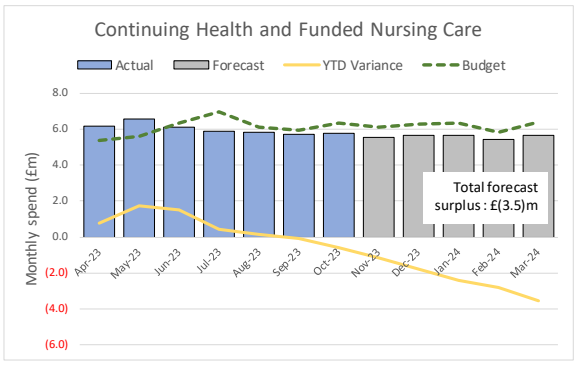


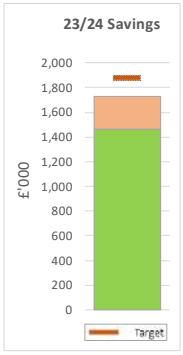
Clinical Support Division reporting a £0.5m forecast surplus

1. Radiology medical pay pressures (vacancy cover/WLIs).
2. Pathology year-to-date underspend linked to scheme slippages

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Clinical Support Services	CSS-01	Generic CIP - Pay	R	IMTP	Red	0	190	0	(190)
Clinical Support Services	CSS-02	Procurement	R	IMTP	Red	0	138	0	(138)
Clinical Support Services	CSS-03	Rostering Efficiencies	R	IMTP	Red	0	139	0	(139)
Clinical Support Services	CSS-04	procurement	R	IMTP	Red	0	21	0	(21)
Clinical Support Services	CSS-05	Generic CIP - Non-Pay	R	IMTP	Red	0	105	0	(105)
Radiology	CSS-06	Radiology - IPFR patients via WhSSC	R	In Year	Green	15	0	50	50
Radiology	CSS-07	Radiology - WHSSC other Commissioning Costs	R	In Year	Red	0	0	0	0
Radiology	CSS-08	Radiology - Reduce Dosage of CT IV Contrast	R	In Year	Green	28	0	50	50
Radiology	CSS-09	Radiology - PICC Line - change of supplier / change of consun	R	In Year	Green	41	0	70	70
Radiology	CSS-10	Radiology - Review Agency Sonographers	R	In Year	Green	15	0	100	100
Radiology	CSS-11	Radiology - Review of overtime CT & MR	R	In Year	Green	15	0	50	50
Radiology	CSS-12	Radiology - Non Pay All Other	R	In Year	Green	41	0	81	81
Pathology	CSS-13	Pathology - Agency Scientist cost reduction	R	In Year	Green	99	0	214	214
Pathology	CSS-14	Pathology - KPI rebates on MSC's - Siemens and Sysmex	NR	In Year	Green	80	0	80	80
Pathology	CSS-15	Pathology - SLA's - Income review	R	In Year	Green	35	0	60	60
Pathology	CSS-16	Pathology - repatriation of tests	R	In Year	Green	12	0	42	42
Pathology	CSS-17	Pathology - DHCW SLA Haemonetics	R	In Year	Green	8	0	13	13
Pathology	CSS-18	Pathology - All Wales Non Pay Procurement scheme	R	In Year	Green	14	0	47	47
Radiology	CSS2	Radiology - Decommission Flouroscopy Equipt NHH - mainte	R	In Year	Amber	0	0	14	14
Radiology	CSS3	Radiology	NR	In Year	Amber	0	0	75	75
Radiology	CSS4	Radiology - restricted GP access MSK scans	R	In Year	Green	7	0	40	40
						409	**593**	**986**	**393**

Divisional analysis – Complex Care



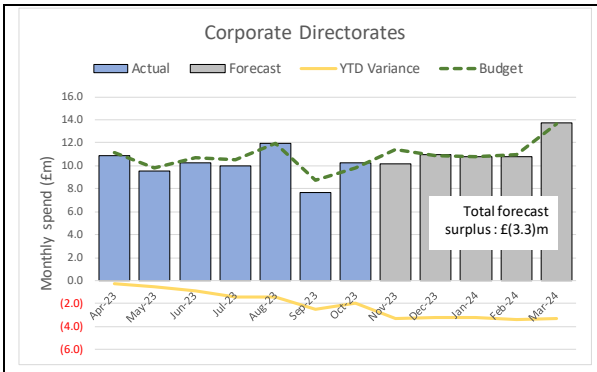


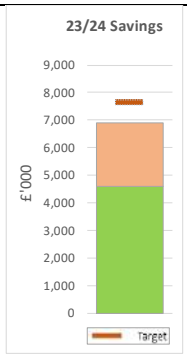
Complex Care Division reporting a £3.5m forecast surplus

1. Reduction in CHC/DTA (£3.6m)
2. Forecast 84 FNC places above plan +£738k
3. Other underspending areas including IRPs (£700k)

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Complex Care	CHC-01	Generic CIP - Pay	R	IMTP	Red	0	34	0	(34)
Complex Care	CHC-02	Rostering Efficiencies	R	IMTP	Red	0	305	0	(305)
Complex Care	CHC-03	Adult CHC Care at home team	R	IMTP	Green	47	100	119	19
Complex Care	CHC-04	Adult CHC high cost packages, 1:1 & chages for hospital visits	R	IMTP	Red	0	100	0	(100)
Complex Care	CHC-05	Adult CHC (balance to NP plan (3m target @40% of spend for	R	IMTP	Red	0	1,000	0	(1,000)
Complex Care	CHC-06	procurement	R	IMTP	Red	0	56	0	(56)
Complex Care	CHC-07	Generic CIP - Non-Pay	R	IMTP	Red	0	288	0	(288)
Complex Care	CHC-08	Right Sizing Commitments	R	In Year	Green	81	0	500	500
Complex Care	CHC-09	Enhanced care working group and panel	R	In Year	Green	83	0	265	265
Complex Care	CHC-10	CHC review assessments	NR	In Year	Green	21	0	41	41
Complex Care	CHC-11	Enhanced care cohort model - TBC	R	In Year	Red	0	0	0	0
Complex Care	CHC-12	CHC placements review	NR	In Year	Green	539	0	539	539
Complex Care	CHC1	Enchanced care	R	In Year	Amber	0	0	195	195
Complex Care	CHC3	Hospital admissions	R	In Year	Amber	0	0	34	34
Complex Care	CHC4	Days after death	R	In Year	Amber	0	0	28	28
Complex Care	CHC5	Deputyship SLA	R	In Year	Amber	0	0	6	6
						771	1,883	1,727	(156)

Divisional analysis – Corporate



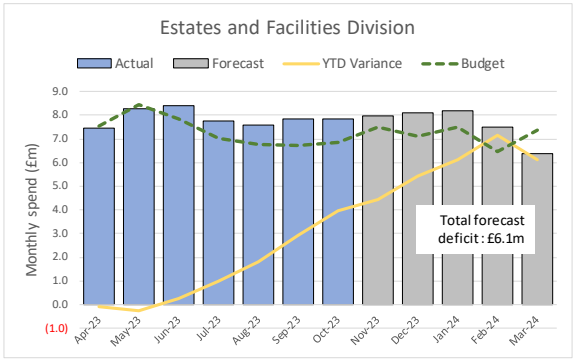


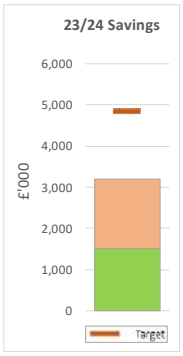
Corporate Directorates reporting a £3.3m forecast surplus

1. Welsh Risk Pool revised estimate (£0.9m pressure)
2. Non-recurrent vacancies providing underspend positions in some areas
3. Forecast unachievement of savings £0.7m
4. Reported surplus within Corporate Directorates currently includes further mitigation actions identified as part of the revised forecast at month 6. These could potentially be shown against other Divisions in future months when plans have been finalised.

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Corporate-ABCi	CORP-01	Generic CIP - Non-Pay	R	IMTP	Red	0	4	0	(4)
Corporate-CEO	CORP-02	Generic CIP - Pay	R	IMTP	Green	76	0	130	130
Corporate-CEO	CORP-03	Review of RIF expenditure	NR	IMTP	Red	0	300	0	(300)
Corporate-CEO	CORP-04	Review of Health protection expenditure	NR	IMTP	Red	0	1,200	0	(1,200)
Corporate-CEO	CORP-05	Generic CIP - Non-Pay	R	IMTP	Green	44	415	203	(212)
Corporate-DirFin	CORP-06	Generic CIP - Pay	R	IMTP	Green	96	46	322	276
Corporate-DirFin	CORP-07	Generic CIP - Non-Pay	R	IMTP	Green	2	5	5	0
Corporate-DirNurs	CORP-08	Generic CIP - Pay	R	IMTP	Red	0	34	0	(34)
Corporate-DirNurs	CORP-09	procurement	R	IMTP	Red	0	1	0	(1)
Corporate-DirNurs	CORP-10	Generic CIP - Non-Pay	R	IMTP	Red	0	6	0	(6)
Corporate-DirOps	CORP-11	Generic CIP - Pay	R	IMTP	Red	0	61	0	(61)
Corporate-DirOps	CORP-12	procurement	R	IMTP	Red	0	2	0	(2)
Corporate-DirOps	CORP-13	Generic CIP - Non-Pay	R	IMTP	Red	0	16	0	(16)
Corporate-DirPCMH	CORP-14	Generic CIP - Pay	R	IMTP	Green	44	2	76	74
Corporate-DirPH	CORP-15	Generic CIP - Pay	R	IMTP	Green	17	33	17	(16)
Corporate-DirPH	CORP-16	Generic CIP - Non-Pay	R	IMTP	Green	8	3	38	35
Corporate-DirPH	CORP-17	Health protection review	NR	IMTP	Green	583	1,000	1,000	(0)
Corporate-DirPH	CORP-18	procurement	R	IMTP	Green	2	1	13	12
Corporate-DirPH	CORP-19	Health protection review	NR	IMTP	Green	1,630	3,000	2,279	(721)
Corporate-DirTher	CORP-20	Generic CIP - Pay	R	IMTP	Green	10	6	58	52
Corporate-DirTher	CORP-21	Generic CIP - Non-Pay	R	IMTP	Green	1	2	6	4
Corporate-DirTher	CORP-22	Rostering Efficiencies	R	IMTP	Red	0	47	0	(47)
Corporate-Governance	CORP-23	Generic CIP - Pay	R	IMTP	Green	7	7	7	0
Corporate-Governance	CORP-24	Generic CIP - Non-Pay	R	IMTP	Red	0	2	0	(1)
Corporate-Litig	CORP-25	Generic CIP - Non-Pay	R	IMTP	Red	0	11	0	(11)
Corporate-Litig	CORP-26	procurement	R	IMTP	Red	0	2	0	(2)
Corporate-MedDir	CORP-27	Generic CIP - Pay	R	IMTP	Green	11	19	19	0
Corporate-MedDir	CORP-28	Generic CIP - Non-Pay	R	IMTP	Green	6	10	10	0
Corporate-PlanICT	CORP-29	Generic CIP - Pay	R	IMTP	Red	0	77	0	(77)
Corporate-PlanICT	CORP-30	procurement	R	IMTP	Green	66	113	113	0
Corporate-PlanICT	CORP-31	Generic CIP - Non-Pay	R	IMTP	Red	0	63	0	(63)
Corporate-WOD	CORP-32	Generic CIP - Pay	R	IMTP	Green	130	43	222	179
Corporate-WOD	CORP-33	procurement	R	IMTP	Green	4	6	6	0
Corporate-WOD	CORP-34	Generic CIP - Non-Pay	R	IMTP	Green	25	43	43	(0)
Corporate-DirOps	CORP-35	NEPT & INTERSITE	R	IMTP	Red	0	1,000	0	(1,000)
Corporate-Plan	CORP-36	Generic CIP - Non-Pay	R	IMTP	Green	12	20	20	0
Corporate-Plan	CORP-37	Generic CIP - Pay	R	IMTP	Green	14	25	25	0
Corporate-DirOps	FAC-41	Reduced Bed Capacity	R	In Year	Amber	0	0	2,250	2,250
Corporate - CAPITAL CHARGE	CAP1	Disposal of unused equipment	NR	In Year	Amber	0	0	50	50
						2,788	**7,623**	**6,912**	**(711)**

Divisional analysis – Estates & Facilities



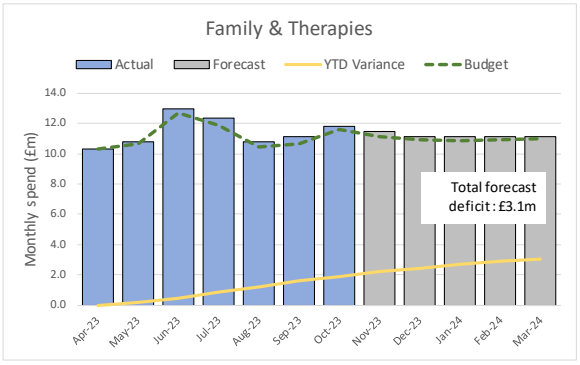


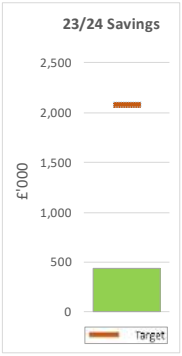
Estates and facilities Division reporting a £6.1m forecast deficit

1. Forecast unachievement of savings £1.6m
2. Energy forecast £4.4m underspend (excl. Decarb savings)
3. Covid legacy Enhanced Cleaning, security, portacabin £7.4m
4. Other items £0.5m including waste and E block flood
5. Bed contract £0.8m

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Estates and Facilities	ESF-01	Generic CIP - Pay	R	IMTP	Red	0	161	0	(161)
Estates and Facilities	ESF-02	Parking	R	IMTP	Green	123	210	210	0
Estates and Facilities	ESF-03	Procurement	R	IMTP	Green	10	40	27	(13)
Estates and Facilities	ESF-04	Rostering Efficiencies	R	IMTP	Amber	0	642	107	(535)
Estates and Facilities	ESF-05	estates and facilities strategy	R	IMTP	Red	0	170	0	(170)
Estates and Facilities	ESF-06	Decarbonisation	R	IMTP	Green	582	1,000	1,000	(1)
Estates and Facilities	ESF-08	Estates Opps / leases (running costs)	R	IMTP	Red	0	1,000	0	(1,000)
Estates and Facilities	ESF-09	procurement	R	IMTP	Red	0	181	0	(181)
Estates and Facilities	ESF-10	Estates and Facilities avoid agency premiums (50%)	R	IMTP	Amber	0	1,095	273	(822)
Estates and Facilities	ESF-11	Generic CIP - Non-Pay	R	IMTP	Red	0	340	0	(340)
Estates and Facilities	ESF-12	Rates Rebates	NR	In Year	Amber	0	0	754	754
Estates and Facilities	FAC-02	Pod-point chargers	R	In Year	Green	1	0	4	4
Estates and Facilities	FAC-03	Catering Subsidy Removal	R	In Year	Amber	0	0	117	117
Estates and Facilities	FAC-04	Hot Vending	R	In Year	Green	2	0	14	14
Estates and Facilities	FAC-12	Security @ GUH	R	In Year	Red	0	0	0	0
Estates and Facilities	FAC-13	Security @ NHH	R	In Year	Red	0	0	0	0
Estates and Facilities	FAC-14	Security @ STC	R	In Year	Red	0	0	0	0
Estates and Facilities	FAC-15	Security @ RGH	R	In Year	Red	0	0	0	0
Estates and Facilities	FAC-17	Enhanced Cleaning - reduced WTE's	R	In Year	Green	20	0	170	170
Estates and Facilities	FAC-22	GUH Carparking	R	In Year	Green	6	0	38	38
Estates and Facilities	FAC-23	All Wales Buying Group Credit for sale of energy procured	NR	In Year	Amber	0	0	423	423
Estates and Facilities	FAC-24	NCC Parking - Kingsway & Park Square	R	In Year	Green	6	0	39	39
Estates and Facilities	FAC-28	Window Cleaning	R	In Year	Green	3	0	15	15
Estates and Facilities	FAC1	GUH OOH Catering	R	In Year	Amber	0	0	0	0
Estates and Facilities	FAC29	Removal of water coolers	R	In Year	Amber	0	0	2	2
						753	**4,840**	**3,193**	**(1,647)**

Divisional analysis – Family & Therapies



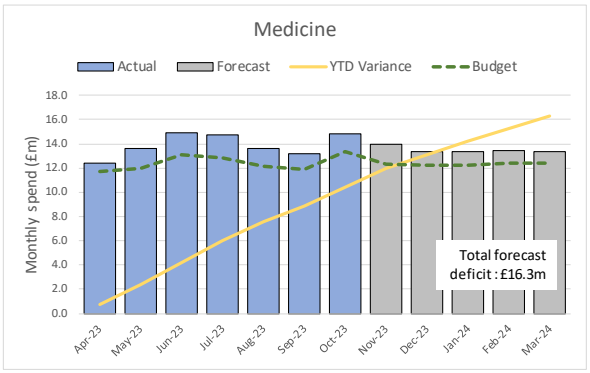


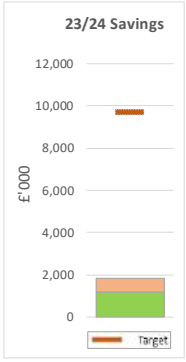
Family & Therapies Division reporting a £3.1m forecast deficit

1. Forecast unachievement of savings £1.6m
2. CHC out of county placements £1m
3. Other operational pressures off-set by operational benefits (e.g. therapies)

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Families and Therapies	FAT-01	Generic CIP - Pay	R	IMTP	Green	124	558	211	(347)
Families and Therapies	FAT-02	BADS	R	IMTP	Red	0	25	0	(25)
Families and Therapies	FAT-03	Outpatient transformation (F2F and Virtual)	R	IMTP	Red	0	93	0	(93)
Families and Therapies	FAT-04	Outpatient transformation (New to Follow Up ratio)	R	IMTP	Red	0	134	0	(134)
Families and Therapies	FAT-05	Procurement	R	IMTP	Red	0	25	0	(25)
Families and Therapies	FAT-06	Rostering Efficiencies	R	IMTP	Green	96	1,021	164	(857)
Families and Therapies	FAT-07	Medicines management	R	IMTP	Green	21	50	30	(20)
Families and Therapies	FAT-08	procurement	R	IMTP	Red	0	72	0	(72)
Families and Therapies	FAT-09	Generic CIP - Non-Pay	R	IMTP	Red	0	96	0	(96)
Families and Therapies	FAT-10	ABUHB Exec decision to cease Flexible Rewards from end of	R	In Year	Green	7	0	26	26
Families and Therapies	FAT-11	Medicines management (VRIII Fluids - supplier Switch)	R	In Year	Green	0	0	1	1
						249	**2,074**	**432**	**(1,641)**

Divisional analysis – Medicine



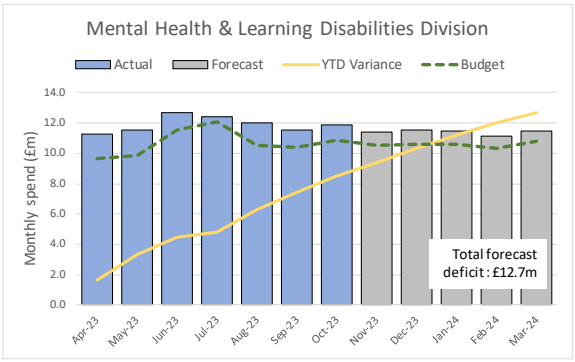


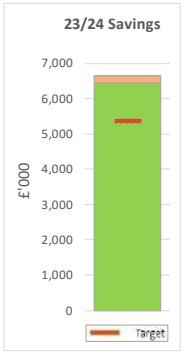
Medicine Division reporting a £16.3m forecast deficit

1. Un-achieved savings forecast £7.9m
2. YYF SDEC - £0.7m
3. Non-pay - £3.9m
4. Drugs/IVIG - £90k
5. Operational nursing pressures above savings unachieved £0.8m
6. Operational medical pressures £4.9m

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Medicine	MED-01	Generic CIP - Pay	R	IMTP	Green	12	516	42	(474)
Medicine	MED-02	Outpatient transformation (F2F and Virtual)	R	IMTP	Red	0	95	0	(95)
Medicine	MED-03	Outpatient transformation (New to Follow Up ratio)	R	IMTP	Red	0	656	0	(656)
Medicine	MED-04	Beds (1 ward Med)	R	IMTP	Red	0	2,223	0	(2,223)
Medicine	MED-05	Procurement	R	IMTP	Amber	0	25	14	(12)
Medicine	MED-06	Rostering Efficiencies	R	IMTP	Green	394	738	914	177
Medicine	MED-07	Insourcing review	R	IMTP	Red	0	1,066	0	(1,066)
Medicine	MED-08	Medicines management	R	IMTP	Green	60	150	125	(25)
Medicine	MED-09	procurement	R	IMTP	Green	62	35	77	42
Medicine	MED-10	Slippage in spend regional eyes / endo / path	NR	IMTP	Red	0	4,000	0	(4,000)
Medicine	MED-11	Generic CIP - Non-Pay	R	IMTP	Amber	0	184	89	(95)
Medicine	Med-12	Green Schemes - Drugs MED 12 & MED 13	R	In Year	Red	0	0	0	0
Medicine	Med-13	Green Sheme - Medical MED 05 & MED 19	R	In Year	Amber	0	0	104	104
Medicine	Med-14	Green Schemes - Non Pay Wound Clinic REF MED-06	R	In Year	Green	4	0	25	25
Medicine	Med-15	Green Schemes - Income Spy Glass MED-07	R	In Year	Amber	0	0	70	70
Medicine	Med-16	Green Scheme - Virtual Outliers	R	In Year	Amber	0	0	120	120
Medicine	Med-22	Green Scheme - HCRU	R	In Year	Amber	0	0	250	250
						532	**9,688**	**1,830**	**(7,858)**

Divisional analysis – Mental Health and Learning Disabilities



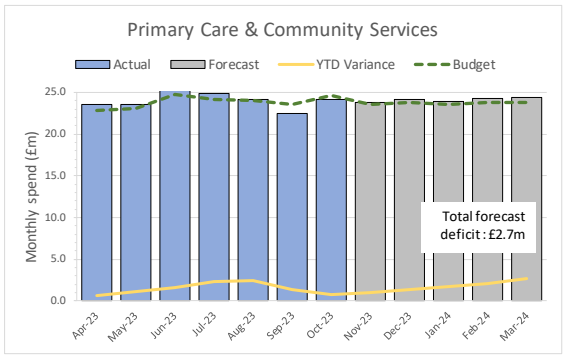


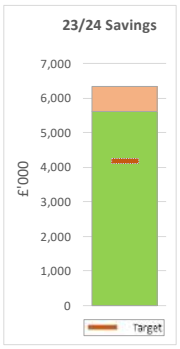
Mental Health & LD Division reporting a £12.7m forecast deficit

1. CHC Fees increases (12%) greater than IMTP assumption (6%)
2. Service Improvement funding assumptions £5m deficit to forecast
3. Ward pressures & medical cover forecast £5.7m

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Mental Health and Learning Disabilities	MHLD-01	Generic CIP - Pay	R	IMTP	Red	0	107	0	(107)
Mental Health and Learning Disabilities	MHLD-01a	MH Adults - Reduction of agency costs due to appointment o	R	IMTP	Green	20	142	122	(20)
Mental Health and Learning Disabilities	MHLD-01b	OAMH - Reduction in LT Med Agency due to successful recrui	R	IMTP	Green	29	50	50	0
Mental Health and Learning Disabilities	MHLD-01c	Flexi rewards ceasing	R	IMTP	Red	0	9	0	(9)
Mental Health and Learning Disabilities	MHLD-02	Generic CIP - Non-Pay	R	IMTP	Red	0	0	0	0
Mental Health and Learning Disabilities	MHLD-02a	Maximise ECT Income generation from private patient referr	R	IMTP	Green	41	70	70	0
Mental Health and Learning Disabilities	MHLD-02b	PCMHS Counselling commissioning	R	IMTP	Green	17	218	100	(118)
Mental Health and Learning Disabilities	MHLD-02c	SLA Recovery works & Sanctuary	NR	IMTP	Green	166	0	285	285
Mental Health and Learning Disabilities	MHLD-03	Rostering Efficiencies	R	IMTP	Red	0	562	0	(562)
Mental Health and Learning Disabilities	MHLD-04	MH CHC - LD	R	IMTP	Red	0	922	0	(922)
Mental Health and Learning Disabilities	MHLD-05	MH CHC High cost packages	R	IMTP	Green	33	250	200	(50)
Mental Health and Learning Disabilities	MHLD-06	MH Older Adults Beds	R	IMTP	Red	0	206	0	(206)
Mental Health and Learning Disabilities	MHLD-06a	OAMH - Capped beds on Annwylfan (YYF) resulting in lower v	R	IMTP	Green	30	150	30	(120)
Mental Health and Learning Disabilities	MHLD-07	Review of Mental Health expenditure	NR	IMTP	Red	0	2,000	0	(2,000)
Mental Health and Learning Disabilities	MHLD-08	MH CHC (balance to NP plan (3m target @60% of spend for M	R	IMTP	Red	0	628	0	(628)
Mental Health and Learning Disabilities	MHLD-09	procurement	R	IMTP	Red	0	55	0	(55)
Mental Health and Learning Disabilities	MHLD-10	CHC Eligibility Reviews	R	In Year	Green	105	0	367	367
Mental Health and Learning Disabilities	MHLD-11	CHC Repatriations to in house wards	R	In Year	Green	503	0	1,104	1,104
Mental Health and Learning Disabilities	MHLD-12	CHC Right Size Packages	R	In Year	Green	130	0	306	306
Mental Health and Learning Disabilities	MHLD-13	CHC Step Down	R	In Year	Green	284	0	601	601
Mental Health and Learning Disabilities	MHLD-14	CHC Change in Need	R	In Year	Green	478	0	1,142	1,142
Mental Health and Learning Disabilities	MHLD-15	Structured Clinical Management	R	In Year	Amber	0	0	157	157
Mental Health and Learning Disabilities	MHLD-16	Paliperidone HC FYE	R	In Year	Green	61	0	111	111
Mental Health and Learning Disabilities	MHLD-17	Paliperidone Non HC FYE	R	In Year	Green	51	0	88	88
Mental Health and Learning Disabilities	MHLD-18	Clozapine repatriation FYE	R	In Year	Green	39	0	71	71
Mental Health and Learning Disabilities	MHLD-19	Clozapine price reduction	R	In Year	Green	3	0	6	6
Mental Health and Learning Disabilities	MHLD-20	Flexi Rewards Ceasing	R	In Year	Green	86	0	301	301
Mental Health and Learning Disabilities	MH2	Step 9 People Down From Secure Placements	R	In Year	Green	99	0	479	479
Mental Health and Learning Disabilities	MH3	Repatriate Individuals From OOA And In House Placements	R	In Year	Green	13	0	75	75
Mental Health and Learning Disabilities	MH6	Review SIF SLAs	NR	In Year	Green	117	0	200	200
Mental Health and Learning Disabilities	MH10	Review secure transport options	R	In Year	Amber	0	0	15	15
Mental Health and Learning Disabilities	MH11	Flexi Rewards Ceasing	R	In Year	Red	0	0	0	0
Mental Health and Learning Disabilities	MH4	West Sussex Dispute	NR	In Year	Green	124	0	742	742
Mental Health and Learning Disabilities	MH12	Non Pay Reduction	R	In Year	Amber	0	0	10	10
						2,428	**5,369**	**6,631**	**1,262**

Divisional analysis – Primary Care and Community



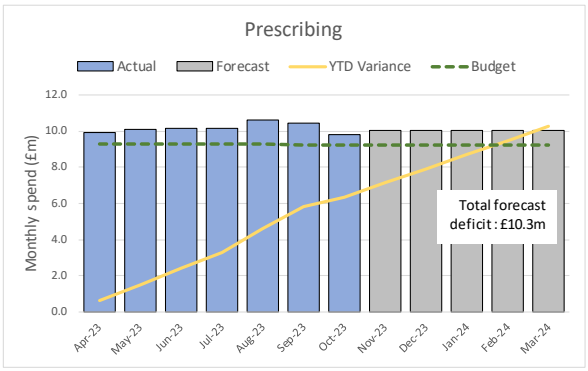


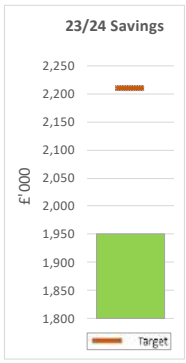
Primary Care & Comm. Division reporting a £2.7m forecast deficit

1. GMS underspend due to reduction in Dispensing Doctors fees
2. Managed Practices pressure due to additional practice (now 5) increased sessional rates and additional locum/agency support.
3. On-going community Hospitals (nursing) pressure
4. Further pressures in EHEW, Palliative Care and GPOOH

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Primary Care and Community	PCC-01	Generic CIP - Pay	R	IMTP	Green	200	278	278	0
Primary Care and Community	PCC-02	Generic CIP - Non-Pay	R	IMTP	Green	193	291	291	0
Primary Care and Community	PCC-04	Beds (1 ward Community)	R	IMTP	Red	0	2,223	0	(2,223)
Primary Care and Community	PCC-05	Procurement	R	IMTP	Amber	0	85	5	(80)
Primary Care and Community	PCC-06	Rostering Efficiencies	R	IMTP	Red	0	1,008	0	(1,008)
Primary Care and Community	PCC-08	Managed practices	R	IMTP	Green	100	100	100	0
Primary Care and Community	PCC-10	procurement	R	IMTP	Red	0	185	0	(185)
Primary Care and Community	PCC-11	LOE - Apixaban	R	In Year	Green	533	0	2,103	2,103
Primary Care and Community	PCC-12	LOE - Sitagliptin	R	In Year	Green	81	0	186	186
Primary Care and Community	PCCS11	Reduce Face To Face CPD Cost	NR	In Year	Green	6	0	15	15
Primary Care and Community	PCCS17	Bank MV HCSW	NR	In Year	Amber	0	0	26	26
Primary Care and Community	PCCS18	Bank & Agency CCH Registered Nurses	NR	In Year	Amber	0	0	48	48
Primary Care and Community	PCCS19	Reduce Non Pay Monnow Vale Ward	NR	In Year	Amber	0	0	7	7
Primary Care and Community	PCCS2	NCN Development Programme Manager No Backfill	NR	In Year	Green	6	0	37	37
Primary Care and Community	PCCS20	Non-Pay Cas Gwent	NR	In Year	Amber	0	0	17	17
Primary Care and Community	PCCS21	Non Pay DNS	NR	In Year	Amber	0	0	8	8
Primary Care and Community	PCCS3	Dental Professional Collaborative On Hold	NR	In Year	Green	8	0	25	25
Primary Care and Community	PCCS36	GMS IT Services	NR	In Year	Green	19	0	33	33
Primary Care and Community	PCCS37	GMS Improvement Grants	NR	In Year	Green	158	0	270	270
Primary Care and Community	PCCS4	Uncommitted SPPC Funding	NR	In Year	Amber	0	0	27	27
Primary Care and Community	PCCS45	Withdraw Band 7 Advert PC Contracting Team	NR	In Year	Green	14	0	37	37
Primary Care and Community	PCCS58	Remove Band 3 Admin Post Newport	NR	In Year	Green	8	0	20	20
Primary Care and Community	PCCS6	Hold Current SPCC Vacancy Band 4	NR	In Year	Amber	0	0	10	10
Primary Care and Community	PCCS7	Reduce Spend On SPCC Promotion	NR	In Year	Green	2	0	5	5
Primary Care and Community	PCCS8	Delay Recruitment Of Band 8A Academy Nurse	NR	In Year	Green	7	0	20	20
Primary Care and Community	PCCS9	Delay Recruitment Of Lead Pharmacist for academy	NR	In Year	Green	7	0	21	21
Primary Care and Community	PCCS1	NCN Academy Funding	NR	In Year	Green	50	0	175	175
Primary Care and Community	PCCS10	Amendment to ANP Programme	NR	In Year	Amber	0	0	9	9
Primary Care and Community	PCCS26	GMS LES Additional Clinics	NR	In Year	Green	40	0	139	139
Primary Care and Community	PCCS30	GDS UDA Clawback 22/23	NR	In Year	Green	282	0	282	282
Primary Care and Community	PCCS32	GDS CR Clawback 22/23	NR	In Year	Green	1,187	0	1,187	1,187
Primary Care and Community	PCCS67	Review ONN Overnight vehicle hire	NR	In Year	Amber	0	0	16	16
Primary Care and Community	PCCS69	Reduce GP & Nurse mobiles	NR	In Year	Green	3	0	18	18
Primary Care and Community	PCCS33	GDS CR Clawback 23/24	NR	In Year	Amber	0	0	200	200
Primary Care and Community	PCCS12	UPC To Support Sustainability	NR	In Year	Amber	0	0	21	21
Primary Care and Community	PCCS14	Additional Managed Practice to Independent Status	NR	In Year	Amber	0	0	28	28
Primary Care and Community	PCCS38	WG Improvement Grant	NR	In Year	Green	5	0	29	29
Primary Care and Community	PCCS73	Review Current Workforce In Managed Practies	NR	In Year	Green	28	0	28	28
Primary Care and Community	PCCS51	Specials And Liquid Preps Review	NR	In Year	Green	1	0	5	5
Primary Care and Community	PCCS52	ONPOS/NWOS Expanded To GP Surgeries	NR	In Year	Green	3	0	16	16
Primary Care and Community	PCCS59	Non Pay Stock Review	NR	In Year	Amber	0	0	50	50
Primary Care and Community	PCCS76	District Nursing Variation	NR	In Year	Amber	0	0	83	83
Primary Care and Community	PCCS78	Community Wards Variation	NR	In Year	Amber	0	0	175	175
Primary Care and Community	PCCS13	Merge Telephone Contracts In Managed Practices	NR	In Year	Amber	0	0	3	3
Primary Care and Community	PCCS79	Flexi rewards saving	NR	In Year	Green	33	0	200	200
Primary Care and Community	PCCS77	Reduce Variation In Managed Practices	NR	In Year	Green	6	0	89	89
						2,978	**4,170**	**6,341**	**2,171**

Divisional analysis – Prescribing



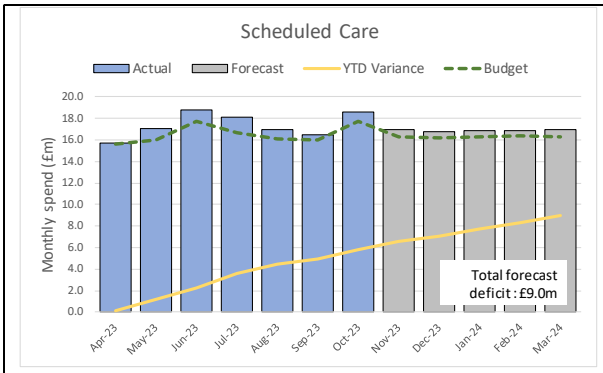


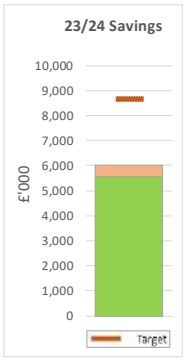
The full year Prescribing forecast overspend is £10.3m

1. Savings unachievement forecast £0.3m
2. Average cost per item: £7.52 for the year
3. Underlying growth assumed at 0.8% above 2022/23 item numbers
This growth equates to 1.4m items
4. Actual 2022/23 growth 1.88%
5. On-going effect of 56-day prescribing

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Prescribing	PCC-03	Generic CIP - Non-Pay	R	IMTP	Green	343	435	435	0
Prescribing	PCC-07	Medicines management	R	IMTP	Green	462	1,125	1,125	0
Prescribing	PCC-09	Medicines management	R	IMTP	Green	283	650	391	(259)
						1,088	**2,210**	**1,951**	**(259)**

Divisional analysis – Scheduled Care





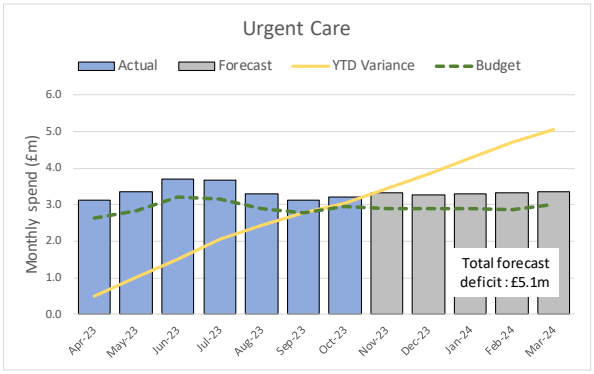
Scheduled care division is currently reporting a forecast overspend for year-end of £9.0m.

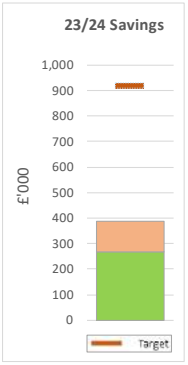
The key reasons for this forecast position are as follows:

1. Un-achieved savings target £2.6m
2. D7E open for the full year £700k
3. T&O backfill costs (net of WLI reduction) £2.2m
4. Additional activity costs £1.1m
5. Plus further variable and operational pressures for review

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Scheduled Care	SCH-01	Generic CIP - Pay	R	IMTP	Red	0	703	0	(703)
Scheduled Care	SCH-02	BADS	R	IMTP	Red	0	478	0	(478)
Scheduled Care	SCH-03	RTT WLI	R	IMTP	Green	1,111	2,296	2,011	(285)
Scheduled Care	SCH-04	RTT Backfill	R	IMTP	Green	91	962	91	(871)
Scheduled Care	SCH-05	Outpatient transformation (F2F and Virtual)	R	IMTP	Red	0	1,490	0	(1,490)
Scheduled Care	SCH-06	Outpatient transformation (New to Follow Up ratio)	R	IMTP	Red	0	277	0	(277)
Scheduled Care	SCH-07	SAU rostering	R	IMTP	Red	0	155	0	(155)
Scheduled Care	SCH-08	Procurement	R	IMTP	Red	0	586	0	(586)
Scheduled Care	SCH-08a	Procurement - Ophthalmology B&L theatre consumables	R	IMTP	Amber	0	38	21	(17)
Scheduled Care	SCH-08b	Procurement - Stryker Pricing review	R	IMTP	Amber	0	72	40	(32)
Scheduled Care	SCH-09	Rostering Efficiencies	R	IMTP	Green	878	895	1,243	348
Scheduled Care	SCH-09a	Ortho Geriatric variable pay saving	R	IMTP	Amber	0	48	30	(18)
Scheduled Care	SCH-10	Medicines management	R	IMTP	Green	430	150	880	730
Scheduled Care	SCH-11	procurement	R	IMTP	Red	0	166	0	(166)
Scheduled Care	SCH-12	Generic CIP - Non-Pay	R	IMTP	Red	0	317	0	(317)
Scheduled Care	SCH11	Stop backfill	NR	In Year	Green	46	0	46	46
Scheduled Care	SCH2	Christmas shutdown of elective activity	NR	In Year	Amber	0	0	50	50
Scheduled Care	SCH23	Retinue accruals hold for 3 months not 6 months	NR	In Year	Green	111	0	111	111
Scheduled Care	SCH6	Nursing - Reduction of flexible rewards for agency / bank	R	In Year	Green	158	0	700	700
Scheduled Care	SCH13	Non-uk resident patient spend target	NR	In Year	Green	9	0	61	61
Scheduled Care	SCH12	Purchasing off frameworks	R	In Year	Amber	0	0	42	42
Scheduled Care	SCH22	Switch all patients from originator drugs to biosimilar	NR	In Year	Green	58	0	348	348
Scheduled Care	SCH24	Rationalisation of Uni Knee and removing Zimmer	R	In Year	Amber	0	0	8	8
Scheduled Care	SCH9	Limit value of study leave with a cap	NR	In Year	Green	1	0	5	5
Scheduled Care	SCH3	Medical staff agency spend reduction	NR	In Year	Green	8	0	50	50
Scheduled Care	SCH NEW	Specialist Rates ITU / Theatres	NR	In Year	Amber	0	0	268	268
						2,901	**8,634**	**6,004**	**(2,630)**

Divisional analysis – Urgent Care



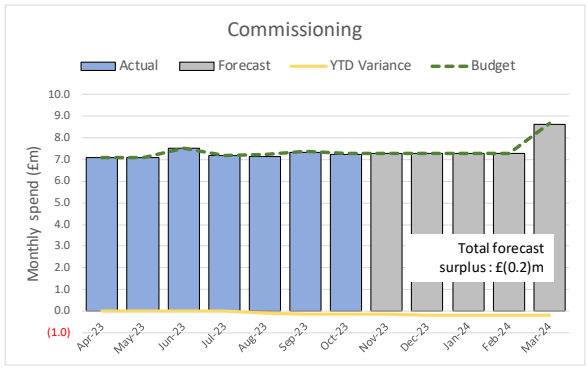


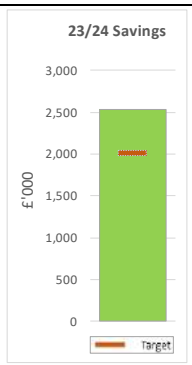
Urgent Care Division reporting a £5.1m forecast deficit

1. ED Middle grade cover and consultant sessions (£2.1m pressure)
2. Nursing vacancy premium (£2.7m)
3. SATU - £0.2m
4. MIU opening times savings assumed unachieveable - £0.4m
5. Drugs pressure - £0.1m

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Urgent care	URG-01	Generic CIP - Pay	R	IMTP	Green	84	198	144	(54)
Urgent care	URG-02	Procurement	R	IMTP	Amber	0	25	19	(6)
Urgent care	URG-03	Rostering Efficiencies	R	IMTP	Green	20	170	53	(117)
Urgent care	URG-04	Reduce opening times of MIU	R	IMTP	Amber	0	500	100	(400)
Urgent care	URG-05	procurement	R	IMTP	Amber	0	4	2	(2)
Urgent care	URG-06	Generic CIP - Non-Pay	R	IMTP	Green	5	22	22	0
Urgent care	UC-01	Hold Rectuiting Assistant PFCs	R	In Year	Green	10	0	26	26
Urgent care	UC-02	Hold Flow Centre Manager Recruitment	R	In Year	Green	9	0	23	23
						128	**919**	**389**	**(530)**

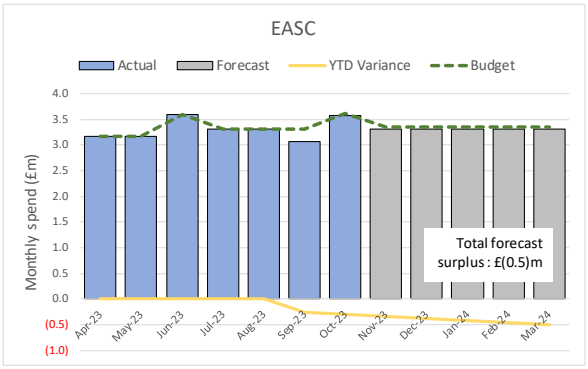
Divisional analysis – External Commissioning / WHSSC / EASC

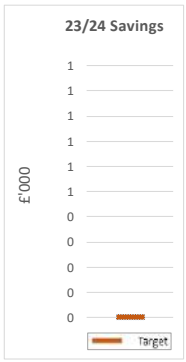




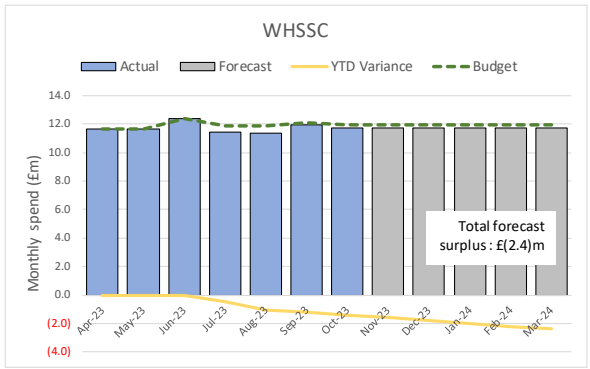
Cwm Taf LTA is subject to a significant reduction in delivery of c.2000 treatments as this has been the profile of delivery over recent years and is not expected to recover.

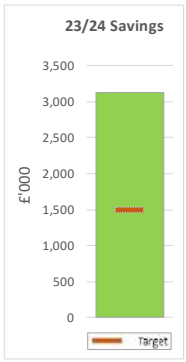
Savings exceeding target due to renegotiation of Velindre LTA





EASC currently reporting £0.5m slippage against plan





WHSSC reporting a forecast underspend of £2.4m in line with agreed WHSSC position

Division	Savings Scheme Number	Scheme / Opportunity	R/NR	IMTP v In Year scheme	Scheme RAG rating	YTD	Full year		
						Achieved £'000	Plan £'000	Forecast £'000	Variance £'000
Contracting and Commissioning	CON-01	External Contracts	R	IMTP	Green	1,167	2,000	2,000	0
Contracting and Commissioning	CON-02	External Contracts	R	In year	Green	193	0	331	331
Contracting and Commissioning	CON-03	External Contracts	NR	In year	Green	109	0	207	207
WHSSC	WHC-01	WHSSC 1% pathways savings	R	IMTP	Red	0	1,363	0	(1,363)
WHSSC	WHC-01a	WHSSC 1% pathways savings	R	IMTP	Green	138	138	138	1
WHSSC	WHC-02	WHSSC 10-20-30% savings	NR	In Year	Green	323	0	554	554
WHSSC	WHC-03	WHSSC Integrated Commissioning Plan Savings	NR	In Year	Green	1,420	0	2,434	2,434
						3,350	**3,500**	**5,664**	**2,164**

National Covid-19 Funding Assumptions

The Health Board has received £5.878m of funding relating to Covid-19 schemes. Anticipated WG funding for Covid-19 is listed below;

Type	Covid-19 Specific allocations - October 2023	£'000
HCHS	Nosocomial Covid 19 cases - Investigation and learning	753
HCHS	C19 PPE (Q1+Q2)	603
HCHS	C19 Health Protection (Q1+Q2)	2,446
HCHS	C19 Vaccination programme (Q1+Q2)	1,676
GMS	GMS Covid19 Vaccinations Q2	400
	Total Confirmed Covid-19 Allocations	**5,878**
HCHS	Adferiad Programme	1,216
HCHS	C19 Vaccination programme	6,024
HCHS	C19 Health Protection	2,354
HCHS	C19 PPE	797
	Total Anticipated Covid-19 Allocations	**10,391**
	Total Covid-19 Allocations	**16,270**

In addition, legacy costs for areas such as enhanced cleaning, security, portacabins continue and provide a significant forecast pressure for 2023/24 (forecast c.£7.4m).

Reserves

7769-ALLOCATIONS TO BE DELEGATED

Confirmed or Anticipated	R / NR	Description	23/24
Confirmed	NR	Regional Planned Care funding-Opthalmology	2,500,000
Confirmed	NR	Regional Planned Care funding-Diagnostics	3,540,000
Confirmed	NR	Planned Care Transformation and Recovery	1,000,000
50% confirmed 50% anticipated	NR	Trans Funding-Outpatient Transformation Unit	202,919
50% confirmed	NR	Trans Funding-Medical retina	81,607
£290k Confirmed	NR	PPE 23-24	1,005,939
Central income	NR	Training Grade Salary and PGMDE	(3,819)
Confirmed	NR	Clinical Leads SLA SP Planned Care Q1 Q2	23,319
Confirmed	R	Building Capacity Community Care-Further, Faster	1,580,000
Confirmed	NR	Vertex months 1 to 6	3,666,242
		Confirmed Allocations to be apportioned	**13,596,207**

7788-COMMITMENTS TO BE DELEGATED

Description	23/24
Innovation and Development Fund (£10m)	461,312
Total Commitments	**461,312**

7501-SUPPORTING FINANCIAL POSITION

Description	23/24
WG funding allocations and reserves previously held for allocation risk and inflation, retained within reserves to support the financial deficit position	16,962,774
Total Commitments	**16,962,774**

7515-IMTP 23/24 DEFICIT

Description			23/24
	R	23/24 recurrent deficit	(112,848,200)
		Additional funding 23-24	
Confirmed	NR	Underlying deficit	28,800,000
Confirmed	NR	Inflationary uplift (conditional recurrrent)	35,700,000
Confirmed	NR	Inflationary uplift (non-recurrrent)	14,400,000
Anticipated	NR	Energy	9,500,000
Total Commitments			**(24,448,200)**

Totals **6,572,093**

Reserves Delegation:

A number of confirmed and anticipated allocations have remained in reserves for month 7 reporting (£13.6m). This funding will be reviewed by the Executive Team to determine whether it is appropriate to delegate to Divisions in the context of the budget setting methodology for 23/24 and the Health Board deficit.

A total of £9.8m was approved and delegated into Divisional positions from reserves in month 7. Significant delegations in-month were:

- ***WAST Mobile Data Vehicle Solutions £186k*** *– Delegate to EASC in line with funding letter and EASC plan (NR)*
- ***WAST ESMCP Resources 23-24 £90k*** *– Delegate to EASC in line with funding letter and EASC plan (NR)*
- ***WAST Control Room Solutions 23-24 £258k*** *– Delegate to EASC in line with funding letter and EASC plan (NR)*
- ***Medical and Dental pay award £6.3m*** *– Pay award actioned in October, backdated to April 23. Anticipate WG funding for £6.3m, and delegate to Divisions as per the CMA analysis taken from payroll. (R)*
- ***Training Grade Salary and PGMDE £680k*** *–Increase central income budget in line with HEIW revised income schedule received October 23, and delegate corresponding budget to Divisions as per HEIW detailed analysis. (R)*
- ***DPIF Video Consultations £1.2m*** *– Funding confirmed via WG letter to cover period April to December 23. Delegate to CEO in line with YTD spend and forecast (NR)*
- ***Innovation fund to Cardiology £1.066m –*** *Recognised in the forecast position within reserves at month 6 as agreed by the Executive team. Delegate to Medicine for month 7 reporting (R)*

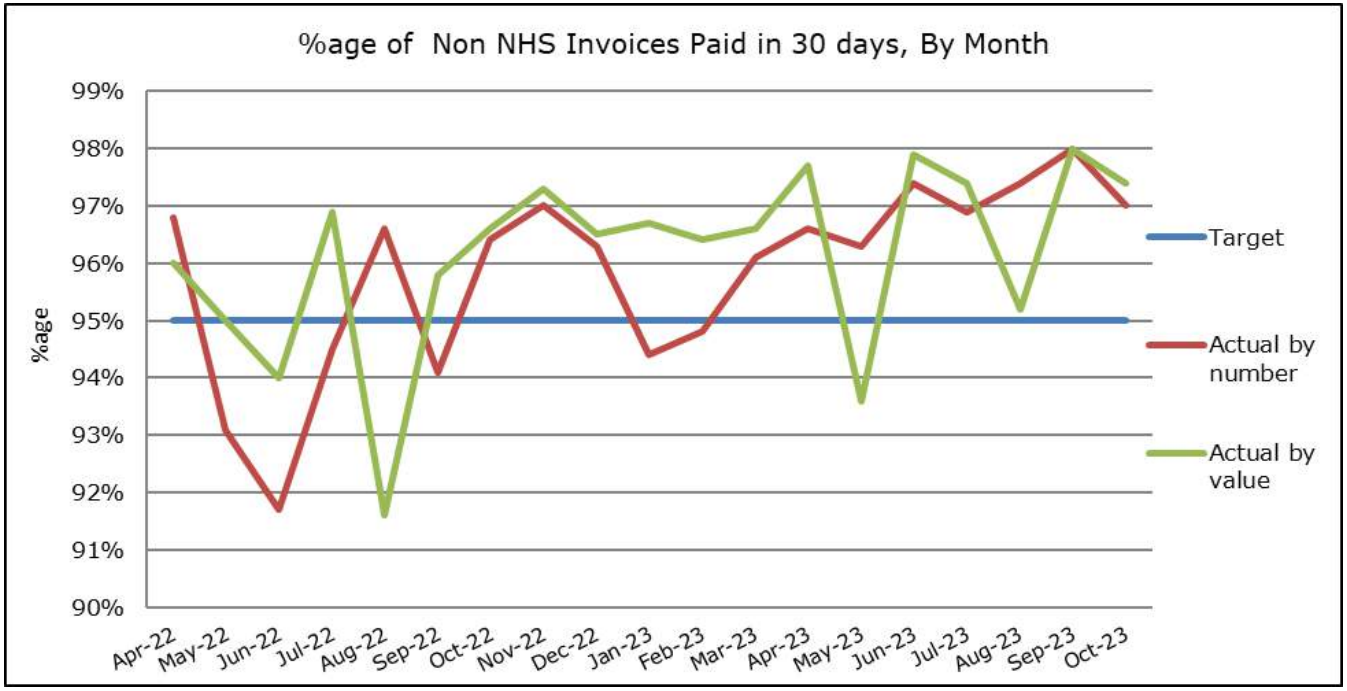
Further delegations will be made in month 8 where confirmed and approved. Other allocations require further information and discussion before delegation can be confirmed.

Cash Position

The cash balance at the 31st October is £4.502m, which is below the advisory figure set by Welsh Government of £6m.

Public Sector Payment Policy (PSPP)

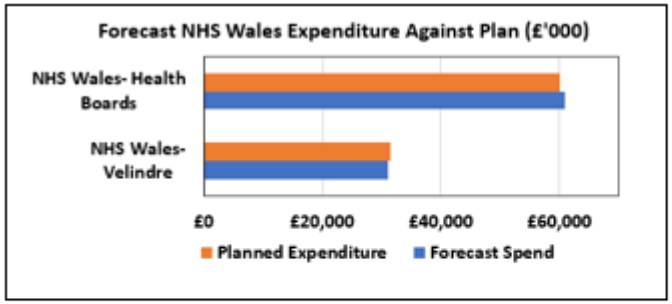
The HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods/services in October and cumulatively. Despite contacting all requisitioners for April to June where the NHS invoices were paid oustide of the payment terms, there has been a small decrease in the number of NHS invoices paid within 30 days. The exercise will be repeated for June to September to once again stress the importance of raising orders upfront and receipting on a timely basis.



Contracting & Commissioning – LTA Spend & Income

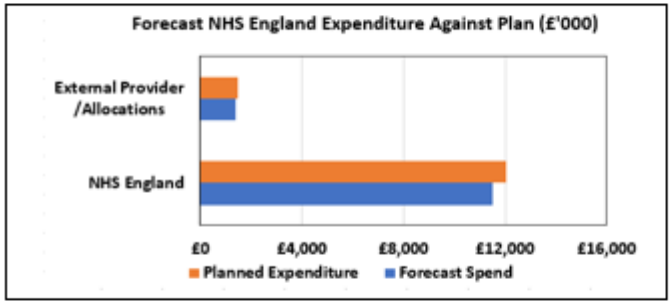
Month/Financial Year:- Month 7 (October) 2023-24

At Month 7 the financial performance for Contracting and Commissioning is a £157k underspend against the delegated budget
The key elements contributing to this position at Month 7 are as follows:



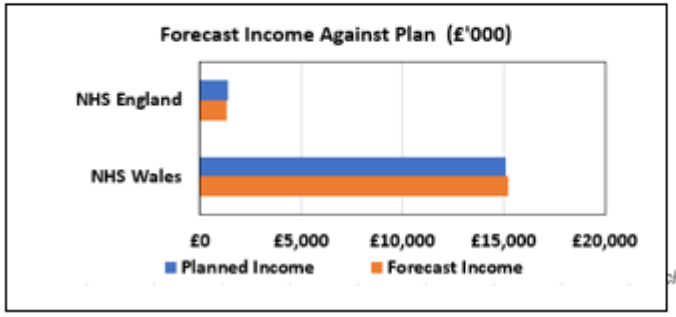
NHS Wales Expenditure

ABUHB pursued additional underperformance from Cwm Taf Morgannwg UHB to reflect reduced activity being provided for Gwent residents WG had to arbitrate on the disputed position and the outcome was a reduction of c£2m compared to the 22-23 LTA



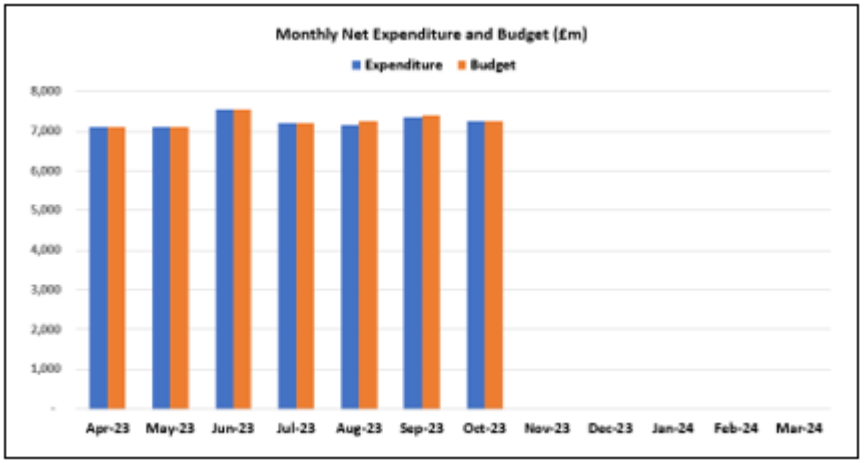
NHS England Expenditure

Contract Expenditure with NHS England organisations is expected to be c£12m in 2023/24 and will continue to be monitored and managed regularly



Provider Income

Provider income of c£16m is being planned and forecast in 2023/24 and will continue to be monitored and managed regularly

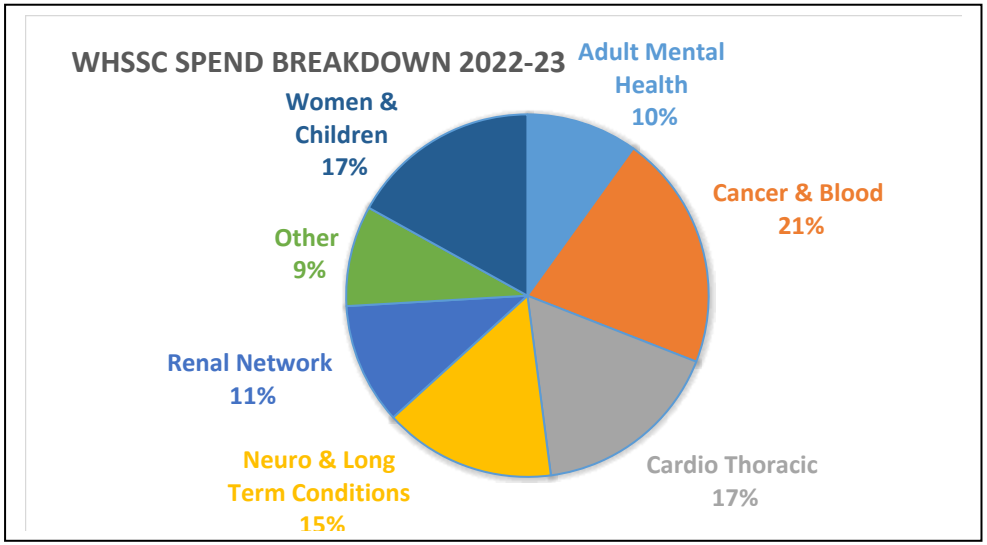


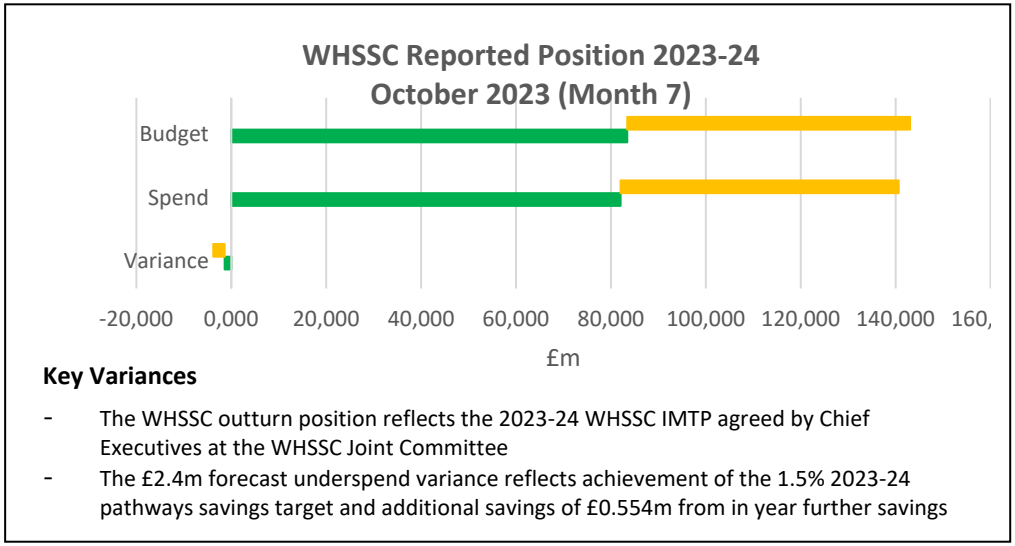
Key Issues 2023-24

- All LTAs have been signed by the end of June 2023 WG deadline with the exception of the Cwm Taf LTA as ABUHB are pursuing additional underperformance from the LTA. The WG arbitration outcome resulted in c£2m reduction in expenditure compared to 22-23 terms and conditions
- The nationally agreed inflationary uplift of 1.5% has been funded and is reflected in the above position
- The forecast spend at Velindre Trust is broadly in line with the provider IMTP however there is a degree of uncertainty around NICE and activity forecasts and the implementation of new service developments.
- A new saving of £331k was achieved in month 5 from negotiating additional underperformance from the Velindre contract
- A cost pressure of c£129k is reflected from month 5 for increased delivery of pancreatic cancer surgery and thyroid surgery for AB patients at Swansea Bay UHB
- The plan and forecast takes into account the full year effect of the regional vascular centralisation project in Cardiff and the phased contract reduction for Powys patients in relation to reduced GUH flows (income)

WHSSC & EASC Financial Position 2023-24: Month 7

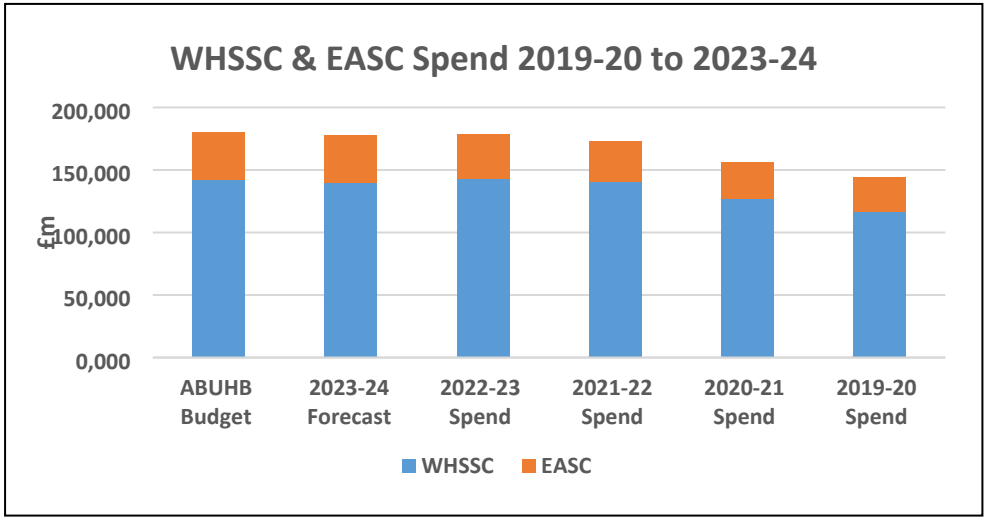
The Month 7 financial performance for WHSSC & EASC is an underspend of £1.692m. The Month 7 position reflects the agreed IMTP with WHSSC and EASC.





Key Variances

- The WHSSC outturn position reflects the 2023-24 WHSSC IMTP agreed by Chief Executives at the WHSSC Joint Committee
- The £2.4m forecast underspend variance reflects achievement of the 1.5% 2023-24 pathways savings target and additional savings of £0.554m from in year further savings



Key Variances

- The EASC outturn position reflects the 2023-24 EASC IMTP agreed by Chief Executives at the EASC Joint Committee.
- The £0.5m underspend reflects slippage against the agreed IMTP.

Balance Sheet

Balance sheet as at 31st October 2023	2023/24 Opening balance £000s	31st October 2023 £000s	Movement £000s	
Fixed Assets	893,408	930,737	37,329	
Other Non current assets	83,283	100,300	17,017	*
Current Assets				
Inventories	9,576	9,965	389	
Trade and other receivables	152,220	169,711	17,491	*
Cash	4,704	4,502	(202)	
Non-current assets 'Held for Sale'	0	0	0	
Total Current Assets	166,500	184,178	17,678	
Liabilities				
Trade and other payables	242,817	217,690	(25,127)	
Provisions	168,466	213,641	45,175	
	411,283	431,331	20,048	
	731,908	**783,884**	**51,976**	
Financed by:-				
General Fund	552,859	586,577	33,718	
Revaluation Reserve	179,049	197,307	18,258	
	731,908	**783,884**	**51,976**	

Fixed Assets:-

- An increase in net additions of £27.2 in relation to new 2023/24 capital expenditure incurred.
- A reduction of £25.0m for depreciation charges. A reduction of £2.3m for IFRS16 related charges.
- An increase in indexation costs of £37.4m

Other Non-Current Assets: This relates to an increase in Welsh Risk Pool claims due in more than one year £18.1m, a decrease in intangible assets of £1.2m and an increase in ICR income due in more than one year of £0.1m since the end of 2022/23.

Inventories: The increase in year relates to changes in stock held within the divisions

Current Assets, Trade & Other Receivables: The main movements since the end of 2022/23 relate to:

- Innovation fund to Cardiology £1m – Recognised in the forecast position within reserves at month 6 as agreed by the Executive team. Delegate to Medicine for month 7 reporting (R)
- Innovation fund to Cardiology £1m – Recognised in the forecast position within reserves at month 6 as agreed by the Executive team. Delegate to Medicine for month 7 reporting (R)
- An increase in the value of prepayments held £5.2m.

Cash: The cash balance held at the end of October is £4.502m.

Liabilities, Provisions:

- The movement since the end of 2022/23 relates to a number of issues the most significant of which are:- a decrease in Capital accruals (£2.2m), an increase in NHS Creditor accruals (£6.0m), a decrease in the level of invoices held for payment from the year end (£5.1m), A decrease in non NHS accruals (£7.5m), a decrease in Tax & Superannuation (£0.5m), a decrease in other creditors (£13.6m), a decrease in the liability for lease payments (£2.1m), an increase in payments on account (£0.1m).
- Due to the increase in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £45.2m.

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: £1.6bn

Funding Allocations - October 23 (M07 2023/24)

	£'000
HCHS	1,460,374
GMS	109,005
Pharmacy	33,709
Dental	32,654
Total confirmed allocations	**1,635,742**
Anticipated allocations	**77,035**
Total Allocations	**1,712,778**

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 £107m. (£108m for 22/23). The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Estimated funding (allocations & income) for the UHB totals £1.73bn (£1.75bn for 22/23).

WG anticipated allocations: £77.0m

WG Revenue Resource Limit : Anticipated Allocations (October)

Funding Type	Description	Value £'000	Recurrent / Non Recurrent
GMS	GMS Refresh	1,603	R
HCHS	(Provider) SPR's	125	R
HCHS	(Provider) Clinical Excellence Awards (CDA's)	251	R
HCHS	Technology Enabled Care National Programme (ETTF)	1,800	R
HCHS	Informatics - Virtual Consultations	1,065	R
HCHS	WHSSC - National Specialist CAMHS improvements	271	R
HCHS	Same Day Emergency Care (SDEC)	1,560	R
HCHS	Adferiad Programme	1,216	NR
HCHS	Exceptional-Incremenntal Real Living Wage	5,404	NR
HCHS	Urgent Primary Care	652	R
HCHS	Trans Funding-PSA self-management Prog Platform development	232	R
HCHS	VBH: Heart Failure and Rehab in the Community	506	R
HCHS	Digital Medicines transformation team	306	NR
HCHS	23-24 C19 Vaccination programme	6,024	NR
HCHS	23-24 C19 TTP	2,354	NR
HCHS	New Medical Training Posts 2017-2022 cohorts	1,100	R
HCHS	Capital - DEL Depreciation - Baseline Surplus/Shortfall	581	NR
HCHS	Capital - DEL Depreciation - Strategic	337	NR
HCHS	Capital - DEL Depreciation - Accelerated	95	NR
HCHS	Capital - DEL Depreciation - IFRS 16 Leases	(344)	NR
HCHS	Capital - AME Depreciation - IFRS 16 Leases (Peppercorn)	116	NR
HCHS	Capital - AME Depreciation - Donated Assets	343	NR
HCHS	Capital - AME Depreciation - Impairments	24,267	NR
HCHS	Capital - Removal of Donated assets / Gvnt grant receipts	(300)	NR
HCHS	IFRS16 Leases New / Renewals DEL Depn	139	NR
HCHS	IFRS16 Leases New / Renewals Revenue Reduction	(4,015)	NR
HCHS	Mental Capacity Act 23-24	189	NR
HCHS	Mental Capacity Act Advocacy 23-24	217	NR
HCHS	Consolidated pay award 1.5% Apr-23	9,321	NR
HCHS	Capital - AME Depreciation - Impairment reversals	(19,552)	NR
HCHS	C19 PPE 23/24	797	NR
HCHS	CAMHS Sanctuary provision	50	R
HCHS	Trans Funding-Outpatient Transformation Unit	101	NR
HCHS	Trans Funding-AB Central support costs	216	NR
HCHS	Trans Funding-Glaucoma optom	41	NR
HCHS	Trans Funding-Medical retina	41	NR
HCHS	Trans Funding-Telemax/TeleENT project	36	NR
HCHS	Welsh Risk Pool Risk Share agreement 23-24	(4,455)	NR
HCHS	Mental Capacity Act 23-24 - Gwent consortium	49	NR
HCHS	A4C Pay award 23-24	26,554	R
GMS	GP/GMS Increase in list size addtl funding 23-24	838	R
HCHS	Informatics - Virtual Consultations platform license	1,023	NR
HCHS	Financial position 23-24 - Energy	9,500	NR
HCHS	Pay award-Medical and Dental 5% 23-24	6,384	R
	Total Anticipated: Per Ledger	**77,035**	

Capital Planning & Performance

	2023/24				
	Original Plan £000	Revised Plan £000	Spend to M7 £000	Forecast Outturn £000	Variance £000
Source:					
Discretionary Capital:					
Approved Discretionary Capital Funding Allocation	9,521	9,521		9,521	0
Less EFAB Contribution	-629	-629		-629	0
Less AWCP Brokerage 22/23	-1,472	-2,278		-2,278	0
Grant Income Received	0	0		0	0
NBV of Assets Disposed	0	427		427	0
Total Approved Discretionary Funding	7,420	7,041		7,041	0
All Wales Capital Programme Funding:					
AWCP Approved Funding	43,396	45,541		45,541	0
Anticipated YYF Breast Inflation Funding (in Unapproved section of CRL)	0	0		20	20
Charitable Donations YYF Breast Centralisation Unit	0	150		150	0
Total Approved AWCP Funding	43,396	45,711		45,711	20
Total Approved IFRS16 Lease funding	0	-211		-211	0
Total Capital Funding / Capital Resource Limit (CRL)	**50,816**	**52,521**		**52,541**	**20**
Applications:					
Discretionary Capital:					
Commitments B/f From 2022/23	321	644	313	635	-8
Statutory Allocations	576	590	388	590	0
Divisional Priorities	2,868	3,118	1,410	3,010	-108
Corporate Priorities	300	1,079	511	1,059	-20
Informatics National Priority & Sustainability	2,170	1,301	373	1,294	-7
Remaining DCP Contingency	1,185	310	0	0	-310
Total Discretionary Capital	**7,420**	**7,041**	**2,995**	**6,588**	**-454**
All Wales Capital Programme:					
Grange University Hospital Remaining works	-3,517	-74	-182	-74	0
Tredegar Health & Wellbeing Centre Development	4,019	3,375	3,545	3,853	478
NHH Satellite Radiotherapy Centre	17,675	16,158	7,511	16,158	0
YYF Breast Centralisation Unit	8,685	8,632	5,249	8,652	20
Newport East Health & Wellbeing Centre Development	10,362	9,411	3,393	9,411	0
RGH Endoscopy Unit	4,004	4,914	4,460	4,914	0
RGH – Block 1 and 2 Demolition and Car Park	404	554	16	660	106
EFAB Schemes	1,764	1,580	196	1,580	0
EOY Funding Schemes	0	239	177	269	30
MH SISU Development	0	10	2	10	0
ICF Schemes	0	16	14	16	0
HCF Schemes	0	10	9	9	-1
ED Waiting Area Funding	0	111	86	111	0
CAMHS Sanctuary Hub	0	662	111	662	0
National Imaging Programme - 2022/23 Old year schemes	0	55	8	55	0
Digital Eye Care	0	10	10	10	0
Radiotherapy Satellite Centre NHH Enabling Works	0	9	2	9	0
SDEC Equipment - Old Year Orders	0	19	-21	22	3
Total AWCP Capital	**43,396**	**45,691**	**24,585**	**46,327**	**636**
Total IFRS16 Lease Expenditure	**0**	**-211**	**-211**	**-211**	**0**
Total Programme Allocation and Expenditure	**50,816**	**52,521**	**27,369**	**52,704**	**183**
Forecast Overspend / (Underspend) against Overall Capital Resource Limit					**163**

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	**CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN ANEURIN BEVAN UNIVERSITY HEALTH BOARD MEETING**

DYDDIAD Y CYFARFOD: DATE OF MEETING:	22 November 2023
CYFARFOD O: MEETING OF:	Board
TEITL YR ADRODDIAD: TITLE OF REPORT:	Financial & Delivery Governance Framework 2023/24
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Rob Holcombe Executive Director of Finance & Procurement
SWYDDOG ADRODD: REPORTING OFFICER:	

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

ADRODDIAD SCAA SBAR REPORT
Sefyllfa / Situation The Health Board is currently facing extremely challenging financial pressures. As a result, the Board has implemented several changes to strengthen financial governance and support financial recovery and performance delivery. This paper provides an overview of the framework developed and implemented to support financial recovery and performance delivery.
Cefndir / Background

ABUHB developed an IMTP for 23/24 that identified a financial deficit of £112m, this position was predicated on delivering an ambitious £51m savings plan and mitigating any further service and cost pressures.

Following the month 6 mid-year review by the Board a revised financial forecast of £145m deficit was reported. Subsequently WG have provided ABUHB with an additional £88m funding, thus the reported position has changed to a £57m deficit.

Throughout 2023/24 actions to deliver savings, cost mitigations and the governance arrangements to progress these have been implemented. This paper outlines these arrangements as a summary framework.

Asesiad / Assessment

The purpose of the framework is to set out in summary the Health Board's system of internal control relating to the corporate governance and delivery arrangements in respect of financial and other statutory responsibilities.

Contents include:

- Regulatory Governance Framework
- Statutory Responsibilities
- IMTP Financial Plan Approval & Financial Recovery Approach
- Revenue Budget Setting Approach
- Structural Governance
- Performance and Accountability Arrangements
- Clinical Advisory Arrangements
- Financial Control Environment

A good practice control environment, advocated by WG, has been used to assess the Board's arrangements.

The Health Board can conclude that it has designed an effective framework of corporate governance and performance management to support service delivery and financial performance.

Argymhelliad / Recommendation

The Board is asked to note for assurance:

The summary framework as presented.

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Good Practice Guides
Rhestr Termau: Glossary of Terms:	WG – Welsh Government IMTP – Integrated Medium Term Plan COTE – Care of the Elderly MSK – Musculo Skeletal eLGH – enhanced local general hospital
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
	Is EIA Required and included with this paper

Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	Choose an item. An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Choose an item. Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs

Financial and Delivery Governance Framework 2023/24

November 2023

Introduction

The purpose of this framework is to set out in summary the Health Board's system of internal control relating to the corporate governance and delivery arrangements in respect of financial and other statutory responsibilities, including additional changes implemented to support financial recovery.

Contents include:

- Regulatory Governance Framework
- Statutory Responsibilities
- IMTP Financial Plan Approval & Financial Recovery Approach
- Revenue Budget Setting Approach
- Structural Governance
- Performance and Accountability Arrangements
- Clinical Advisory Arrangements
- Financial Control Environment

Regulatory Governance Framework

The Health Board has well established arrangements to ensure that public funding is used within delegated responsibilities and applied in the most cost effective way to ensure value for money.

These arrangements include:

- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation
- Financial Control Procedures
- Audit & Risk Committee

These align with Welsh Government guidelines and are approved by the Board. They are tested for adequacy and compliance as part of independent Audit arrangements.

Statutory Responsibilities

The financial provisions and obligations of the Health Board are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure that the Health Board meets its statutory obligation to perform its functions within its available financial resources.

The Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. They are as follows:

- First Duty - A duty to secure that its expenditure, which is attributable to the performance by it or its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.
- Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.

IMTP Financial Plan Approval

At its meetings in March and May 2023, the Board approved its Integrated-Medium Term Plan (IMTP) 2023-26 and Annual Plan 2023-24 respectively. The detailed financial plan contained within these confirmed that the Health Board had an underlying deficit of £89m & was unable to develop a balanced financial plan, with a likely forecast deficit (after assumed delivery of £51m savings) of £112m for 2023/24, thus breaching the above duties.

Within the IMTP 2023-26, the Board confirmed its ambition to achieve recurrent revenue financial balance over the life of 3-year plan. In doing so, cost reduction was deemed a priority, whilst recognising patient quality and safety would not be compromised. Significant service change and improvement opportunities would also be required to drive sustainability and financial recovery.

IMTP Financial Recovery Approach

The IMTP has previously established the ABUHB savings approach. The four key elements of the sustainability approach are as follows and a high-level 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

<u>People focussed</u>
Establishment of Senior Leaders Group
Regular facilitated financial recovery sessions with budget holders

Regular messaging has been issued by the CEO to all staff
A staff 'savings' suggestion box has been implemented
New Budget holder training pack issued on internet
Financial management and Procurement training provided

Support to drive Transformational change
Six goals programme
Planned care programme
Discharge support project
COTE project
MSK project
eLGH programme
Heart Failure value programme

Autonomy & Accountability
New Budget setting approach implemented for 2023/24
Budget holder governance 'self-assessment' checklists issued on intranet
Divisional level governance checklist issued

Other Enabling Actions
Variable Pay Group
Non-Pay Group
Efficiency Opportunities & best practice Compendium
Business intelligence, ABCI & Value project work

Monitoring reporting & holding to account
Comprehensive revised financial reports to Executive Committee, Finance & Performance Committee and Board, including in depth board briefing sessions.
Efficiency Board established.

The new proposed structural revisions outlined in this paper provide further strengthening to financial governance to support financial sustainability and achievement of financial plans.

Revenue Budget Setting Approach

In-line with the Standing Financial Instructions, the Health Board is required to set budgets prior to the beginning of the financial year, which are in accordance with the aims and objectives of the Integrated Medium-Term Plan 2023-26. Specifically, this means preparing and setting budgets within available funds.

Recognising that it had committed to achieving financial balance over the course of its 3-year IMTP (as a recovery plan), revenue budgets were agreed by the Board and set on the basis of recognising the deficit position and the expenditure levels required to achieve the aims of the IMTP 2023-26.

The principles that underpinned the delegation of revenue budgets for 2023/24 were that:

- Budget delegation plan values reconciled with allocation funding;
- Budget allocations were prioritised to making historical/underlying commitments sustainable as part of the 'core' IMTP plan;
- Budget delegation included Covid cost estimates and exceptional National Cost pressures as part of the 'core' IMTP plan;
- Contingency reserves were established;
- Budget holders were required to operate & deliver within delegated budgets;
- The IMTP's likely forecast deficit of £112m was only achievable if £51m of savings were delivered to support service costs identified;
- Budgets were delegated net of expected savings targets, and all other risks & pressures were required to be pro-actively managed & mitigated by budget holders; and
- A strengthened accountability approach with budget holders was established.

The approach for budget setting in 2023/24 therefore moved away from historical budgets with incremental changes, to one that focussed on current and forecast expenditure, taking account of savings opportunities. Budget Delegation responsibilities included as part of performance delivery letters will be issued to each Executive Director for signature.

The aim is to better engage budget holders to deliver financial balance within realistic budget levels, support autonomy and accountability and holding to account.

Structural Governance

<u>The Board</u>

In view of the financial position, and the level of associated risk, the Board has resolved to reserve for itself the oversight, monitoring and scrutiny of financial recovery for 2023/24. The Board receives financial performance reports and financial briefings on a regular basis including clarity on the in year financial position, savings performance and forecasts. In performing this scrutiny, the Board will:

- Approve and oversee delivery of the financial recovery programme and financial risk mitigation plans which capture all of the actions,

the governance arrangements and sets out overarching delivery plans for each of the financial recovery workstreams;
- Ensure a clear understanding of the financial risk relating to the financial recovery programme. The Board will review the financial risk on a monthly basis, based on actual financial performance;
- Receive assurance from identified Executive Leads that robust financial recovery workstreams are in place with effective management of risks and delivery of agreed actions;
- Where forecast financial delivery falls short of target and does not adequately mitigate risk, the Board will agree the approach to identifying the further schemes necessary to resolve the gap, including the review and approval of any additional cost reduction and cost avoidance measures;
- Consider the Health Board's capacity and capability to deliver financial recovery actions and consider proposals to address where necessary;
- Consider lessons learnt and ensure that these are reflected in future planning and delivery mechanisms.

Additional Board briefing sessions and in committee sessions have been allocated to financial recovery for 2023/24.

<u>The Finance and Performance Committee</u>

The Board has an established Finance and Performance Committee which has delegated responsibility to provide advice and assurance on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan. In doing so, the Committee seeks assurance that there is ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the Health Board's business. Included within this, the Committee seeks assurance that arrangements for service, workforce and financial management and performance delivery are sufficient, effective and robust. The Committee meets on a quarterly basis.

In respect of financial management and financial performance, the Board has requested that the Finance and Performance Committee dedicate a specific focus to financial planning & performance improvement for 2023/24, and in particular to seek assurance on actions underway to develop a robust financial sustainability plan for inclusion in the Board's Annual Plan for 2024/25. In addition, the Board will delegate specific financial recovery workstreams for further focus by the Committee where required.

A particular focus on efficiency improvement has been taken for 2023/24 to improve financial recovery.

The Finance and Performance Committee will also maintain its usual focus on organisational performance, with attention to risk-based exception reporting.

The Executive Committee

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

The Executive Committee is the executive decision-making committee of the organisation, chaired by the Chief Executive as Accountable Officer. The Executive Committee is therefore responsible for ensuring the effective and efficient co-ordination of all functions of the organisation, and thus supporting the Chief Executive/Accountable Officer to discharge her responsibilities.

The Executive Committee meets on a weekly basis and focusses on the breadth of the organisation's business, including financial performance and sustainability.

There is a specific monthly executive performance review meeting focussing on financial and service delivery.

In addition, the Executive Committee has established a Value and Sustainability Board where it comes together with Divisional Directors to oversee delivery of the financial plan and lead the organisation to long term financial sustainability.

The Value and Sustainability Board

The Value and Sustainability Board has been established to replace the Efficiency Board and ensure the organisational delivery of the whole programme of work that the Board has approved in order to deliver the financial plan and lead the organisation to long term financial sustainability.

The Value and Sustainability meets 2-weekly to oversee the development and delivery of the overall financial recovery and sustainability programme ('the Programme') and constituent projects within the programme by:

- providing assurance to Board that leadership, management and governance arrangements are robust and appropriately discharged to deliver the outcomes and benefits of the programme;

- providing oversight of the workstreams involved in the development and delivery of the Programme and the subsequent development and delivery of opportunities and project plans, and oversight of any external advisors engaged to support the Health Board;
- reviewing and approving reports and papers put forward by the workstreams showing progress made in the achievement of cost reduction and value improvement aims; and
- scrutinising the progress of the Programme and providing the Health Board with confidence that target deliverables and outputs are produced on time, to budget and in accordance with all professional standards.

The thematic workstreams, along with respective leads, established within the financial recovery and sustainability programme of the Value and Sustainability Board are as follows:

Thematic group	**Executive Lead**
Workforce	Director of Workforce & OD
Medicines Management	Chief Operating Officer
Prevention	Director of Public Health
Non-Pay	Finance Director
Continuing Health Care	Chief Operating Officer
Service Redesign	Director of Planning & Partnerships
Digital	Director of Digital
Other opportunities	As appropriate

As well as receiving progress reports on priority themes, specific actions agreed by the Board include -

Pay controls:

- Revising variable pay arrangements
- Establishing a vacancy scrutiny panel
- Freeze all administrative consultancy across the health board

Non-essential non pay controls:

- Limit attendance to external conference venues
- Enhanced IT equipment scrutiny & re-deploy assets
- Freeze office equipment and furniture purchases

Governance:

- Further training for staff related to finance and procurement
- Self-assessment governance control checklists issued to Divisions for review and improvement

Communications:

- Regular staff briefings and messaging
- Staff suggestion box launched with over 300 ideas received and being considered

Performance and Accountability Arrangements

In addition to the specific oversight arrangements in place to oversee delivery of the financial recovery and sustainability plan, the Board has established a Performance Management and Accountability Framework (PMAF). The PMAF sets out the approach to establishing and maintaining an effective performance management mechanism within the organisation to enable, monitor and achieve delivery of the Health Board's strategic priorities and operational plans.

Specifically in relation to financial performance, the PMAF sets out that where corporate directorate or divisional level budgets are overspending by more than £0.5m Year to date or £1m forecast (identified through monthly financial reporting) escalation to 'Enhanced Monitoring' will be enacted.

In this circumstance, the Chief Executive Officer will call a special 'Budget Review Meeting' of all Executive Directors and the Divisional or Corporate budget holder, where relevant. The purpose of the review meeting will be to establish an agreed action plan which will be monitored through financial reporting arrangements. The PMAF sets out additional escalation measures should improvement not be deemed sufficient.

During October '23 escalated budget review meetings were held for overspending delegated budget areas. The following divisions were asked to attend:

- Urgent Care
- Families & Therapies
- Scheduled Care
- Facilities & Estates
- Mental Health & Learning Disabilities
- Primary & Community Care
- Medicine Division

The meetings considered the challenges and opportunities for each delegated budget with an action plan established for each budget holder to progress with appropriate support as agreed. Delivery will be monitored through the divisional assurance meetings with the Chief Operating Officer & through established financial reporting arrangements.

Clinical Advisory Arrangements

Within the IMTP 2023-26, the Board confirmed its ambition to achieve recurrent revenue financial balance over the 3-year plan. In doing so, cost reduction and effectiveness were deemed to be a priority whilst recognising patient quality and safety would not be compromised. Significant service change and improvement opportunities would also be required to drive sustainability and financial recovery.

The Board has therefore established a new Clinical Advisory Forum (CAF) to provide a multi-disciplinary view of healthcare professional issues to advise the Board on local strategy and delivery. The CAF will provide a forum to facilitate engagement and debate amongst the wide range of clinical interests within the organisation, with the aim of reaching and presenting a cohesive and balanced healthcare professional perspective to inform the Board's decision making, including quality impact assessments.

The *Health & Social Care (Quality and Engagement) (Wales) Act 2020* came into force on 1 April 2023, placing both an enhanced duty of quality and an organisational duty of candour that will strengthen the approach to quality in NHS Wales. The duty of quality requires each organisation to provide demonstrable evidence that all strategic decisions and plans have been made through a quality lens for both clinical and non-clinical aspects. A key element of demonstrating this is the completion of QIAs.

The Health Board's agreed QIA process and tool looks at the project, function or change as a whole and asks how it will impact 'patient / staff safety', 'clinical effectiveness' and 'patient / staff experience' and how any risks or negative impacts could be mitigated. The assessment is undertaken against the six domains of quality: Safe; Effective; Person Centred; Timely; Staffing and Resources; and Equitable.

The CAF has delegated responsibility for overseeing the Health Board's Quality Impact Assessment (QIA) process, including consideration of risk, and making recommendations to the Board and Executive Committee to inform robust decision making.

Financial Control Environment

The Board is required to have a robust and effective system of internal control and corporate governance to deliver an effective financial control environment.

Specific financial governance includes:

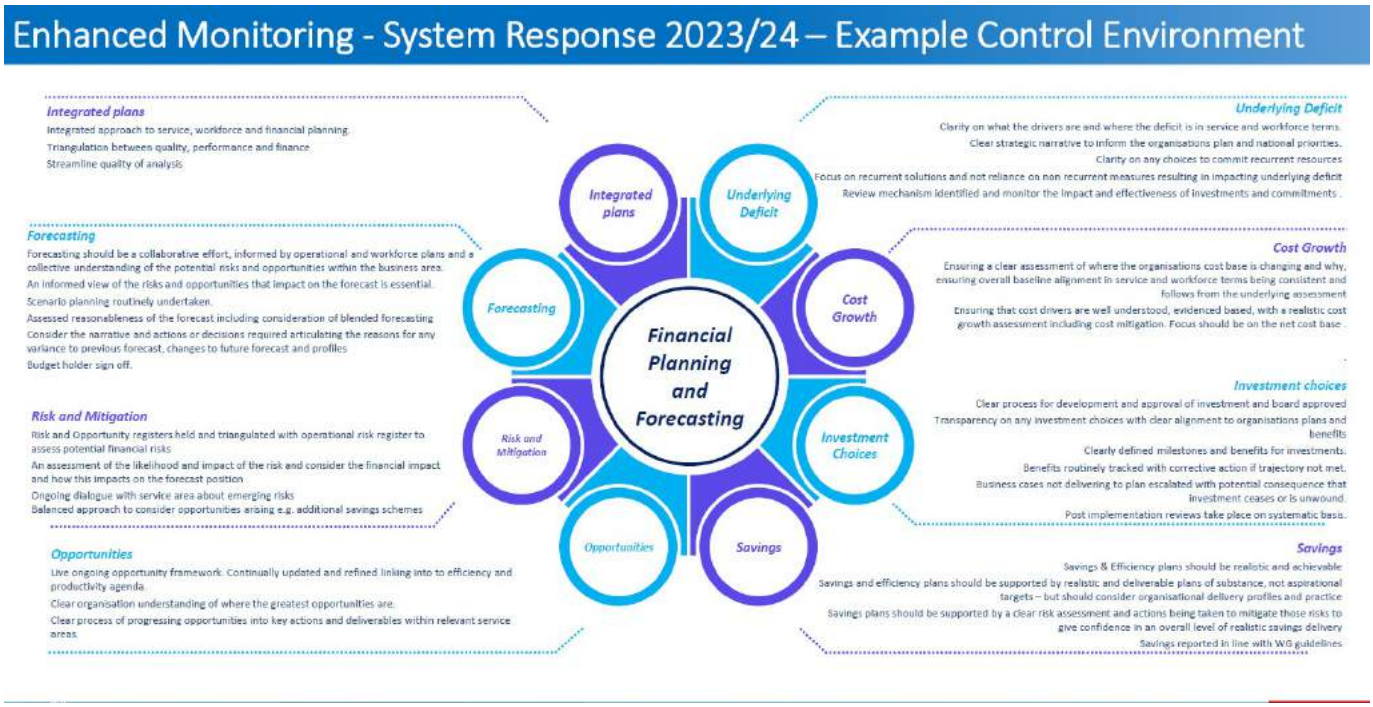
- Well established and comprehensive systems to support financial governance and internal control, including procurement, workforce and financial systems
- Clear Scheme of Delegation
- Effective Financial Control Procedures
- An effective Finance Directorate structure and appropriately trained and qualified finance directorate team
- Effective budget holder financial support
- Clear communication & learning provision of the financial controls to all staff throughout the organisation.
- Financial training packages – induction, procurement, financial systems, budget holder
- Self assessment control checklists
- Regular Clear, accurate and timely financial reporting mechanisms – from budget holder to Board – current & forecast position
- Additional Briefings sessions on financial performance, governance and issues to Board, Sub committees, Executive Committee, System Leadership Group
- Business Case Investment Scrutiny Panel – 'Pre-Investment Panel' & Staff Scrutiny Panel.
- Comprehensive & transparent financial planning models based on workforce and service assumptions.
- Identification of financial opportunities and risks.

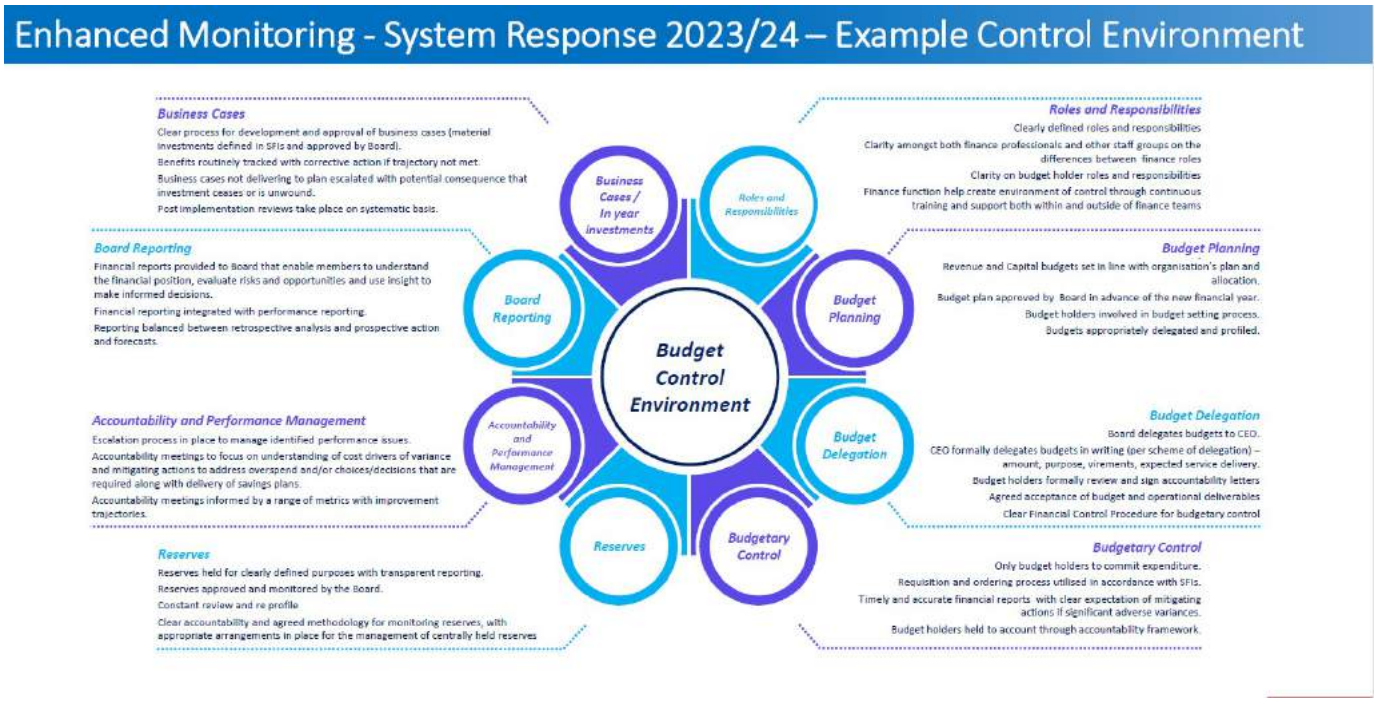
External Scrutiny and Assessment of system effectiveness through Audit arrangements, both system design and compliance.

Conclusion

The appendix below includes an example of a good practice control environment. Using this as the benchmark, the Health Board can conclude that it has designed an effective framework of corporate governance and performance management to support service delivery and financial performance.

Appendix – Example good practice control environment





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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Strategic Risk and Assurance Report (Board Assurance Framework)
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Head of Corporate Risk and Assurance

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

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

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

Sefyllfa / Situation & Cefndir / Background

The Executive Committee conducted a tabletop exercise earlier this year to review the Board's strategic risks and identify any potential risks on the horizon. As a result, the Health Board's strategic risks were updated to reflect the current operating environment and take into account any internal and external factors that may impact the delivery of the Health Board's strategic objectives as outlined in the Integrated Medium-Term Plan (IMTP).

At its meeting in July 2023, the Board approved the refreshed assessment of its strategic risks and agreed on **8** high-level strategic risks comprising **18** sub-risks. The Board delegates responsibility for receiving and scrutinising assurances

against specific strategic risks to various committees for focus and assurance aligned to the agenda of the Committee.

Table 1 below sets out the eight high-level strategic risks compromising 18 sub-risks by risk level, theme, and oversight committee.

The full Strategic Risk Register is included as Appendix A and the individual risk assessments for the **18** sub-risks are included as Appendix B.

Table 1

High-Level Strategic Risks	Number of Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (10 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**7** (A-G)	2	2	People	People and Culture Committee
		2	-	Service Delivery	Partnerships, Public Health & Planning Committee
		-	1	Financial Sustainability	Finance and Performance Committee
SRR 002 - There is a risk that there will be significant failure of the Health Board's estate.	**2** (A -B)	1	1	Compliance and Safey	Partnerships, Public Health & Planning Committee
SRR 003 - There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	**2** (A – B)	-	2	Compliance and Safey	Patient Quality, Safety & Outcomes Committee
SRR 004 - There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.	**1**	-	1	Compliance and Safey	Partnerships, Public Health & Planning Committee
SRR 005 - There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.	**1**	1	-	Service Delivery	Patient Quality, Safety & Outcomes Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	**3** (A – C)	2	1	Service Delivery	Finance and Performance Committee
SRR 007 - There is a risk that the Health Board will be unable to deliver truly	**1**	-	1	Transformation & Partnership Working	Partnerships, Public Health &

integrated health and care services for the population					Planning Committee
SRR 008 - There is a risk that the Health Board fails to build positive relationships with patients, staff, and the public.	**1**	-	1	Transformation & Partnership Working	Patient Quality, Safety & Outcomes Committee

Asesiad / Assessment

As of November 2023, it remains the case that the Board has identified **8** high-level strategic risks, with a total of **18** sub-sets, that present a direct threat to the Board's strategic priorities.

Since the last Board meeting in September, **14** sub-risks have been reviewed, updated, and received focused scrutiny from the delegated Committee as outlined above in Table 1. The remaining **4** sub-risks, which are related to Finance (1) and Digital (3) outlined in Table 2, have been reviewed and updated for inclusion in this report; however, they have not received focused scrutiny, due to the Finance and Performance Committee not being scheduled to meet until 21 December 2023.

The risk assessment considers the control environment and assurances that the controls in place are managing the level of risk; since the last Board meeting in September there have been no changes to the risk level of the 18 sub-risks, as evidenced by the run charts for the individual risk assessments in Appendix B.

Table 2

High-Level Strategic Risks	Sub-Risks	Risk Level		Sub-Risk Theme	Delegated Committee
		High (10 – 12)	Extreme (15 – 25)		
SRR 001 - There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population.	**G**	-	1	Financial Sustainability	Finance and Performance Committee
SRR 006 - There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.	**A-C**	2	1	Service Delivery	Finance and Performance Committee

At the Partnerships, Population Health, and Planning Committee meeting on 01 November 2023, the Director of Public Health & Strategic Partnerships presented a paper outlining progress with the delivery of the Winter Respiratory Vaccination programme, which is part of the National Immunisation Framework (NIF), as well as the service sustainability and delivery risks.

The current financial environment has created resource challenges, specifically in the recruitment of registered and non-registered immunisers for the COVID-19 vaccination; coupled with last-minute changes to vaccination plans as a result of a new COVID-19 variant, which has moved the completion date to mid-January for all eligible cohorts and will not meet the mid-December deadline set out in the WHC

(2023) 029, or ahead of winter. The Health Board may face financial consequences if it is required to extend leases or find new locations to complete the Vaccination programme. Furthermore, in the context of funding challenges and the savings that Health Boards are being asked to provide, any response to broader Health Protection threats still carries significant risk. Additionally, the failure to vaccinate to the level required escalates potentially the increased pressure on the care system during the winter.

As a result, the Partnerships, Population Health, and Planning Committee has requested that the risk outlined below be escalated to the Board for oversight and added to the Strategic Risk Register for ongoing monitoring.

Proposed Strategic Risk				
High-Level Strategic Risk	**Sub-Risk**	**Risk Level**	**Sub-Risk Theme**	**Delegated Committee**
SRR 009 - The Health Board will be unable to protect those most vulnerable to serious disease.	Due to delays in providing COVID-19 vaccinations as a result of challenges with the recruitment of registered and unregistered immunisers, as well as changes to the vaccination delivery programme.	**Extreme** (20)	Service Delivery	Partnerships, Population Health, and Planning Committee

A detailed risk assessment has been undertaken and is presented at Appendix C.

For each Strategic Risk Assessment, the following information is provided:

- A description of the main risks to achieving that objective – i.e., what are the things that might potentially impact on the Health Board's ability to deliver its objectives;
- The cause of the risks (the threat) - this is a description of why something could go wrong;
- The impact of the risks – this is the consequence should the risk occur;
- The risk appetite level and threshold set for the nature of the risk – informed by the risk appetite statement that is under development and subject to final endorsement;
- The key controls in place to manage the risks – these are the actions that are in place to reduce or eliminate the risks;
- The gaps in controls – this is a description of actions that have not been taken, or where systems / processes are not in place to manage the risk;
- The sources of assurance that the risk is being managed – these are the mechanisms we have in place to test the controls are effective and are described in three levels:
    - Level 1 – Operational: the way risks are managed day to day. The assurance comes directly from those responsible for delivering specific objectives and processes.
    - Level 2 – Organisational Oversight: the way in which the organisation oversees the control framework so that it operates effectively.
    - Level 3 – Independent Assurance: objective and independent assurance (e.g., internal audit) or assurance from external

independent bodies (e.g., Healthcare Inspectorate Wales and Audit Wales);

- The gaps in assurance against each level of assurance – this is where we do not have the oversight / testing mechanisms in place to give us the assurance needed to have confidence that risks are being addressed.
- The mitigating actions to address gaps in control or assurance – these are the additional actions we need to take, or mechanisms we need to put in place to address any gaps we have identified.

As we progress in implementing and embedding effective risk management, risk owners will be required to review their risk assessments regularly in accordance with risk management best practices; the review period is determined by the level of risk, as shown below.

Risk Score	Risk Level	Review Risk Assessment
1 - 3	**Low**	12 months
4 - 6	**Moderate**	6 months
8 - 12	**High**	3 months
15 - 25	**Extreme**	1 month

Work will continue with risk owners to assess and refine the controls and assurances, as well as to focus on the financial context and its impact on the individual strategic risks, to ensure a thorough assessment of the risk. This will be completed and documented as part of the next reporting cycle to the delegated committees and subsequent Board meeting, providing greater assurance to the Board that strategic risks are managed effectively in the current operating environment.

A mapping exercise is currently underway in line with effective risk management to ensure that assurance reporting related to strategic risks is included in the respective Committees' Forward Work Programme.

Furthermore, a suite of documents, listed below, has been developed to support the embedding of risk management processes and assurance reporting throughout the Health Board. These documents will be received by the Audit Risk and Assurance Committee on 28 November 2023 for discussion before wider consultation and final submission to the Board in January 2024 for approval for use within the Health Board.

- Risk Management and Assurance Framework (inc. the Health Board's Risk Appetite and Tolerance Statement)
- Risk Management Policy
- Standard Operating Procedure for Applying Risk Management

Argymhelliad / Recommendation

The Board is requested to:

- **REVIEW** the strategic risks identified, ensuring that these remain fully reflective of any direct threat to the Board's strategic priorities;
- **CONSIDER** whether it has sufficient assurance that strategic risks are being assessed, managed, and reviewed appropriately and effectively.
- **APPROVE** the inclusion of the Health Protection Vaccination Programme and Uptake risk on the Strategic Risk Register, with the Partnerships, Population Health, and Planning Committee delegated responsibility for overseeing effective risk management and assurance; and,
- **NOTE** the ongoing work to implement and embed risk management throughout the Health Board.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	The Strategic Risk Report is informed by Datix, ensuring a bottom-up approach to risk escalation.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item. Choose an item. The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Governance
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	N/A

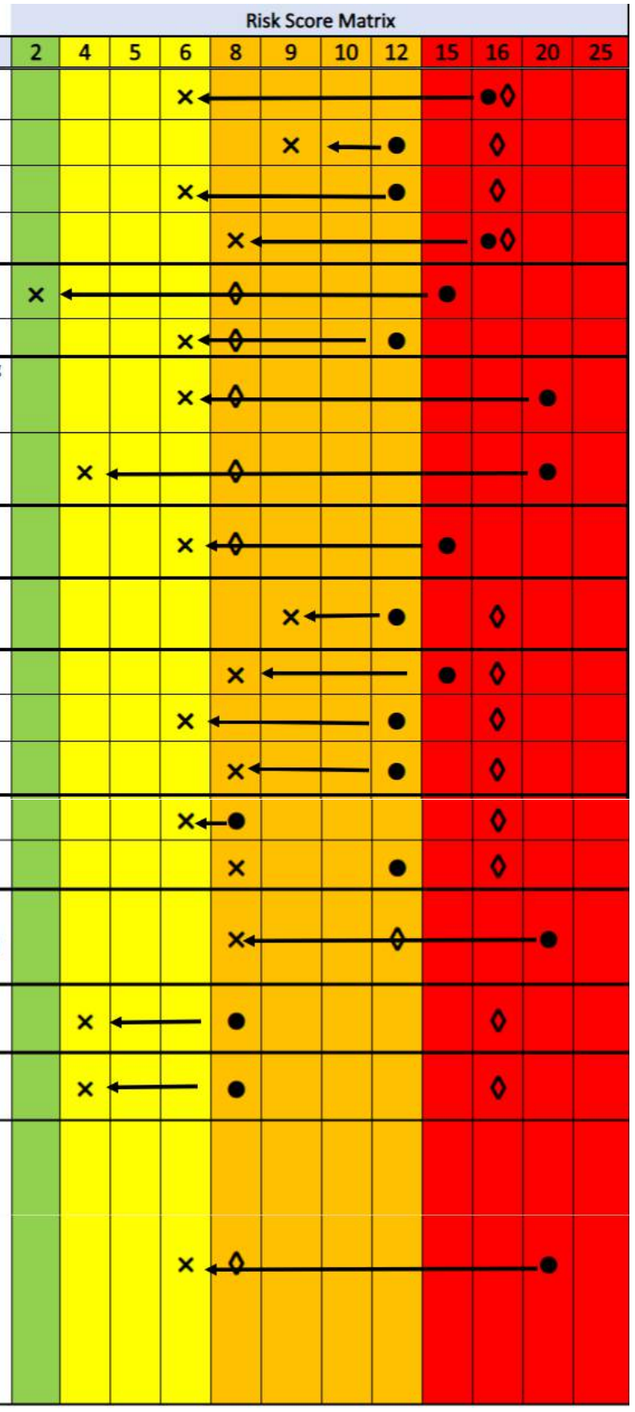
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	At each meeting, the relevant Committee will monitor the risk theme relevant to its responsibilities.

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

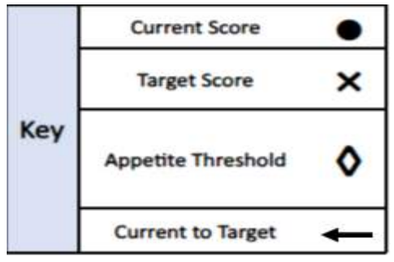
Risk ID	Monitoring Committee	Risk Theme	Risk Owner	Risk Description	Reason For The Risk	Impact	Current Risk Score				Risk Appetite		Actions to Reduce Risk to Target	Assurance that the Risk is being manged	Target Risk Score				Review of Risk	
							Likelihood Of The Risk Occuring	Impact Of Risk Occuring	Current Risk Score	Risk Level	Current Status Against	Risk Appetite and Threshold Explained			Likelihood Of The Risk	Impact Of Risk Occuring	Target Risk Score	Risk Level	Last Reviewed	Next Review
SRR 001	People & Culture Committee	People	Director of Workforce and Organisational Development	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reliance on agency and bank staff •Litigation & Financial Penalties	4	4	16	Extreme	Above Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	**Staff attendance** Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. "Hot spot" areas identified and plans in place to support. **Recruitment** Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor. Annual programme of Apprentice recruitment Overseas Nursing (All Wales) Nursing Workforce Strategy Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) Partnerships with employability schemes such as Kickstart and Restart. Actively working with Local Authorities to promote joint recruitment activities. Registration – Temporary register extended for 2 years to enable staff to return to practice. **Retention:** Development of career pathways (e.g., non-clinical to clinical).	Medium	3	2	6	Low	24/09/2023	24/10/2023
					b) Due to a deterioration in, and a failure to improve, the well-being of our staff	•High absence levels, with some sustained long periods •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Reputational damage to the health board as an employer •Work-related industrial injury claims •Moral injury	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars). Increase wellbeing initiatives: Implement and progress new Integrated Psychological Well-being roles and peer support networks within divisions and hospital sites. Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders) Train Mediators so there is team and organisational resilience and network. Regular Schwartz rounds arranged across the Health Board Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. Close links with the Arts in Health programme Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. Chaplaincy service for staff Re-launching Chill out in the Chapel Recruitment of staff counsellors Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being Scope, design and deliver a programme of research 'Healthy Working Day'. Enhanced our financial well-being offer.	Medium	3	3	9	Moderate	24/09/2023	24/12/2023
					c) Due to insufficient and ineffective leadership levels throughout the organisation.	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Poor levels of accountability and delivery •Reputational damage to the health board as an employer •Adverse impacts on staff recruitment and retention	3	4	12	High	Below Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Talent and Succession Planning lead appointed in July 2023 on a 6-month secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. Development leadership capabilities Designing learning journeys and access to Gwella Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development. CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.	Medium	3	2	6	Low	24/09/2023	24/12/2023
					d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with safe staffing principles and standards •Litigation & Financial Penalties •Reputational damage to the health board and loss of public confidence	4	4	16	Extreme	Above Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Services Business continuity plans in place. All Wales training sessions provide by legal and risk to support industrial action. Ensure early identification of mandated Statutory, and core critical clinical services. Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces. Reducing impact on patients - Support for early supported discharge prior to industrial action. Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action). Establish WOD hub with emergency planning to stand up as required Ensure early identification of mandated Statutory, and core critical clinical services. Review of business continuity plans Map services and staff provision and impacts of industrial action. Assess variable pay usage in case of work to rule applies.	Medium	2	4	8	Moderate	24/09/2023	24/10/2023
SRR 002	Partnerships, Public Health & Planning Committee	Compliance and Safety	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation & Financial Penalties	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a	At this stage, the controls in place are appropriate and practicable to monitor the issues and prepare medium-term responses in line with the timelines within the expert report.	Medium	1	2	2	Very Low	27/09/2023	27/10/2023
					b) Due to significant levels of backlog maintenance	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Non-compliance with Health & Safety legislation •Litigation	3	4	12	High	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Active estate rationalisation (including leases) is required to reduce estate demands and help prioritise capital spend to reduce backlog maintenance. A water/ventilation engineer to enable all critical ventilation systems to undergo annual validation in accordance with HTM 04/01. Ongoing attempts to recruit to workforce gaps and a new model of Estate Officer also being developed to assist with recruitment and retention of staff in the workforce. Planning function leading a review of capital priorities which may help identify additional funding priority given to backlog maintenance.	Medium	3	2	6	Low	10/10/2023	10/01/2024
SRR 003	Patient, Quality, Safety and Outcomes Committee	Compliance and Safety	Director of Nursing	There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	a)Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care practitioners	•Missed safeguarding concerns, resulting in harm or death •Vulnerable individuals not identified appropriately, resulting in harm or death •Lack of staff understanding of reporting and escalation process •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	4	5	20	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after	Updated training packages. Training sessions booked for children and adult level three safeguarding training. Communication with practitioners, via share point intranet pages, emails to divisional nurses. Protected time to complete Level 2 and 3 training where possible.	Medium	3	2	6	Low	14/09/2023	14/10/2023
			Chief Operating Officer		b)Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement	•Harm or injury to patients and/or staff •Health Board breaches statutory duties •Litigation & Financial Penalties •Reputational damage and loss of public confidence	4	5	20	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of	Medium	2	2	4	Low	14/09/2023	14/10/2023
SRR 004	Partnerships, Public Health & Planning Committee	Compliance and Safety	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a)Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level	•Adverse impacts on delivery of care to patients across acute and non-acute settings •Harm or injury to patients and/or staff •Health Board breaches statutory duties under the Civil Contingencies Act 2004 •Litigation & Financial Penalties •Reputational damage and loss of public confidence	3	5	15	Extreme	Above Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Testing programme of business continuity plans. Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. Repository being created on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. Joint planning with PH response in response to infection disease and public health incidence. Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages. Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. Continue to promote awareness in a timely manner.	Medium	2	3	6	Low	10/10/2023	10/11/2023

SRR 005	Patient, Quality, Safety and Outcomes Committee	Service Delivery	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a)Due to inadequate arrangements to support system-wide patient flow	•Avoidable deaths or significant harm •Delays in releasing ambulances from hospital sites back into the community •Delayed discharges from acute and non-acute settings resulting in deteriorating patients •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: Focus Processing power Capacity Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. Regional flow processes not always supported with neighbouring HBs (Health Board)	**Medium**	**3**	**3**	**9**	**Moderate**	14/09/2023	**14/12/2023**
SRR 006	Finance & Performance Committee	Service Delivery	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a)Due to the full or partial failure of existing digital infrastructure and systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**5**	**15**	**Extreme**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising	Information Governance and Cyber Security governance and assurance processes are now under review. Governance group terms of reference agreed, and reporting arrangements discussed with Director of Corporate Governance. Meetings will commence in November with clear reporting on progress to the relevant committees on our cyber security action plan. SIRO training arranged for the 25th September for the Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO).	**Medium**	**2**	**4**	**8**	**Moderate**	10/09/2023	**10/10/2023**
					B)Due to an adverse impact on service delivery in the implementation of new digital systems	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Data breaches •Litigation & Financial Penalties •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising	Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee	**Medium**	**2**	**3**	**6**	**Low**	10/09/2023	**10/12/2023**
					c)Due to a failure to develop digital solutions that are sustainable and fit for the future	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve sustainability •Reputational damage and loss of public confidence	**3**	**4**	**12**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of	New governance structures to be put in place by the end of 2023. Review of New Digital Request processes considering governance changes.	**Medium**	**2**	**4**	**8**	**Moderate**	10/09/2023	**10/12/2023**
SRR 007	Partnerships, Public Health & Planning Committee	Service Delivery	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe and sustainable services which meet the changing needs of the population	a)Due to inadequate strategic plans which respond to population health and socio-economic needs	•Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to train teams in multi-morbidity management •Failure to comply with the Wellbeing of Future Generations Act (Wales)	**2**	**4**	**8**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising	Area plan is being refreshed through the RPB Marmot Region Implementation Plan Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Refresh organisational strategy with a central focus on population health and wellbeing. Action through SEW Regional Collaborative to identify additional service areas where collaboration and networking would support sustainability.	**Medium**	**2**	**3**	**6**	**Low**	10/10/2023	**10/01/2024**
					b)Due to unsustainable service models	•Harm or injury to patients and/or staff •Adverse impacts on delivery of care to patients across acute and non-acute settings •Increased demand •Increased patient acuity levels •Worsening of health inequalities •Worsening of health outcomes •Failure to deliver health board priorities, required improvements and achieve sustainability •Failure to meet statutory duty to unravel the	**3**	**4**	**12**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Area plan is being refreshed through the RPB. Population health management – test and learn using segmentation and risk satisfaction using linked data to target resource. Review of enhanced local general hospital service models to ensure sustainable quality services. Development of SEW plan for fragile. Review of organisational strategy – to launch Summer 2024.	**Medium**	**2**	**3**	**6**	**Low**	10/10/2023	**10/01/2024**
SRR 008	Finance & Performance Committee	Financial Sustainability	Director of Finance and Procurement	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe and sustainable services which meet the changing needs of the population	a)Due to long term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes	•Failure to meet statutory duty to breakeven over 3 years •Instigation of NHS Wales Escalation & Intervention Arrangements •Non – delivery of health board priorities, required improvements and achieve longer-term sustainability •Prioritisation and possible disinvestment in service delivery •Reputational damage and loss of public confidence	**5**	**4**	**20**	**Extreme**	**Above** Appetite Level	Cautious = 12 or below - Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.	Update performance management framework Assessment of financial control environment within divisions and corporate teams.	**Medium**	**2**	**4**	**8**	**Moderate**	10/09/2023	**10/10/2023**
SRR 009	Partnerships, Public Health & Planning Committee	Transformation and Partnership Working	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	Due to ineffective relationships with strategic partners	•Ineffective use of combined resources •Delayed decision making •Adverse impacts on delivery of care to patients across acute and non-acute settings •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence	**2**	**4**	**8**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a	Governance review of Regional Partnership Board undertaken in August 2023. Renewed Strategy for strategic partnership Capital in place and revised governance processes. New Long-Term Strategy for Health Board to focus on Partnership approach.	**Medium**	**2**	**2**	**4**	**Low**	10/10/2023	**10/01/2024**
SRR 010	Patient, Quality, Safety and Outcomes Committee	Transformation and Partnership Working	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff, the public and partners	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	•Adverse impact on patient experience •Failure to deliver health board priorities, required improvements and achieve longer-term sustainability •Reputational damage and loss of public confidence •Failure to deliver Duty of Quality	**2**	**4**	**8**	**High**	**Below** Appetite Level	Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure.	Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. PCCT staff training to support Civica data entry and retrieval. Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff and relatives. Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. National directives around new national surveys that need to be managed additional to internal roll out programme. Volunteer feedback to be reviewed to identify themes.	**Medium**	**2**	**2**	**4**	**Low**	14/09/2023	**14/12/2023**
SRR 011	Partnerships, Public Health & Planning Committee	Compliance and Safety	Director of Public Health and Strategic Partnerships	There is a risk the Health Board is unable to provide COVID-19 vaccinations and thus protect those most vulnerable to serious disease in accordance with Welsh Government Milestones WHC 2023 (029)	Due to the fixed-term nature of the Welsh Government allocation for the Vaccination programme, the Health Board processes in place for recruitment, and challenges related to the Health Board's current financial position, it has not been possible to fill existing immuniser vacancies to the funded establishment level. As a result, the Vaccination and Health Protection Service is unable to provide an active offer of a vaccine to those in the eligible groups within the timeframes anticipated by the Welsh Government. This may necessitate an extension of venue licences or the identification of alternative venues if the vaccination	• Adverse impacts on delivery of vaccinations to patients across the vaccine service – including outreach/in reach delivery to vulnerable population, childhood immunisation & MMR catch up and flu wrap-around service. • Harm or injury to patients and/or staff - Winter modelling suggests a peak in Covid-19 cases and associated bed pressures is anticipated during December 2023 and in mid-January 2024. Potential for Nosocomial spread, increase in acuity of patients, and length of stay. • Resource – potential increase in staff sickness due to lack of protection from the vaccine in staff member groups. • Financial implications due to the extension of venues. • Reputational damage and loss of public confidence.	**5**	**4**	**20**	**Extreme**	**Above** Appetite Level	Minimal = 8 or below - Ultra-Safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurance of the risk after application of controls.	Secured additional funding against the existing allocation for bank vaccination staff. Exploring deployment options to the Vaccination programme and use of those previously trained as vaccinators that are on the bank. Alternative advertising methods of vacant shifts to improve uptake – liaising with bank co-ordinator to improve this. Draft community pop-up plan to be further explored. If required, extend venue licence in key location(s).	**Medium**	**2**	**3**	**6**	**Moderate**	03/11/2023	**03/12/2023**

Reference	Risk Owner	Risk Description	Reason For The Risk	Risk Score Matrix
SRR 001	Director of workforce and OD	There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population	a)Due to an inability to recruit and retain staff across all disciplines and specialities.	
			b) Due to a deterioration in, and a failure to improve, the well-being of our staff	
			c) Due to insufficient and ineffective leadership levels throughout the organisation.	
			d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level	
SRR 002	Chief Operating Officer	There is a risk that there will be significant failure of the Health Board's estate	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures	
			b) Due to significant levels of backlog maintenance	
SRR 003	Director of Nursing	There is a risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse	a) Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care practitioners	
	Chief Operating Officer		b) Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placement	
SRR 004	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board is unable to respond in a timely, efficient and effective way to a major incident, business continuity incident or critical incident	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level	
SRR 005	Chief Operating Officer	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system	a) Due to inadequate arrangements to support system-wide patient flow	
SRR 006	Director of Digital	There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery	a) Due to the full or partial failure of existing digital infrastructure and systems	
			B) Due to an adverse impact on service delivery in the implementation of new digital systems	
			c) Due to a failure to develop digital solutions that are sustainable and fit for the future	
SRR 007	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe and sustainable services which meet the changing needs of the population	a) Due to inadequate strategic plans which respond to population health and socio-economic needs	
			b) Due to unsustainable service models	
SRR 008	Director of Finance and Procurement	There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe and sustainable services which meet the changing needs of the population	a) Due to long term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes	
SRR 009	Director of Strategy, Planning and Partnerships.	There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population	a) Due to ineffective relationships with strategic partners	
SRR 010	Director Of Nursing	There is a risk that the Health Board fails to build positive relationships with patients, staff and the public	Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement	
SRR 011	Director of Strategy, Planning and Partnerships.	There is a risk the Health Board is unable to provide COVID-19 vaccinations and thus protect those most vulnerable to serious disease in accordance with Welsh Government Milestones WHC 2023 (029)	Due to the fixed-term nature of the Welsh Government allocation for the Vaccination programme, the Health Board processes in place for recruitment, and challenges related to the Health Board's current financial position, it has not been possible to fill existing immuniser vacancies to the funded establishment level. As a result, the Vaccination and Health Protection Service is unable to provide an active offer of a vaccine to those in the eligible groups within the timeframes anticipated by the Welsh Government. This may necessitate an extension of venue licences or the identification of alternative venues if the vaccination delivery plan is extended beyond the agreed-upon campaign window.	



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

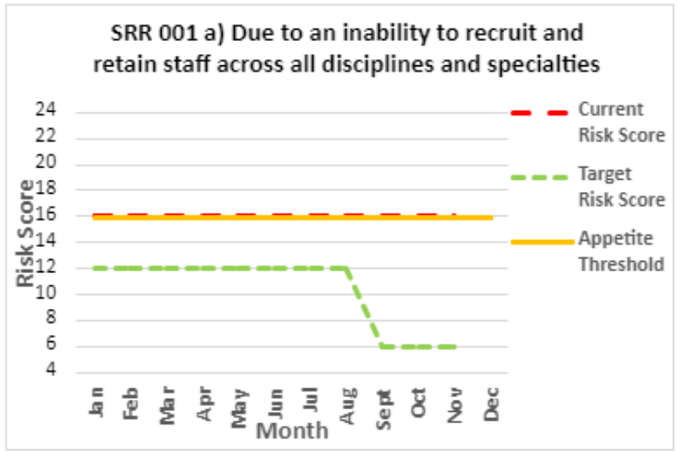


RISK THEME	PEOPLE			
Strategic Risk (SRR 001A)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**a)** Due to an inability to recruit and retain staff across all disciplines and specialties.			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reliance on agency and bank staff ➢ Litigation & Financial Penalties			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	10/10/2023	**Risk rating**	**= 16** *(Extreme)*	**= 6** *(Moderate)*

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

Risk Appetite Threshold - Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Monitoring Framework to support roll-out of the People Plan. • Workforce Dashboard to track activity – recruitment, turnover, sickness absence. • Supply and demand tracker (Nursing). • People Plan tracker to support delivery of actions within the People Plan 2022-25. • Health Care Support Worker tracker. • Agency Reduction Plan approved June 2022 and supported by the Programme Board. • Management of attendance through All Wales Management Attendance at Work Policy. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture. • Nurse Staffing Levels (Wales) Act 201625b/25c.	**Staff attendance** • Continuing support for staff who are absent in line with Managing Attendance at Work Policy, including those on long term absence with a view to signposting to self-help support, and adapting/adjusting roles to enable a safe return to work. • "Hot spot" areas identified and plans in place to support. **Recruitment** • Engagement with national recruitment campaigns such as BAPIO, Train, Work, Live and Student Streamlining for Registered Nurses, Physician's Associates, Midwives, and therapy staff and with HEIW for Junior Doctor. • Annual programme of Apprentice recruitment • Overseas Nursing (All Wales) • Nursing Workforce Strategy	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Workforce reports to the Nurse Strategic Workforce Group. • Update reports on Agile working data and support to the Agile Programme Board to promote the benefits of agile working. • Daily sickness monitoring reports. • Filled and unfilled shift reports (RN). • Occupational Health and Wellbeing dashboards report KPIs. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reports to the People and Culture Committee and the Board on the progress of the People Plan 2022-25 • Workforce Dashboard presented to the Executive Committee, P&CC Committee, and the Board. • Measurements of Wellbeing through the ABUHB Staff Survey. • Routine Reporting against nurse staffing levels.	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Positive Assurance**

• Review of staffing and recruitment plan internally in line with Royal College Guidance, i.e., RCP. • Development of new roles to support vacancies. • Recruitment KPI's. • IMTP Educational Commissioning. • Workforce Establishment controls national working group has been instigated.	• Streamlining and improve recruitment timescales through recruitment modernisation programme (started Oct 22) • Partnerships with employability schemes such as Kickstart and Restart. • Actively working with Local Authorities to promote joint recruitment activities. • Registration – Temporary register extended for 2 years to enable staff to return to practice. **Retention:** • Development of career pathways (e.g., non-clinical to clinical). • Engagement chat cafes providing information and support for key topics such as Agile Working, Learning and Development, Wellbeing Activity, Occupational Health, and Complex HR. • Internal Exit interview group has been established with a view to 1) Increase the numbers of people completing the forms and 2) Turn the data into intelligence so that we can understand and respond to organisational and local level impacts. • Changes in pension regulation and flexile retirement options from October 23 and reduced break in service required following retire and return. **Agency reduction** • Plan in place to monitor and review all agency, bank pay incentives supply and demand. **E- Systems** • Effective deployment of current staff - Programme Plan to introduce Workforce Medical E-Systems to support effective deployment of medical staff. **Development of alternative and new roles** • Continued implementation of new roles such as Physician Associates, Enhanced and Advanced roles to support workforce skills gaps in line with IMTP. • Primary Care workforce The Regional Integrated Fund (RIF) Workforce Programme is in development to support the wider health and social care staffing issues as required in Healthier Wales. Gwent Workforce Board is being tweaked to support scaling up of initiatives and pace. **Training** • The HEIW Education & Training Plan continues the investment in education and training in Wales that has been increasing over past years - Adult Nursing (36%) and Mental Health Nursing (20%), Healthcare science, Allied Health Professionals Clinical Psychology (11%- 43%). This will increase the number of graduates coming out of training in 2022 and beyond which are required to support turnover and existing vacancies. • HEIW are increasing the capacity of training through creating more spaces for training the future Primary Care workforce. Including Primary Care Academy • Development of Leadership Development programmes for key roles such as the Clinical Director post (CDx) started with 3 cohorts in September 2022 and recruiting the 4th cohort to start Oct 23. Nursing Academy, Leadership Development program (entry level) and Leading People (advanced Level) programs fully booked. Core Leadership prog currently delivering to 200 staff. **Vacancy Numbers and establishment control**	**Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023 -24** 1. Long Term Sickness Absence Management (Q4) 2. Flexible Working (Q4) • External quarterly vacancy reporting to WG • External reporting on Nursing Staffing Levels • National Acuity Audits (Nursing) • National Workforce Implementation Plan: Addressing NHS Wales Workforce Challenges - The Strategic Workforce Implementation Board will report to the Minister for Health and Social Services with a collective view from a range of key partners including policy and professional leads in WG, and representatives of NHS employers, staff organisations and professional representative.		

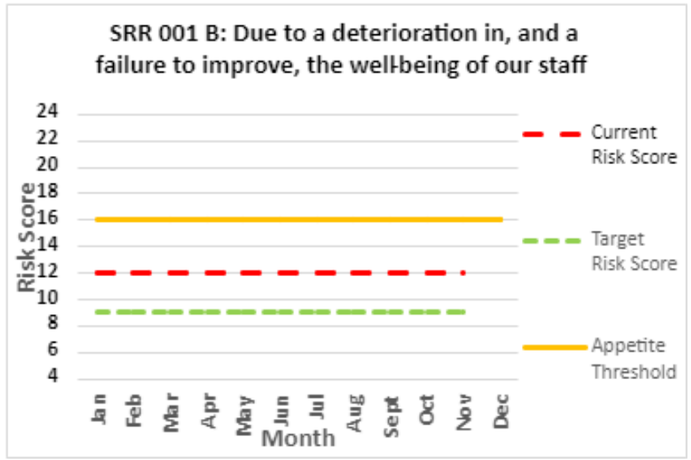
	• Quarterly reporting of vacancy numbers for each staff to the WG. Last reporting period March 23 there were circa 728 WTE vacancies. • Development of ESR establishments commenced on a national basis w/c 03/09/23.			

RISK THEME	PEOPLE			
Strategic risk (SRR 001B)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	**b)** Due to a deterioration in, and a failure to improve, the well-being of staff.			
Impact	➢ High absence levels, with some sustained long periods ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Reputational damage to the health board as an employer ➢ Work-related industrial injury claims ➢ Moral injury			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	**3** *(Possible)* x
Initial Date of Assessment	01/06/2023	**Impact**	**4** *(Major)*	**3** *(Moderate)*
Last Reviewed	10/10/2023	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*

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

Risk Appetite Threshold – Open Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Monitoring Framework to support roll out of the People Plan. • Monitoring delivery of the #peoplefirst project though Executive Team reports, KPI sickness metrics underpinned by People Plan Delivery framework. Engagement ongoing with divisional management teams. • Monitoring of absence, reasons for absence and trends in referrals to Occupational Health and Employee Well-being Service through Workforce Performance Dashboard. • Dashboard reported to Executive Team, TUPF and LNC colleagues and People and Culture Committee with regular summary of Well-being and Occupational Health activity. • Strategic Equality plan • Rest and Facilities charter – monitoring and compliance	• Continue to work with other Health Boards and Trust in NHS Wales (recent work with WAST & Powys delivering well-being webinars). • Increase wellbeing initiatives: • Implement and progress new Integrated Psychological Well-being roles and peer support networks within divisions and hospital sites. • Identify, training and develop Respect and Resolution advocates (similar to Mental Health first aiders) • Train Mediators so there is team and organisational resilience and network. • Regular Schwartz rounds arranged across the Health Board • Taking Care giving care Rounds integrated into our leadership offers and available for teams to undertake either with support or on their own. • Close links with the Arts in Health programme • Promotion of walking meetings in leadership programmes Working with Planning and Estates team to ensure the Queens Canopy is designed to promote clear walking routes for that can be used during breaks for meetings Inclusion of break times and staff rooms in wellbeing survey to audit current provision. • Chaplaincy service for staff • Re-launching Chill out in the Chapel • Recruitment of staff counsellors	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Monitoring Framework to support roll out of the People Plan 22-25 • Monitoring of demand on wellbeing services • Staff diversity networks • Race/LGBT groups **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • People and Culture Committee reports (People Plan 22-25) • Local surveys • LNC – reporting of compliance of BMA Rest and Facilities **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • National workforce surveys	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance** • Meetings with Divisions ongoing.	**Positive Assurance**

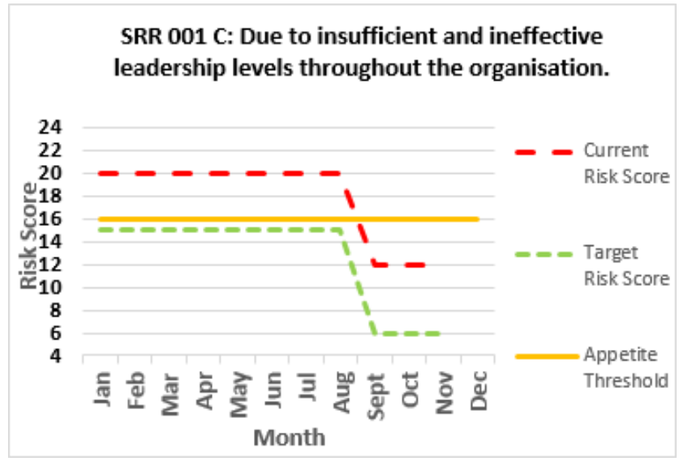
• Staff related policies.	• Establishment of new bilingual Health and Well-being AB Pulse page on the intranet with library of resources for staff well-being • Scope, design and deliver a programme of research 'Healthy Working Day'. • Enhanced our financial well-being offer. • Support offered to Trade Union Representatives and their members to ensure a positive experience of work and rapid escalation when appropriate. • Support availability of "Safe Space" conversations for senior medical leaders from Faculty of Medical Leadership & Management. • Drafting of a 10-year plan focusing on optimising the employee experience of work • The Avoidable Employee Harm Programme was launched on 5th July 2022 initially focusing on HR processes it will then look to other formal processes that inadvertently cause harm to all those involved and the organisation. The training day that supported the launch has evaluated very well and organisations beyond ABUHB are keen to engage. Within ABUHB we have subsequently seen a >60% reduction in gross misconduct investigations. **Occupational Health** • Occupational Health and NWSSP are working in partnership to implement a new Occupational Health Software system across Wales called OPASG2. OPASG2 provides benefits to employment and recruitment processes. • Occupational Health and the Well-being Service continue to work with Therapies colleagues on support for staff experiencing Long Covid-19. • Reviewed Occupational Health provision and consider options to improve sustainability within the service, paper drafted. **Support equality and diversity of workforce** • Review of staff diversity networks • Review of wellbeing survey through and equality lens to understand variations within diverse workforce demographic profile. • Development of a buddy system to assist international medical staff with induction and orientation and support values and current norms. • Development of an empowerment passport to support disabled staff and reasonable adjustments and wellbeing. **Other** • Assessment of compliance against BMA Rest and Facilities charter complete with action plan developed, reporting to LNC. • Reducing fatigue poster developed	• Monitoring and compliance of BMA Rest and Facilities via NHS Employers		

RISK THEME	PEOPLE			
Strategic risk (SRR 001C)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	c) Due to insufficient and ineffective leadership levels throughout the organisation			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve sustainability ➢ Poor levels of accountability and delivery ➢ Reputational damage to the health board as an employer ➢ Adverse impacts on staff recruitment and retention			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	**3** *(Possible)* *x*	3 *(Possible)* x
Initial Date of Assessment	01/06/2023	**Impact**	**4** *(Major)*	2 *(Minor)*
Last Reviewed	10/10/2023	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*

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

Risk Appetite Threshold - Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Monitoring Framework to support roll out of the People Plan- focus on Talent and Succession Planning • Monitoring frameworks with HEIW	**Talent and Succession Planning** • lead appointed in July 2023 on a 6-month secondment funded by HEIW to create an organisational talent management framework to enable the organisation to deliberate and consistently attract, identify and develop talent for critical roles across ABUHB • Pilot planned for Finance, Occ Health and divisional managers focusing on how to identify critical roles, development sessions on holding career conversations and culminating in a Talent Management Strategy • Local management trainee scheme scoped, and project plan created, JDPS created and evaluated. Project team convened. Paused in May 2022 due to lack of funding. • 2021/23 HEIW schemes complete. Two HEIW Grads have successfully completed the programme and have secured promotional roles within NHS in Wales; one within the health board and one at Powys, both at Band 7 level • 1 x HEIW funded graduate management trainee successfully appointed August 2023 following additional recruitment process. Executive Director of Planning sat on interview panel. Trainee commences scheme 5th September 2023 at HEIW at joins ABUHB Friday 8th September. **Development leadership capabilities** • Designing learning journeys and access to Gwella • Leadership journey and programmes mapped and 1 pager flyer designed & on intranet. Exploring Directorate Manager development.	Level 1 Operational *(Implemented by the department that performs daily operation activities)* • WOD Divisional reporting • Evaluation of internal leadership programmes Level 2 Organisational *(Executed by risk management and compliance functions.)* • Reporting to People and Culture Committee - progress against People Plan 22-25 **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal Audit Review • Talent and Succession Board	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Positive Assurance**

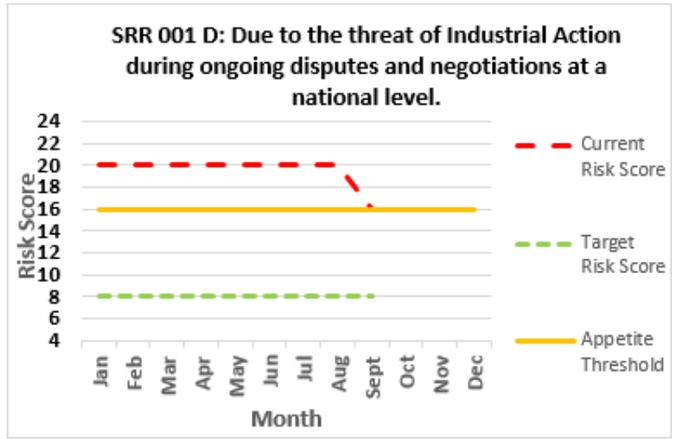
	• CDx Leadership Development for clinical directors completed for 2022/23 with 45 attendees and CDx cohort 2 starts October 23- open for current and aspiring CDs • 2022/2024 Academi Wales scheme the Health Board are sharing a graduate with Monmouthshire Council, our Graduate joined the Health Board in March 2023 and is supporting the decarbonisation agenda.			

RISK THEME	PEOPLE			
Strategic Risk (SRR 001D)	**The Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	d) Due to the threat of Industrial Action during ongoing disputes and negotiations at a national level			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Non-compliance with safe staffing principles and standards ➢ Litigation & Financial Penalties ➢ Reputational damage to the health board and loss of public confidence			
Lead Director	Director of Workforce & Organisational Development	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	People & Culture Committee	**Likelihood**	**4** *(Likely)* *x*	**2** *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	**4** *(Major)*	**4** *(Major)*
Last Reviewed	10/10/2023	**Risk rating**	**= 16** *(Extreme)*	**= 8** *(High)*

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

Risk Appetite Threshold – Open Score 16 and below
Risks relating to recruitment and retention of the right people with the appropriate skills and risks relating to the successful delivery of our people strategy which would include culture and wellbeing.

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Section 234A of the Trade Union and Labour Relations (Consolidation) Act 1992; and • CODE OF PRACTICE Industrial Action Ballots and Notice to Employers • Under sections 231 and 231A of the 1992 Act a union must, as soon as reasonably practicable after holding an industrial action ballot, take steps to inform all those entitled to vote18, and their employer(s), of the number of individuals entitled to vote in the ballot; the number of votes cast in the ballot. • Business Continuity Processes - Redeployment Principles and Risk Assessment agreed. • Duty of Quality - Section 6.8.2 Workforce and Section 6.8.3 Culture	• Services Business continuity plans in place. • All Wales training sessions provide by legal and risk to support industrial action. • Ensure early identification of mandated Statutory, and core critical clinical services. • Trade union provides a list of the categories of employee to which the affected employees belong, figures on the number of employees in each category, figures on the numbers of employees at each workplace, the total number of affected employees. Such information will enable the employer to readily deduce the total number of employees affected, the categories of employee to which they belong, the number of employees concerned in each of those categories, the workplaces at which the employees concerned work and the number of them at each of these workplaces. • Reducing impact on patients - Support for early supported discharge prior to industrial action. • Trade Unions specifies: (i) whether the union intends the industrial action to be "continuous" or "discontinuous" (14); and (ii) the date on which any of the affected employees will be called on to begin the action (where it is continuous action), or the dates on which any of them will be called on to take part (where it is discontinuous action). • Establish WOD hub with emergency planning to stand up as required • Ensure early identification of mandated Statutory, and core critical clinical services. • Review of business continuity plans • Map services and staff provision and impacts of industrial action.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Local Staff re-deployments assessment • Trade Union Partnership meetings **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Reporting to Executive team • Business Continuity groups **Level 3 Independent**	**Gaps in Assurance** • Unknown outcome of current BMA ballot and outcomes if members vote for industrial action the level of action imposed or if all medical staff will be involved, mitigating actions would not support whole scale medical workforce. **Action to Address Gaps in Assurance**	**Reasonable Assurance**

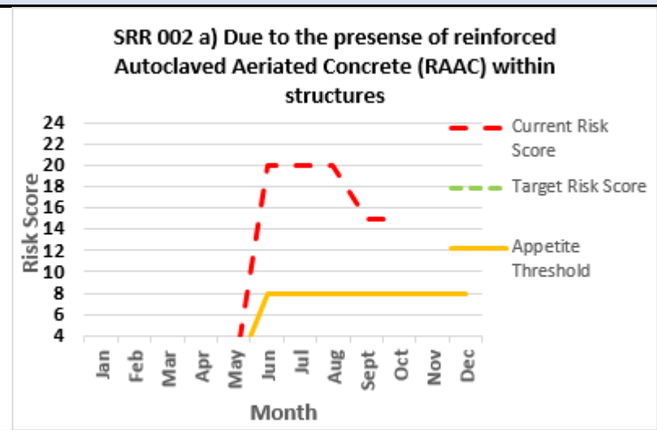
• Operational planning, led by the Chief Operating Officer, to respond to implications of strikes action in other NHS organisations.	• Assess variable pay usage in case of work to rule applies. • Assess current vacancies. • Working with partners in Gwent on a system wide basis. • Implementation of business continuity plans. • Communication plans. • Establish working mechanisms with NWSSP to consider derogations for junior doctors (who are the employer).	*(Implemented by both auditors internal and external independent bodies.)* • All Wales IA group		

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk (SRR 002)	**There is a risk that there will be significant failure of the Health Boards Estates.**			
Strategic Threat	a) Due to the presence of Reinforced Autoclaved Aeriated Concrete (RAAC) within structures.			
Impact	Harm or injury to patients and/or staff. Adverse impacts on the delivery of care to patients across acute and non-acute settings. Non-compliance with health and safety legislation. Litigation and financial penalties			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	1 (*Rare)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
Last Reviewed	10 October 2023	**Risk rating**	**= 15** *(Extreme)*	**= 2** *(Low)*

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

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

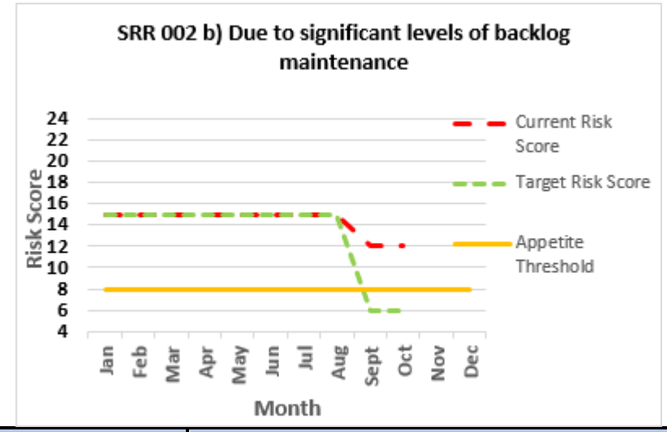
SUMMARY
The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment)*
• Work to access the risk has been undertaken with expert external surveyor advice. • Current measures including props and additional support have been put in place in line with the latest guidance and learning from other organisations working through RAAC issues. Plans will be modified in line with any further guidance. • Remediation work to areas of high-risk areas	• Additional Surveys are to take place with expert surveyors to inform the next steps relating to further remediation of the issues.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Weekly checks in place for the additional props and will be undertaken by an external company in the coming weeks. • Ongoing engagement with expert surveyor and monitoring of RAAC. • The estate's function has controlled access to roof areas and has developed and implemented toolbox talks for awareness for estate teams and contractors to work in those areas. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Estates and Facilities Divisional Compliance team engaged in supporting estate's function response to the ongoing management. • Health Board Fire and Health and Safety function engaged in fortnightly governance group to monitor risks and issues associated with any remedial measures implemented. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Weekly dialogue with Welsh Government and Shared Services Estates.	**Gaps in Assurance** • Ongoing management of the issues. **Action to Address Gaps in Assurance** • Additional surveys have been commissioned and will be undertaken as promptly as possible through the contractor to provide assurance on the work to date as well as determine further management of the risk/issues.	**Reasonable Assurance**

		• Links with NHS England and other Health Boards in Wales for shared learning. • Ongoing engagement of external surveyors for regular monitoring of the situation in line with recommended timelines.		

RISK THEME	COMPLIANCE AND SAFETY			
Strategic Risk (SRR 002)	**There is a risk that there will be a significant failure of the Health Board Estates.**			
Strategic Threat	B) Due to significant levels of backlog maintenance.			**Risk Appetite Level – MINIMAL** Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible/low likelihood of occurrence of the risk after application of controls.
Impact	Harm or injury to patients and/or staff. Adverse impacts on the delivery of care to patients across acute and non-acute settings. Non-compliance with health and safety legislation. ➢ Litigation and financial penalties.			**Risk Appetite Threshold – SCORE 8 AND BELOW** Risks relating to all aspects of patient safety but also including safeguarding, staff & public security in addition to risks relating to compliance and/or legal implications. **SUMMARY** The current risk level is **outside** of the target level and appetite threshold. The target level to be achieved is **within** the set appetite threshold.
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Health Protection & Planning Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	**2** (*Minor)*
Last Reviewed	10 October 2023	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*



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

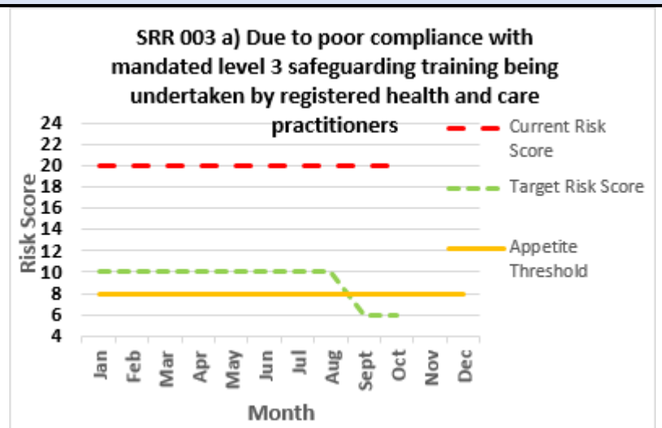
• A robust internal training programme in place covering all aspects of estate management including food hygiene. • Asbestos reinspection programme (over the next 3 years)	• Additional escalation for capital funding by the Division Estates and Facilities to support the prevention of seasonal issues and plant failure if possible.	1. Estates Assurance - Estate Condition to be undertaken in Q3. 2. Authorising Engineer (Shared Service Estates) reports in line with normal timelines, but active engagement with AEs through compliance processes. 3. Health Board contributes to annual Estates Facilities and Performance Managements (EFPMS) at all Wales level		

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**			
Strategic Threat	a) Due to poor compliance with mandated level 3 safeguarding training being undertaken by registered health and care professionals.			
Impact	Missed safeguarding concerns, resulting in harm or death. Vulnerable individuals not identified appropriately, resulting in harm or death. ➢ Lack of staff understanding of reporting and escalation process ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Minor)*
Last Reviewed	14 September 2023	**Risk rating**	**= 20** *(Extreme)*	**= 6** *(Moderate)*

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

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

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Safeguarding policies • Safeguarding Training offered at level 1 & 2 via ESR. (Current compliance data - adult & child level 1 -81%; Children level 2 55.7% Adult level 2 58.0) • Supervision and case review available. • Safeguarding Hub –for ad hock advise from a band 7 safeguarding lead nurse: Monday – Friday 09.00 – 17.00 • Utilising all communication methods available to promote completing safeguarding training.	• Updated training packages. • Training sessions booked for children and adult level three safeguarding training. • Communication with practitioners, via share point intranet pages, emails to divisional nurses. • Protected time to complete Level 2 and 3 training wher possible. • Clear mandate of level 3 training is required on ESR.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Training compliance reported at Senior Nursing Team meetings. • Good use of the adult and child safeguarding hub facility **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Robust monitoring of safeguarding activity through the Safeguarding Committee via quarterly reporting • Safeguarding Committee Assurance Report to the Patient Quality, Safety & Outcomes Committee *(PQSOC)* • Audit Reports reviewed by the Audit, Risk and Assurance Committee (ARAC) • Progress of Audit Recommendations monitored and tracked through the ARAC. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit 2023 – 24** 1. Safeguarding (Q1) Reasonable Assurance Outcome 2. HIW Inspections	**Gaps in Assurance** • As level three training is mandated every three years, the expectation is that we will not see an acceptable level of compliance until 2026. • Level 2 safeguarding training compliance levels below expectation of 85%. **Action to Address Gaps in Assurance** • Spot check of Level 2 safeguarding training through ESR to target improvement. • Monitor at SMT	**Negative Assurance**

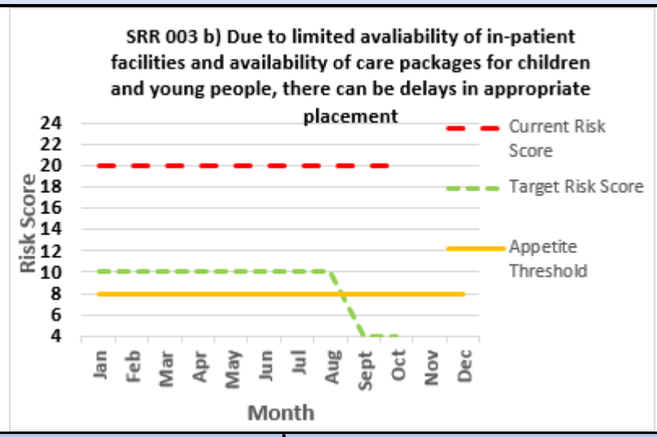
RISK THEME	COMPLIANCE AND SAFETY
Strategic risk (SRR 003)	**There is a Risk that the Health Board breaches its duties in respect of safeguarding the needs of children and adults at risk of harm and abuse.**
Strategic Threat	b) **Due to limited availability of in-patient facilities and availability of care packages for children and young people, there can be delays in appropriate placements.**
Impact	➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence

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

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

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

Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient, Quality, Safety and Outcomes Committee.	**Likelihood**	4 *(Likely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	5 *(Catastrophic)*	2 *(Unlikely)*
Last Reviewed	14 September 2023	**Risk rating**	**= 20** *(Extreme)*	**= 4** *(Moderate)*



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• CAMHS now have a team of healthcare support workers, at band 4 (our BOOST team), who are in the process of being trained, prior to being ready to be available over 7days to directly support young people who are in hospital because of a delayed discharge. • CAMHS have an agreement with adult Mental Health Services in place, enabling us to access a 'holding bed 'situated in the Extra Care area at Ty-Cyfanol ward, at YYF. This allows us to support young people experiencing suspected serious mental illness for up to 72 hours, whilst a gatekeeping assessment is carried out by our colleagues at the tier 4 in-patient unit. • Our Emergency Liaison Team are present at GUH on a daily basis, assessing young people at the point of need. • Windmill farm therapeutic residential home, a partnership project between CAMHS and social services, is now open and can accommodate young people struggling with complex mental distress that are environmental and not organic. There are 4 places at the home, and we have already successfully placed, supported, and transitioned	• Development of the CAMHS Crisis Hub (CCH), based at Bettws ward in St Cadoc's. We are in the process of developing a safe space for families and young people who are in distress, so that they have access to a team of people, out of hours, who can work directly with them in order to attempt to prevent burgeoning emotional distress from developing into a crisis situation that can cause further trauma. The CCH is being developed in order to help young people who fit the following criteria: • Young people whose distress compels them to frequently attend the Emergency Department, or who frequently find themselves detained under section 136 of the Mental Health Act. • Young people who having been assessed under Section 136 at the Section 136 suite at Adferiad, find themselves discharged with no immediate safe discharge destination. • Young people who having presented at the Emergency Department following self-harm or overdose requiring medical treatment, are admitted overnight for treatment as per NICE guidelines, but once	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Senior Management Team meetings to track progress against the action plan. • Twice-daily X-Site flow meetings to provide a position report **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee • Regular reporting to the Mental Health Act Monitoring Committee • Reporting to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • HIW Inspections of Mental Health Wards across all sites	**Gaps in Assurance** • Under review **Action to Address Gaps in Assurance**	**Reasonable Assurance**

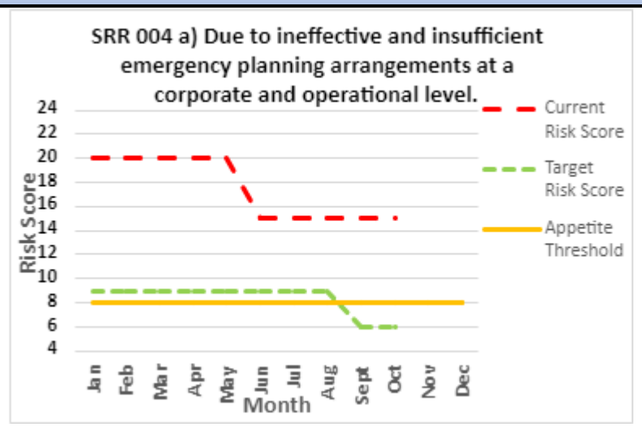
several young people who may previously have required an out of county placement. • BOOST team manager in place. • Crisis Outreach Team are the designated team who manage and co-ordinate admission to the holding bed. • Standard Operational Policy in place for CAMHS teams to be able to access BOOST workers. • Agreed referral process to Windmill Farm, with a gatekeeping team comprised of CAMHS and social care colleagues who are able to advise whether or not a referral is suitable; attendance at Complex Needs panels to operationalise the gatekeeping process. • Standard operational policy and care pathway in place for admission to the holding bed. • Detailed Standard Operational Policy in place for Windmill Farm. • Regular communication meetings between CAMHS teams and the Windmill Farm team.	medically fit do not have a safe discharge destination, resulting in an extended stay at GUH for social reasons. In these cases, qualified professionals and BOOST support workers will work closely with the family and colleagues from social care, in order to ensure that a safe discharge can be agreed. • Young people who are currently working with a CAMHS professional and are felt to be at risk of experiencing imminent mental health crisis and cannot be supported out of hours by the referring professional. The aim will be to focus on helping young people to stay safe by working with them to develop a short- term plan of what to do in the moment. The CCH will provide a venue that is safe, so that community -based treatment at the point of crisis can be implemented in the least restrictive of settings. • Regular Crisis Hub planning meetings; ongoing development of the SOP; recruitment of a Crisis Hub team lead.			

RISK THEME	COMPLIANCE AND SAFETY			
Strategic risk (SRR 004)	**There is a risk that the Health Board is unable to respond in a timely, efficient, and effective way to a major incident, business continuity incident or critical incident.**			
Strategic Threat	a) Due to ineffective and insufficient emergency planning arrangements at a corporate and operational level.			
Impact	➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Harm or injury to patients and/or staff ➢ Health Board breaches statutory duties under the Civil Contingencies Act 2004 ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning and Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	5 (*Catastrophic)*	3 *(Moderate)*
Last Reviewed	10/10/2023	**Risk rating**	**= 15** *(Extreme)*	**= 6** *(Moderate)*

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

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

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
Major Incident • Health Board major incident plan in place. • Local/Divisional action cards are in place. • Training undertaken service-specific relating to local response. • Regular liaison with Gwent Local Resilience Forum (Strategic and tactical) **Business Continuity (BC) /Critical Incident** • BC Policy • BC Response Guidance • BC Template • BC Exercise • BC debrief learning. • HB and LRF Plans. 3 C (Command/Control, Communication) structure in place to respond to incidents. • Ongoing Participation in exercise UK, Wales, LRF and HB.	• Testing programme of business continuity plans. • Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. • Improved Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, Conduct BIAs develop plans, Exercise, review, to mitigate the risks and threats to service delivery. • Repository being created on intranet for BC plans to be added by areas for audit, maintenance, review of interdependencies. • Joint planning with PH response in response to infection disease and public health incidence. • Provide quarterly training sessions for on call gold and silver managers, to maintain skills in incident management, update knowledge in relation to risks and learning from local and national incidents. Test and exercise using the multiagency Joint decision model and the principles of joint working (JESIP). • Embed an alert, activation and escalation pathway that follows the Health Board predefined C3 (Command, control, and Co-Ordination) structure of strategic, tactical, and Operational. • Working with ICT to scope how to maintain critical communications during loss of IT linked telephone systems or national power outages.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Departmental debrief following an incident to inform learning and enhance controls. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Debrief with key stakeholders following an incident to inform learning and enhance controls. • Report to the Executive Committee following any incident. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Review(s)** 1. Business Continuity Planning (Q1) outcome report published. 2. Outcome and feedback from national exercises	**Gaps in Assurance** • Robustness of service business continuity plans **Action to Address Gaps in Assurance** • Recommendations for strengthening resilience following testing of service business continuity plans	**Reasonable Assurance**

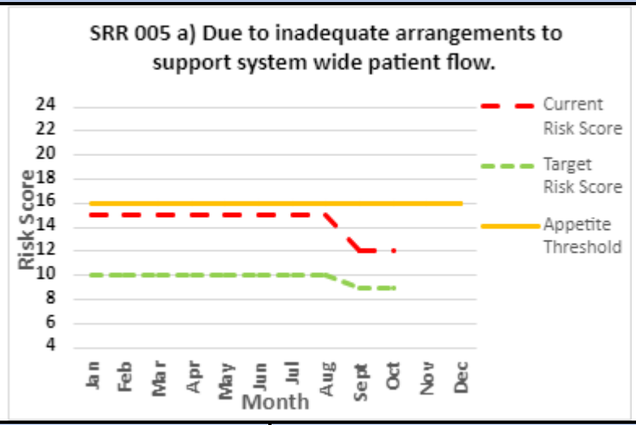
	• Work with the communication team to improve incident cascade during an event to ensure Health Board wide awareness in a timely manner. • Continue to promote awareness in a timely manner. • Continue to promote awareness of the requirement for BC across the Health Board. • A tabletop BC exercise is planned for the 10th of October 2023. • Continuing participation in multi-agency exercises. • Programme plan to be developed to address the weaknesses in business continuity planning. • Review of revised Civil Contingency Act anticipated later this year to determine the impact on the Health Board. • Development of Pandemic Plan.			

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 005)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe services across the whole of the healthcare system.**			
Strategic Threat	a) **Due to inadequate arrangements to support system-wide patient flow**			
Impact	➢ Avoidable deaths or significant harm ➢ Delays in releasing ambulances from hospital sites back into the community ➢ Delayed discharges from acute and non-acute settings resulting in deteriorating patients; ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Chief Operating Officer	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	3 *(Possible)* x	3 *(Possible)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Catastrophic)*	3*(Minor)*
Last Reviewed	14 September 2023	**Risk rating**	**= 12** *(High)*	**= 9** *(High)*

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

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

SUMMARY
The current risk level is **outside** of target level but **within** appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Escalation Policy. • Performance and Accountability Framework • Major incident Procedures • Daily X-site flow meetings - Twice daily flow calls to receive updates from all acute sites as well as community services. Allowing opportunity for escalation of risks. • Escalation communications – ambulance focussed email escalation when congestion begins to build up on the GUH forecourt. Aim to escalate to senior management to aid in quick risk-based decision making. Includes members of the Executive team. • Weekly safety flow forum – Cross divisional focused forum to look at priority areas to improve flow from across the system. Action focussed and task driven. • Range of performance measures/metrics in place • Repatriation mechanism with neighbouring Health boards – Daily repatriation calls between head of operations and counterparts in south Wales to ensure regular dialogue to repeat patients between hospitals and health boards. • Maximum Capacity Plan – Executive team agreed maximum capacity plan to ensure there is clear description ad guide for where extra capacity can be accessed to ensure patient flow is maintained. • Planned care recovery meetings with the NHS execs • Regular Dialogue with WAST regarding flow across the patch/regional and attending national calls.	• Escalation framework – evidence suggesting inconsistent escalation of ambulance position / long waits and rationale. • Winter planning – Ahead of winter 23/24 there are a series of meetings which will ensure that tangible / practical plans are put in place to ensure: • Focus • Processing power • Capacity • Mental health-focussed flow meeting – implement a MH-focussed daily forum to ensure the flow requirements and risk profile is understood across all MH sites. • Build in more impromptu, OoH and site visits to check on processes i.e., patient safety, risk, and performance across the Divisions. • Improve regional acceptance of flow processes with neighbouring Health Boards	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • The Escalation Framework has been enacted and is effective in mitigating threats and impact to services. • Performance report against measures/metrics **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Divisional Assurance reviews. • Performance against measures/metrics reported to the Executive Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • **Internal Audit Reviews** • Intra-site Patient Transfers (Q1) - Not Yet Reported (expected to be received at Audit, Risk & Assurance Committee in February 2024. • External inspections/visits.	**Gaps in Assurance** • Evidence that the Escalation Framework is delivering improvements across all areas of patient flow e.g., ambulance handovers. • The impact of the Performance and Accountability framework in improving patient flow **Action to Address Gaps in Assurance** • Close monitoring and reporting of the frameworks in practice to support learning and improvements.	**Reasonable Assurance**

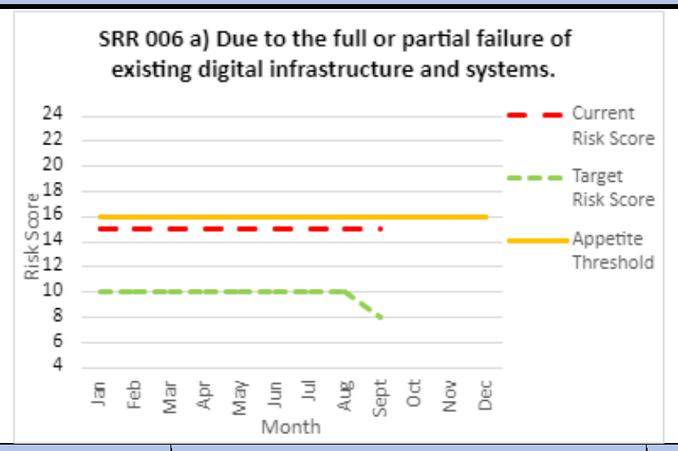
• WG – IQPD meetings to review areas of focus.				

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**			
Strategic Threat	a) Due to the full or partial failure of existing digital infrastructure and systems.			
Impact	Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 (Possible) x	2 (Unlikely) x
Initial Date of Assessment	01/06/2023	**Impact**	5 (Catastrophic)	4 (Major)
Last Reviewed	13/09/2023	**Risk rating**	**= 15** (Extreme)	**= 8** (High)

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

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

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall)*
• Cyber has developed a Remedial Action Plan to address issues identified within the NIS CAF assessment 2021. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually. • Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff • Cyber now undertakes scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report. • Cyber has also worked with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber and the Teams to	• Information Governance and Cyber Security governance and assurance processes are now under review. Governance group terms of reference agreed, and reporting arrangements discussed with Director of Corporate Governance. Meetings will commence in November with clear reporting on progress to the relevant committees on our cyber security action plan. • SIRO training arranged for the 25th September for the Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO).	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings being setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* • Internal audit for cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.	**Gaps in Assurance** • Governance and assurance groups. • Oversight from NHS Wales Cyber Resilience Unit. **Action to Address Gaps in Assurance**	**Reasonable assurance**

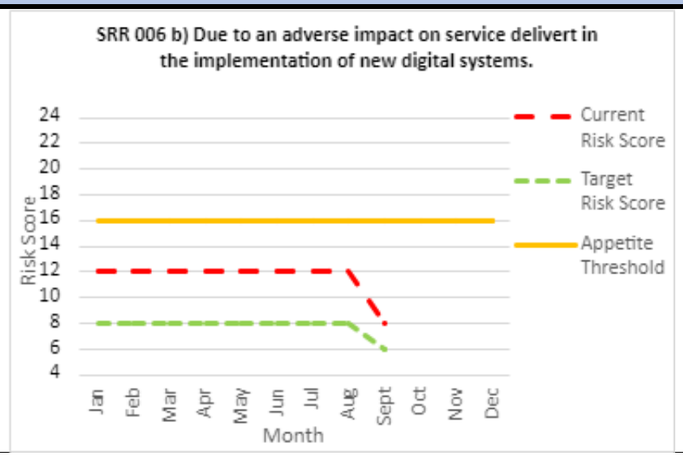
review compliance levels against policy. Results are captured within the monthly Cyber Report. • Cyber has worked with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The less service impacting Version 1 is being managed through ICT Departmental risk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

RISK THEME	SERVICE DELIVERY
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**
Strategic Threat	b) Due to an adverse impact on service delivery in the implementation of the new digital systems.
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties Reputational damage and loss of public confidence

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

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

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold



Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* *x*	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	17/09/2023	**Risk rating**	**= 12** *(High)*	**= 6** *(Moderate)*

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

• Projects support backfilling of clinical time where required		• Internal audit for cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.		

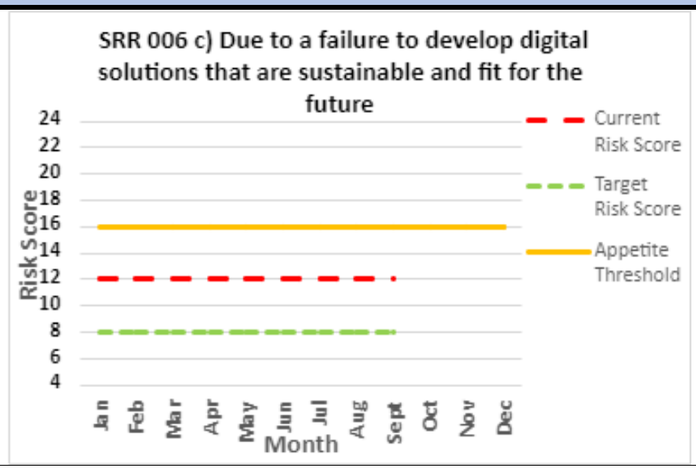
RISK THEME	SERVICE DELIVERY
Strategic Risk (SRR 006)	**There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.**
Strategic Threat	c) Due to failure to develop digital solutions that are sustainable and fit for the future.
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Data breaches ➢ Litigation & Financial Penalties ➢ Reputational damage and loss of public confidence

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

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

SUMMARY
The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold

Lead Director	Director of Digital	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	15/09/2023	**Risk rating**	**= 12** (High)	**= 8** *(High)*



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	Plans to Improve Control *(Are further controls possible to reduce risk exposure within tolerable range?)*	Sources of Assurance *(Evidence that the controls/ systems which we are placing reliance on are effective)*	Gaps in Assurance/ Actions to Address Gaps *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	Assurance Rating *(Overall Assessment based on the information supplied)*
• New Digital Service Request process in place which provides governance in several key areas: • Information Governance – ensuring new services have appropriate controls to keep patient information safe. • Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework. • Patient Safety – ensuring services do not introduce any patient safety risks. • Records – ensuring new systems comply with the requirements of records management.	• New governance structures to be put in place by the end of 2023. • Review of New Digital Request processes considering governance changes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Internal directorate meetings being setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular Reporting to the Finance & Performance Committee **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)*	**Gaps in Assurance** To be determined **Action to Address Gaps in Assurance**	**Reasonable assurance**

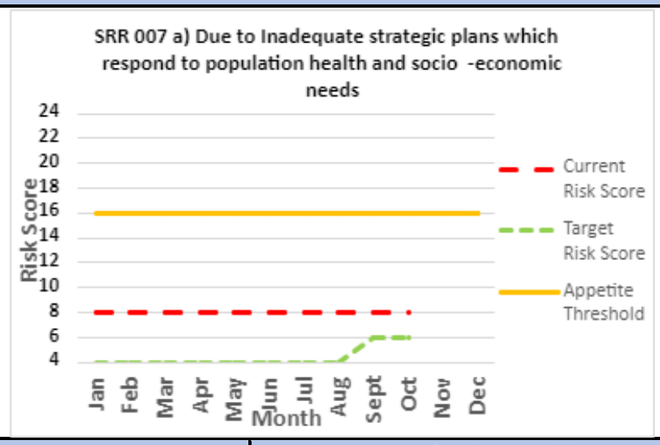
• Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require. • Business change function which ensures implemented systems are effective and deliver the benefits required. • Formal framework in place for the adoption of new digital services and best practice guidance followed. • Operational delivery aligned to ITIL standards		• Internal audit for cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.		

RISK THEME	SERVICE DELIVERY			
Strategic risk (SRR 007)	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**			
Strategic Threat	a) **Due to inadequate strategic plans which respond to population health and socio-economic needs.**			
Impact	➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to train teams in multi-morbidity management ➢ Failure to comply with the Wellbeing of Future Generations Act (Wales) ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)*	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 (*Major)*	3 *(Moderate)*
Last Reviewed	10/10/2023	**Risk rating**	**= 8** *(High)*	**= 6** *(Moderate)*

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

Risk Tolerance Level - Open Score 16 and below
Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.

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



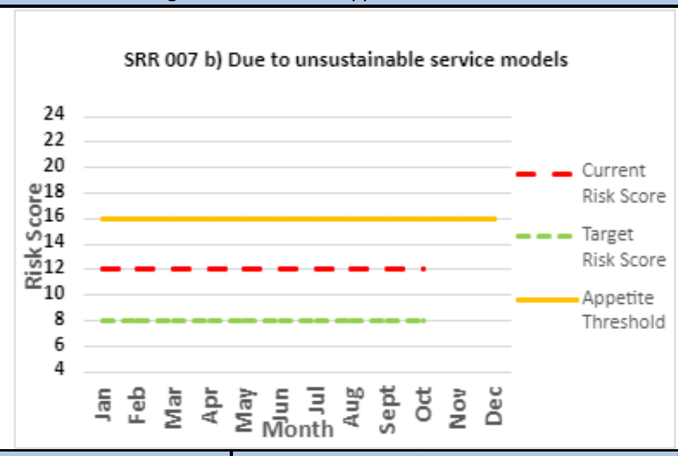
Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence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

RISK THEME	SERVICE DELIVERY			
Strategic risk (SRR 007)	**There is a risk that the Health Board will be unable to deliver and maintain high quality, safe and sustainable services which meet the changing needs of the population.**			
Strategic Threat	b) **Due to unsustainable service models**			
Impact	➢ Harm or injury to patients and/or staff ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Increased demand ➢ Increased patient acuity levels ➢ Worsening of health inequalities ➢ Worsening of health outcomes ➢ Failure to deliver health board priorities, required improvements and achieve sustainability ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	3 *(Possible)* x	2 *(Unlikely)* x
Initial Date of Assessment	01/06/2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	10/10/2023	**Risk rating**	**= 12** *(High)*	**= 8** *(Moderate)*

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

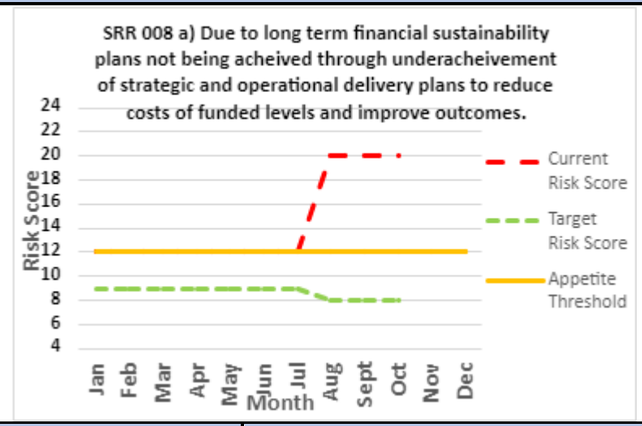
Risk Tolerance Level - Open Score 16 and below
Risks relating to all aspects of our ability to deliver, manage and improve service quality and performance along with all relating risks relating to the current performance of our infrastructure such as IM&T and estates including our ability to deliver associated strategy.

SUMMARY
The current risk level is **outside** of target level but within appetite threshold.



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

RISK THEME	FINANCIAL SUSTAINABILITY			
Strategic Risk (SRR 008)	**There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.**			
Strategic Threat	Due to long-term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes.			**Risk Appetite Level - Cautious.** Preference for safe, through accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.
Impact	➢ Breach of statutory duty to breakeven over 3 years. ➢ Instigation of NHS Wales Escalation & Intervention Arrangements. ➢ Non–delivery of health board priorities, required improvements, and achieving longer-term sustainability. ➢ Prioritisation and possible disinvestment in service delivery. ➢ Reputational damage and loss of public confidence			**Risk Appetite Threshold - Score 12 and below** Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies. **SUMMARY** the current risk level is **outside** of the target and appetite threshold. The target level to be achieved is **within** the set appetite threshold.
Lead Director	Director of Finance and Procurement	**Risk Exposure**	**Current Level**	**Target**
Monitoring Committee	Finance & Performance Committee	**Likelihood**	5 *(Almost certain)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	4 *(Major)*
Last Reviewed	10 November 2023	**Risk rating**	= **20** *(Extreme)*	= **8** *(Moderate)*



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• IMTP 2023/24-25/26 • IMTP Delivery Framework • Accountability Framework • Performance Framework • Scheme of Delegation • Standing Financial Instructions (SFIs) • Standing Orders (SOs) • Financial Control Procedure (FCP) Budgetary control • Financial Budget Intelligence (FBI) • Budget holder training • Cost intervention procedures • 23/24 savings plans & opportunities. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs. • Quarterly financial budget plan approach agreed. • Executive groups and structures established to deliver statutory duties	• Update performance management framework – in place • Assessment of financial control environment within divisions and corporate teams. – in place	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Adherence to SO/SFI/FCPs • Regular AFD meetings to discuss position and performance. • Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Performance escalation meetings established • Financial assessment and review report to the Board and Finance & Performance Committee • Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee. • Board Briefing sessions on the financial position. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies.)* **Internal Audit Reviews 2023 - 24** 1. Savings Programmes - Q3 Not yet undertaken. 2. Financial Controls – Q2 Not yet reported. 3. Asset Management – Q3 Not yet undertaken. **External Audit Reports 2023 -24** 1. Efficiency Review Q3/Q4 2. Structured Assessment Q3/Q4	**Gaps in Assurance** • Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability. **Action to Address Gaps in Assurance** • Revise accountability arrangements being progressed as part of Executive governance. – in place	**Medium Assurance**

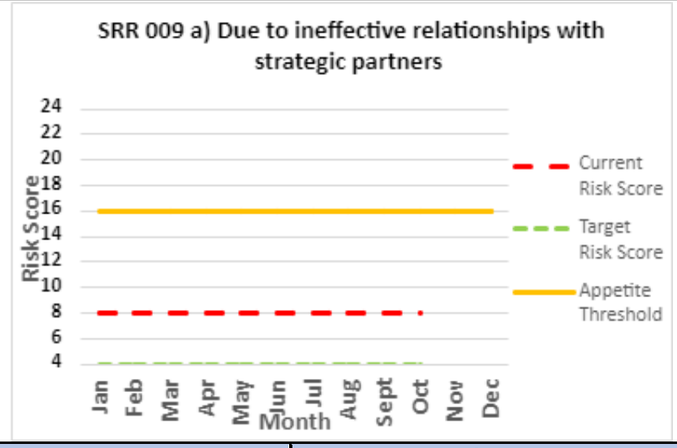
		3. Audit of Financial Statements Q4 4. Financial assessment and review reports to Welsh Government		

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 009)	**There is a risk that the Health Board will be unable to deliver truly integrated health and care services for the population.**			
Strategic Threat	a) **Due to ineffective relationships with strategic partners**			
Impact	➢ Unmet patient need resulting in harm ➢ Ineffective use of combined resources ➢ Delayed decision making ➢ Adverse impacts on delivery of care to patients across acute and non-acute settings ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence			
Lead Director	Director of Strategy, Planning, and Partnerships.	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Public Health & Planning Committee	**Likelihood**	2 *(Unlikely)* x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	10 October 2023	**Risk rating**	**= 8** *(Moderate)*	**= 4** *(Moderate)*

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

Risk Appetite Threshold - S**CORE 16 AND BELOW**
All risks relating to our ability to engage effectively with other organisations including development of collaborations and partnerships along with all risks associated with innovation, transformation, and strategic change.

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



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

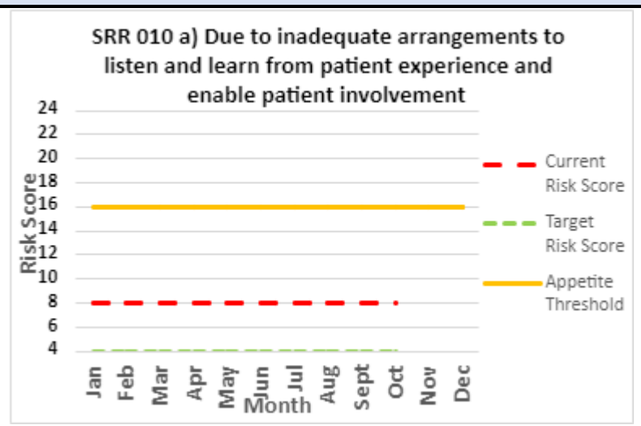
Joint working between operational teams including integrated operational arrangements and combined multidisciplinary teams, for example, Community Resource Teams				

RISK THEME	TRANSFORMATION AND PARTNERSHIP WORKING			
Strategic Risk (SRR 010)	**There is a risk that the Health Board fails to build positive relationships with patients, staff and the public.**			
Strategic Threat	a) **Due to inadequate arrangements to listen and learn from patient experience and enable patient involvement.**			
Impact	➢ Adverse impact on patient experience ➢ Failure to deliver health board priorities, required improvements and achieve longer-term sustainability ➢ Reputational damage and loss of public confidence ➢ Failure to deliver Duty of Quality			
Lead Director	Director of Nursing	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Patient Quality, Safety & Outcomes Committee	**Likelihood**	2 (Unlikely) x	2 *(Unlikely)* x
Initial Date of Assessment	01 June 2023	**Impact**	4 *(Major)*	2 *(Minor)*
Last Reviewed	14 September 2023	**Risk rating**	**= 8** *(High)*	**= 4** *(Moderate)*

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

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

SUMMARY
The current risk level is **outside** of target but within the appetite threshold. Target level is **within** the set appetite threshold.



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• Corporate Engagement Team • Patient Experience and Involvement Strategy- organisational ownership • Person Centred Care (PCC) Surveys via CIVICA • PCC KPI's (support PCC Quality pillar) • 'You said…… we did' public facing information for service areas • PLO service at GUH • Introduction of PALS Service (Oct 23) • Volunteer Patient Experience Feedback • Collaboration to recruit community listeners to support Dementia Awareness • Digital patient stories to support listening and learning. • Patient Experience and Involvement Strategy • DATIX	• Structured graduated approach to roll out of Civica to ensure divisional teams can use and access data. This will ensure sustainable progress. • PCCT staff training to support Civica data entry and retrieval. • Programme Manager for Dementia working regionally to improve public engagement and promote the role of Community Listeners. • Employment of dedicated PALS team in progress who will have a key role in gaining feedback from patients, staff and relatives. • Completion of surveys limited to QR code access or physical presence of PCCT to manually ask and in-put data. No SMS provision. • National directives around new national surveys that need to be managed additional to internal roll out programme. • Volunteer feedback to be reviewed to identify themes.	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Person Centred Care Team oversee patient experience through dedicated work programme and link in with divisional teams. • Concerns are fed back to divisional teams when identified. • Outcome of the volunteer feedback to drive improvements. **Level 2 Organisational** *(Executed by risk management and compliance functions.)* • Regular reporting to the Patient Quality, Safety & Outcomes Committee (PQSCO) • Listening and Learning reported through QPSOG/ Outcomes Committee **Level 3 Independent**	**Gaps in Assurance** • No SMS provision to increase the number of PCC surveys. • No single point of contact or 'drop in' provision for patients/families/staff to raise initial patient experience concerns. **Action to Address Gaps in Assurance** • Discussions with VBHC team to consider SMS through DrDoctor • PALS Single point of contact is being established. PALS officers will have key role in patient experience and involvement- including establishing 'drop in' clinics on	**Reasonable Assurance**

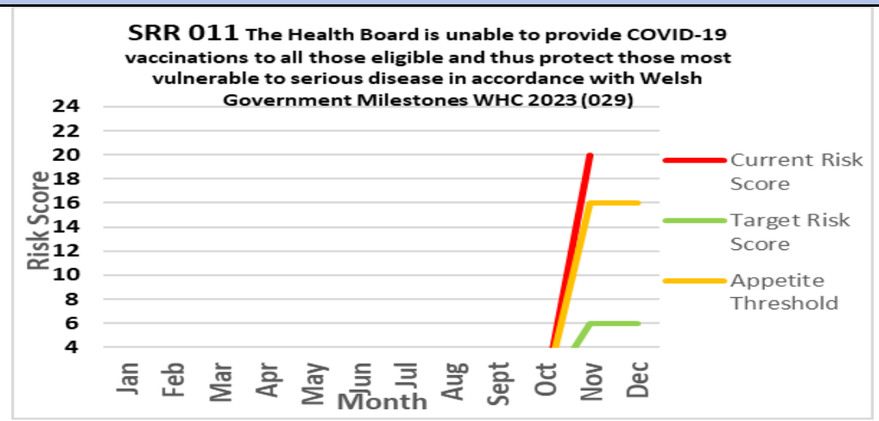
		(Implemented by both auditors internal and external independent bodies.) • LLais Reports • HIW inspections	hospital sites should patients/staff/relatives wish to discuss concerns. • PCC KPI's and common themes need to be identified and reported through the PCC Survey. These will be added to a template patient experience report and CIVICA surveys will be built into ward accreditation. • Implement PALS DATIX Module	

RISK THEME	SERVICE DELIVERY			
Strategic Risk (SRR 011)	**The Health Board is unable to provide COVID-19 vaccinations to all those eligible and thus protect those most vulnerable to serious disease in accordance with Welsh Government Milestones WHC 2023 (029)**			
Strategic Threat	Due to the fixed-term nature of the Welsh Government allocation for the Vaccination programme, the Health Board processes in place for recruitment, and challenges related to the Health Board's current financial position, it has not been possible to fill existing immuniser vacancies to the funded establishment level. As a result, the Vaccination and Health Protection Service is unable to provide an active offer of a vaccine to those in the eligible groups within the timeframes anticipated by the Welsh Government. This may necessitate an extension of venue licences or the identification of alternative venues if the vaccination delivery plan is extended beyond the agreed-upon campaign window.			
Impact	➢ Harm or injury to patients and/or staff - Winter modelling suggests a peak in Covid-19 cases and associated bed pressures is anticipated during December 2023 and in mid-January 2024. Potential for Nosocomial spread, increased acuity of patients, and length of stay. ➢ Adverse impacts on delivery of vaccinations to patients across the vaccine service – including outreach/in reach delivery to vulnerable population, childhood immunisation & MMR catch up and flu wrap-around service. ➢ Resource – potential increase in staff sickness due to lack of protection from the vaccine in staff member groups. ➢ Financial implications due to the extension of venues. ➢ Reputational damage and loss of public confidence.			
Lead Director	Director of Public Health & Strategic Partnerships	**Risk Exposure**	**Current Level**	**Target Level**
Monitoring Committee	Partnerships, Population Health, and Planning Committee	**Likelihood**	5 *(Almost Certain)* *x*	2 *(Unlikely)* *x*
Initial Date of Assessment	06 November 2023	**Impact**	4 (*Major)*	3 *(Moderate)*
Last Reviewed	10 November 2023	**Risk rating**	**= 20** *(Extreme)*	**= 6** *(Moderate)*

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

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

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



Key Controls *(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)*	**Plans to Improve Control** *(Are further controls possible to reduce risk exposure within tolerable range?)*	**Sources of Assurance** *(Evidence that the controls/ systems which we are placing reliance on are effective)*	**Gaps in Assurance/ Actions to Address Gaps** *(Insufficient evidence as to the effectiveness of the controls or negative assurance)*	**Assurance Rating** *(Overall Assessment)*
• **Dedicated** pool of bank staff to fill shifts – although there have been challenges in filling shifts within this pool of staff. • Opening venues on additional days to allow more vaccine appointments to be offered (provided staff are available) • Daily monitoring of public vaccinations administered. • Weekly planning and delivery meetings to monitor progress, identify alternative solutions, and implement or escalate as appropriate. • Weekly programme board to approve key decisions and escalate potential risks. • Health protection Incident plan has been drafted for approval by the Executive Committee (Dec 2023) • Monitoring filled/non-filled shifts report. • Monitoring costs associated with the use of Bank staff. • Monitoring uptake of staff vaccination • Dedicated internal and external communications support.	• Secured additional funding against the existing allocation for bank vaccination staff. • Exploring deployment options to the Vaccination programme and use of those previously trained as vaccinators that are on the bank. • Alternative advertising methods of vacant shifts to improve uptake – liaising with bank co-ordinator to improve this. • Draft community pop-up plan to be further explored. • If required, extend venue licence in key location(s).	**Level 1 Operational** *(Implemented by the department that performs daily operation activities)* • Costs of bank staff reported to Programme Board • Uptake on staff vaccination reported to Programme Board • National and regional data shared with Programme Board on the % of the population vaccinated **Level 2 Organisational** *(Executed by risk management and compliance functions)* • Risk monitored by the Partnerships, Population Health, and Planning Committee via the Committee Risk Report • Exception reporting to the Executive Committee regarding uptake of the vaccine by staff and public, and capacity to deliver the milestones. **Level 3 Independent** *(Implemented by both auditors internal and external independent bodies)* • Monthly reporting to Welsh Government on uptake • PHW national data on vaccination uptake	**Gaps in Assurance** • Reporting on filled and non-filled shifts to determine the slippage in milestones of the programme. **Action to Address Gaps in Assurance** • Start reporting the filled and non-filled shifts report to the Programme Board • Model delivery based on the current resource, dedicated bank staff, and wider bank staff to determine the workforce resource to deliver.	**Reasonable Assurance**

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Executive Committee Activity: September 2023 – November 2023
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rani Dash, Director of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Board with an overview of a range of issues discussed by the Executive Committee during the period 7th September 2023 – 19th October 2023. Due to the nature of the Executive Committee's business, not all issues will be suitable for disclosure into the public domain.

Cefndir / Background

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

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

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

Asesiad / Assessment

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

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

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

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

1. Quality, Safety and Culture
2. Delivery, Performance and Efficiencies
3. Strategic Planning and Service Development
4. Strategic Partnership Arrangements
5. Transformational programmes (IMTP/Clinical Futures).

During the period 7th September 2023 – 19th October 2023, the following matters were some of the issues considered by the Executive Committee:

Quality, Safety & Culture

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

Other matters discussed include:

- Assessment of Mental Health Services: The Health Board has received reports following a review of Cwm Taf Morgannwg University Health Board (CWMUHB) by Health Inspectorate Wales Review (HIW) on Discharge Planning and an All-Wales Delivery Unit Assurance Review of Crisis and Liaison Psychiatry Services for Older Adults. The Executive Committee received an update on reviews that have been conducted regarding the Health Board's compliance with the

recommendations from these reports. An action plan has been devised, which is being implemented and audits have been planned to provide more assurance.

- Patient Safety Incident Reporting & Management Policy: The Executive Committee received the update of the Policy in line with an updated Welsh Government NHS Executive Policy, to incorporate learning from previous Serious Incidents and realignment of the Central Patient Safety Teams. The Executive Committee endorsed the policy with minor amendments for Board approval.

- Maternity & Neonatal Safety Support Programme Discovery Phase Report: Following the publication of the Countess of Chester's Maternity & Neonatal Safety Support Programme Discovery Phase Report for Welsh Health Boards, the Health Board is undertaking a multidisciplinary review of the report's recommendations and developing an Improvement Plan with priority actions.

Delivery, Performance & Efficiencies

The Executive Committee has monitored and discussed the Health Board's financial position continuously and determined the mitigating actions to improve the forecast financial position. These discussions have taken place as part of the Executive Committee meetings and in finance related specific Executive Team discussions. To ensure sufficient focus on delivery and the further examine opportunities across the Health Board, an Executive Value and Sustainability Board has been established and meets fortnightly. Specific updates in respect of financial performance are provided within the Financial Performance report to the Board.

In line with the new Performance and Accountability Framework, the Executive Team have held special budget meetings with seven divisions to discuss Divisional financial plans, financial governance arrangements, current financial position and forecast, key factors for overspend, key opportunities and risks and for joint agreement on how the Executive Team can support the Divisions.

Other matters discussed include:

- Welsh Nursing Care Record (WNCR): The Executive Committee received an update on the implementation of the WNCR in the Grange University and Royal Gwent Hospitals and the phased implementation across the Health Board.

- 2022/23 End of Year General Dental Services (GDS): The financial costs of the Health Board's NHS GDS for 2022/23 were presented to the Executive Committee. The report provided information on financial 'clawback' and options to carry forward activity to 2023/24.

- Funded Nursing Care (FNC) Rate 2023/24: The Executive Committee was briefed on the FNC Rate, which had been approved by the Minister of Health & Social Services and its impact on the Health Board.

- Reverse Mentorship Programme and Staff Diversity Networks: The Executive Committee supported a proposal to pilot a Reverse Mentorship Programme for 6 months across the Health Board. The Reverse Mentorship Programme is intended to enhance workplace diversity and assist in the retention and recruitment of staff.

- Agile/Hybrid Working Strategy: An update on the Agile/Hybrid Working Strategy was presented to the Executive Committee. The update included a revised set of documents, an Implementation Plan and guidance to support the strategy. The Executive Committee reaffirmed the vision, goals, and proposed approach.

- Translation and Interpretation Services: The Executive Committee received a report on the use of Translation and Interpretation Services across the Health Board, which highlighted the financial costs and the inequality of services being offered to patients. The Executive Committee requested that further work was undertaken to consider all translation and interpretation services available and to communicate to staff this information, whilst developing a formal control/booking process.

Strategic Planning & Service Development

- Integrated Medium Term Plan (IMTP): The Executive Committee received a presentation on the development of the IMTP for 2023/24, which provided information on the approach taken, planning principles and priorities.

- S2 Funding for Treatment in Europe: The Executive Committee received a briefing on recently released Welsh Government Guidance on Funding Treatment in Europe. The Executive Committee noted that these services were arranged by patients themselves and not the Health Board. The Health Board would have no authority to monitor the quality of services on behalf of patients.

- Hospital Electronic Prescribing & Medicines Administration (HEP&MA): An update was provided on the HEP&MA Programme, which was being administered by Digital Health & Care Wales. The benefits of the Programme in enhancing medicines optimisation, for patient safety and drug expenditure was explained. Additionally, an update on the Health Board's implementation of the Programme was received.

- Information Governance Sub-Committee: The Executive Committee approved the establishment of an Information Governance Sub-Committee and its Terms of Reference. The Information Sub-Committee will provide governance in the compliance with Information Governance, Cyber Security, Health Records legislation, guidance, and best practice.

- Communicating with Patients Waiting: The Executive Committee received a briefing on the development of an information resource to help patients on waiting lists to 'Wait Well'. The briefing also provided information about the development of a Patient Waiting List Dashboard, which would be available to patients and Primary Care to assist in decision making and the overall management of conditions.

Strategic Partnership Arrangements

- National Data Resource: The Executive Committee received an update on the National Data Resource Programme, which included benefits for the Health Board, the wider Health Service, and the impact on the Health Board. The

Executive Committee supported the local National Data Resource Work Programme and its objectives.

Other Formal Business

As standing agenda items, the Executive Committee receives:
- Internal Audit reports issued;
- Routine reporting against Audit Recommendations Tracking; and
- Published Welsh Health Circulars and Ministerial Guidance.

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

- Retaining Our Workforce
- Patient Safety Incident Reporting & Management Policy
- Strategic Equality Plan 2024-28
- Health & Safety Annual Report
- Strategic Capital Plan Update

System Leadership Group

The Executive Team has established monthly System Leadership Group meetings throughout 2023 with leaders from across the Health Board. The meetings have been used to discuss systemwide priorities, including a focus on how to deliver improvements and financial savings, and feedback from the most recent staff wellbeing survey.

It is planned that the Systems Leadership Group sessions will have greater focus on prevention and future sustainability. A particular focus of the 13th of October 2023 meeting was on Diabetes and the meeting received a presentation of the Diabetes projects and plans, including the work of the All-Wales Diabetes Prevention Pathway and an overview of the Value-Based approach and National Programmes for Diabetes Care.

Executive Team Development

The Executive Team continues to hold monthly sessions to focus on team development, informal discussion on the development of cultural and strategic aspects as well as enable dedicated attention to key risks and issues. In the last reporting period, the Executive Team has dedicated informal time to focus on team resilience and wellbeing.

Argymhelliad / Recommendation

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:	

Datix Risk Register Reference and Score:	
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Experience Quality and Safety
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Improve the Wellbeing and engagement of our staff Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse Improve the access, experience and outcomes of those who require mental health and learning disability services Choose an item.

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

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

Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio **Well Being of Future Generations Act – 5 ways of working** https://futuregenerations.wales/about-us/future-generations-act/	Integration - Considering how the public body's well-being objectives may impact upon each of the well-being goals, on their objectives, or on the objectives of other public bodies Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Public Services Board Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Executive Director for Public Health & Strategic Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Consultant in Public Health

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

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper provides Board members with an update on the work of Gwent Public Services Board. This paper is for discussion.

Cefndir / Background

Gwent Public Services Board approved a five-year Well-being Plan for Gwent in July 2023. The plan has two strategic priorities and five supporting steps. These are:

Strategic objectives:

1. We want to create a fairer, more equitable and inclusive Gwent for all.
2. We want a climate-ready Gwent, where our environment is valued and protected, benefitting our well-being now and for future generations.

Supporting steps:

1. Take action to reduce the cost-of-living crisis in the longer term.
2. Provide and enable the supply of good quality, affordable, appropriate homes.
3. Take action to reduce our carbon emissions, help Gwent adapt to climate change, and protect and restore our natural environment.
4. Take action to address inequalities, particularly in relation to health, through the framework of the Marmot Principles.
5. Enable and support people, neighbourhoods, and communities to be resilient, connected, thriving and safe.

A full copy of the Gwent Public Services Board Well-being Plan is available at: https://www.gwentpsb.org/en/well-being-plan/gwent-well-being-plan/.

Asesiad / Assessment

Gwent Public Services Board last met in a formal capacity on the 20th of July 2023. At that meeting the Gwent Well-being Plan was approved, and the final report and recommendations from the University College London (UCL) Institute of Health Equity were presented for discussion. Both the Well-being Plan and the Institute's report 'Building a Fairer Gwent' are available on the Gwent Public Services Board website (http://www.gwentpsb.org/en/). The Public Services Board is next scheduled to meet in December 2023.

Since July, Public Services Board members have met a number of times informally to reflect on the Gwent Well-being Assessment, the Well-being Plan, and the recommendations set out in 'Building a Fairer Gwent'. These meetings have been in the context of aiming to maximise the opportunities presented by working together at scale, and developing tangible plans based on activity where evidence suggests impact will be greatest. This has resulted in the identification of a number of priority areas of focus. These are:

- That every child has the best start in life.
- That everyone lives in a place they feel safe.
- That everyone has the same economic chances.
- That everyone lives in a community where their environment is valued and protected.

Gwent Public Services Board has now tasked its officer group (Gwent Strategic Well-being Action Group (GSWAG)) to undertake the following actions:

- Frame the work that is already taking place locally and sub-regionally.
- Consider opportunities and make the case for scaling up in areas with a focus on big impact.
- Consider areas not currently being worked on within the region where there are opportunities for PSB partners to work at scale.
- Develop a project priority matrix and using that matrix prioritise a list of projects identified as a result of the above activity.
- Present findings and recommendations back to Gwent Public Services Board.

GSWAG will present initial feedback to Gwent Public Services Board in December, ahead of a final set of proposals being presented in February 2024.

Supporting the work described above, Gwent Public Services Board also organised a 'Building a Fairer Gwent' leaders' event on 31st October 2023. This brought together around a hundred delegates drawn from regional and national organisations and provided a forum for partners to begin to move from plan to action in addressing equity, equality, and social justice in Gwent. A number of questions were posed to attendees at the event, including:

- What do we need to change in how we work together to galvanise action?
- Who needs to be involved who isn't already?
- How can a Gwent-wide focus add value?
- What questions are we not asking?

The findings from this event are still being analysed, but there was strong support for a common, consistent policy framework across the regional partnerships in Gwent, as well as a recognition of the need to engage with business and citizens

in a more coordinated way. There was also support for the Public Services Board's approach to concentrating efforts and adding value around a limited number of areas where (collective) impact can be greatest. This will now be taken forward as part of the work described above.
Argymhelliad / Recommendation Board is asked to examine and consider the content of this paper by way of update.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	1. Staying Healthy Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well Every Child has the best start in life
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Partnership First
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Not Applicable Choose an item. Choose an item. Choose an item.

Gwybodaeth Ychwanegol: **Further Information:**	
Ar sail tystiolaeth: Evidence Base:	Gwent Well-being Assessment Gwent Well-being Plan Building a Fairer Gwent
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	None.

Effaith: (rhaid cwblhau) **Impact: (must be completed)**

Resource Assessment:	A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:
• **Workforce**	Not Applicable
• **Service Activity & Performance**	Yes, outlined within the paper
• **Financial**	Not Applicable
Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed	**No does not meet requirements** An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact ABB.EDI@wales.nhs.uk
Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working https://futuregenerations.wales/about-us/future-generations-act/	Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Regional Partnership Board Update
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Executive Director of Strategy, Planning and Partnerships
SWYDDOG ADRODD: **REPORTING OFFICER:**	Deputy Director of Strategy, Planning and Partnerships

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

Er Gwybodaeth/For Information

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

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

This report provides an update on, the Governance Review of the Regional Partnership Board (RPB) completed in August 2023, consultation on the draft Strategic Capital Plan, Quarter 2 reporting submissions including the Regional Integrated Fund (RIF) evaluation and impact assessment, and an update on the recently confirmed funding to realise the objectives previously outlined within the statement of intent for the Ministerial directive, 'Further, Faster'.

Cefndir / Background

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

Since the last reporting period, several activities have taken place and continue to be taken forward. These are outlined within this report, and some have also been shared with the Planning, Partnerships and Population Health Committee.

Assessment

The Board is asked to note that since the last reporting period (September 2023) the following progress updates in relation to key areas of work for the RPB, have been reported at relevant Strategic Partnership meetings, Regional Leadership Group and at the Planning, Partnerships and Population Health Committee.

Governance Review

An independent governance review of the Gwent Regional Partnership Board (RPB) has been undertaken. The review scope covered five areas:

- ✓ governance framework,
- ✓ financial governance,
- ✓ risk management,
- ✓ escalation and reporting to partnership bodies,
- ✓ openness and transparency and
- ✓ business processes.

The independent review highlighted **13** findings against the scope outlined above. A task and finish group has been established and includes Health Board representation (Director of Public Health) and governance expertise from the Director of Corporate Governance, in addition to social care representation and an equivalent governance professional from Torfaen Local Authority.

It is anticipated that proposed management responses and subsequent actions will be developed by this group and enable the efficient and effective delivery of a system of internal control and assurance across the RPB and its supporting structures.

The RPB will be hosting a strategy development session on 14th November 2023 to re-focus the RPB in determining its objectives, primary purpose, and strategic priorities. This approach will also support the development of a clear risk management strategy that can be focussed on the delivery of the objectives of the RPB.

Final Draft Strategic Capital Plan

Gwent Regional Partnership Board has established a draft 10-year Regional Capital Strategy 2023-2033 to deliver accommodation and integrated working solutions to support priority population groups to remain at home or as close to home as possible.

The Strategy and supporting Capital Plan articulate how the approach to capital development will ensure the planning activities remain relevant in the context of population projections, demand on services and interdependencies across models of care. The plan builds on a good foundation of capital programme delivery within the region supporting national policy agendas but has a very clear focus on regional delivery to address identified population needs.

The final draft version of the plan is currently out for consultation across all Partners in Gwent. Due diligence has been followed with regard to the consultation process, enabling equitable opportunity for all key Partners to contribute. The draft Strategic Capital Plan has been presented to the Planning, Partnerships and Population Health Committee where comments and suggestions were invited from colleagues as part of the formal consultation process.

Following the consultation process, a final version will be presented to the RPB for formal endorsement and adoption at its December 2023 meeting.

Quarter 2 Reporting

Project reporting submissions have been received from most of the Regional Integrated Fund (RIF) funded projects to inform the Quarter 2 reporting period. Jointly working with Welsh Government, a revised reporting tool has been produced to demonstrate impact of RIF funded programmes on Ministerial priorities. The Quarter 2 report will be available at the end of November.

RIF Evaluation and Impact Assessment

In conjunction with the Q2 reporting, an evaluation of all RIF funded projects is currently being developed. The outcomes of the evaluation will be pivotal in informing decisions in relation to viability of projects and potential future funding, including if tapering of RIF is applied by Welsh Government. Further confirmation on

tapering, and if it will be implemented in the forthcoming year, is awaited from Welsh Government. Clarity is expected from Welsh Government by the end of December 2023 in relation to this decision, together with confirmation of funding for 2024/25.

Contingency planning has been undertaken with Partners around potential tapering of funding and consideration of immediate impact on short term funded posts.

Further details and outcomes in relation to the impact assessment of projects will be shared with the Board and relevant Committees as it becomes available as part of the RIF evaluation.

Further Faster Funding

On 27th October 2023, the RPB received written confirmation from NHS Wales Director General of an additional part year allocation in 2023-24 of £8.24m and full year recurrent funding of £11.95m from 2024-25. This funding is being provided to enable the realisation of the objectives as described within the statement of intent (published on 6th June 2023) "Building Capacity through Community Care – Further, Faster." The allocation for Gwent is £1.58m.

Plans are currently being developed to ensure the full and most appropriate utilisation of this funding, in line with Ministerial directives and regional priorities.

Argymhelliad / Recommendation

The Board is asked to note this update.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	**SRR009 – Transformation and Partnership Working**
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Adults in Gwent live healthily and age well
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Regional Solutions
Amcanion cydraddoldeb strategol Strategic Equality Objectives	Work in partnership with carers to continue awareness raising, provide information and improve practical support for carers

Strategic Equality Objectives 2020-24	Improve the access, experience and outcomes of those who require Mental Health and Learning Disability Services Choose an item. Choose an item.

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

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

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) Update Report – November 2023
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Jones Head of Board Business

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the Welsh Health Specialised Services Committee as a Joint Committee of the Board.

Cefndir / Background

WHSSC was established in 2010 by the seven Health Boards in Wales to ensure that the population of Wales had fair and equitable access to a full range of specialised services. WHSSC is therefore responsible for joint planning of Specialised and Tertiary Services as delegated 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 accountable to citizens and other stakeholders for the provision of specialised and tertiary services.

Asesiad / Assessment

The Joint Committee last met on 19th September 2023 and the papers for the meetings are available at: 2023/2024 Meeting Papers - Welsh Health Specialised Services Committee (nhs.wales). A summary of key matters discussed included:

- Development of the Integrated Commissioning Plan (ICP) 2024/25
- South Wales Sexual Assault Referral Centres (SARC) Regional Model Implementation Briefing Paper
- Welsh Government National Commissioning Review Update
- Single Commissioner for Secure Mental Health Service Project Initiation Document (PID)
- Revision to Financial Delegated Limits
- WHSSC Model Standing Orders - Governance and Accountability Framework
- WHSSC Performance Report – June 2023
- Financial Performance Report Month 4 2023-2024
- South Wales Neonatal Transport Delivery Assurance Group Report (April 2023 - June 2023)
- South Wales Trauma Network Delivery Assurance Group Report (Q1)
- Specialised Paediatric Services Strategy – Implementation Board Highlight Report
- All Wales PET Programme Progress Report

The assurance report from this meeting is shown at Appendix 1.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this update report on WHSSC Joint Committee activity.

Attachments

Appendix 1.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	Governance, Leadership and Accountability Choose an item. Choose an item. Choose an item.
Blaenoriaethau CTCI IMTP Priorities Link to IMTP	Choose an item.
Galluogwyr allweddol o fewn y CTCI Key Enablers within the IMTP	Choose an item. Choose an item. Choose an item. Choose an item.
Amcanion cydraddoldeb strategol Strategic Equality Objectives Strategic Equality Objectives 2020-24	Choose an item. Choose an item. Choose an item. Choose an item.

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

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

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

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 19 SEPTEMBER 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 19 September 2023. 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 using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings
The minutes of the meetings held on the 18 July 2023 & 1 August 2023 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 Update
Members received a presentation on how the All Wales Medical Genomics Service (AWMGS) is leading the way in many areas of genomics (Rare Disease, Cancer, Pharmacogenomics, and Mental Health) covering prevention, diagnosis and targeted treatments where was clinically needed and cost effective.

Members noted the Genomics Delivery Plan for Wales 2022-2025, how genomics was transforming cancer diagnostics and drug prescriptions; and how the AWMGS was delivering equitable genomic testing for improved outcomes in cancer and rare disease enabling precision medicine and reducing adverse drug reactions.

Members **noted** the presentation.

4. Chair's Report
Members received the Chair's Report and **noted**:

- **Appointment of a Vice Chair -** To ensure effective business continuity for WHSSC and the Joint Committee it was proposed that Chantal Patel, Independent Member (IM), WHSSC is appointed to the unremunerated role of Vice Chair for the Joint Committee, in accordance with the WHSSC Standing Orders (SOs),
- **Establishment of WHSSC/EASC Vacancy Control Panel –** Following receipt of a letter to WHSSC on behalf of the CEOs,

WHSSC and EASC have established a joint Vacancy Control Panel, aligned with that of CTMUHB but responsive to the needs of both functions,

- **Chair of the Individual Patient Funding Request (IPFR) Panel** Further to the Extraordinary Joint Committee meeting held on 1 August 2023, which supported the request to take forward the urgent recruitment of the WHSSC Individual Patient Funding Request (IPFR) panel Chair and approved the proposed remuneration package, the post has now been advertised following earlier delays. The aim is to appoint a substantive IPFR Chair by the end of October 2023. **Interim arrangements have been put in place to cover October;** and
- Key meetings attended.

Members (1) **Noted** the report, (2) **Noted** the update on the recruitment of the Chair of the Independent Patient Funding Request (IPFR) Panel; (3) **Noted** the establishment of the WHSSC/EASC Vacancy Control Panel and (4) **Approved** the appointment of Chantal Patel as Vice Chair of the WHSSC Joint Committee.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- **Progress on South Wales Neonatal ODN** - Funding for the South Wales Neonatal Transport Operational Delivery Network (ODN) was agreed at the 14 March 2023 Joint Committee meeting and funding has been released. However, the recruitment process has not yet taken place and therefore in line with our approach for other, as yet uncommitted investments, we have suspended implementation for this financial year. We will review the need and/or different options for delivering the scheme in 2024-2025. This scheme will now be considered within our process for prioritisation of all uncommitted expenditure and we have requested further information from Swansea Bay UHB (SBUHB), the provider Health Board (HB) to inform this evaluation,
- **Fertility Update - WHSSC Policy development: - CP37 Pre-implantation Genetic Testing-Monogenic Disorders, Commissioning Policy - CP38, Specialist Fertility Services: Assisted Reproductive Medicine, Commissioning Policy -** The WHSSC team met with Llais on 31 August 2023 to discuss the next steps regarding the policy development. WHSSC informed Llais that because of the uncertainty surrounding the budget impact of any policy changes, the current financial challenges for the NHS in Wales meant that policy development has been halted. Colleagues in Llais understood the financial challenge and the difficult choices faced by WHSSC and HBs. A further update meeting is planned for late September 2023; and
- **South Wales Spinal Network (SWSN) -** Following discussion at the NHS Wales Health Collaborative Executive Group (CEG), the

Cardiff and Vale UHB (CVUHB) and SBUHB Regional and Specialised Services Provider Planning Partnership (RSSPPP) set up a project to develop a new service model, to clarify the regional model for South East and South West Wales respectively, as well as the supra-regional model for South Wales, West Wales and South Powys. The project was launched in October 2020, with the aim of developing recommendations for delivering a safe, effective and sustainable model for spinal surgery in South and West Wales.

The final report was presented to the NHS Wales Health CEG on the 6 April 2021. The recommendation was accepted by the CEG, and the responsibility for commissioning the ODN was delegated to the Welsh Health Specialised Services Committee (WHSSC).

Members (1) **Noted** the report; and (2) **Noted** that the South Wales Spinal Network (SWSN) will go live on 25 September 2023.

6. Development of the Integrated Commissioning Plan (ICP) 2024/25

Members received a report offering assurance regarding the development of the 2024/2025 Integrated Commissioning Plan (ICP) and the approach to its development within wider NHS Wales situational context.

Members (1) **Noted** the report (2) Received assurance on the planning process to date which is in line with timeline received by the Joint Committee in May 2023; and (3) **Noted** the approach being taken to respond to the NHS Wales situational context, including an enhanced risk assessment.

7. South Wales Sexual Assault Referral Centres (SARC) Regional Model Implementation Briefing Paper

Members received a report providing an update on the implementation of the South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme following the Business Case approval in 2019, which proposed that the WHSSC Joint Committee fulfil the CEO reporting function at the request of the NHS Wales Chief Executives; and which requested that the Joint Committee give final approval for Phase 1 implementation of the Programme.

Members (1) **Noted** the report, (2) **Approved** the updated South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme model, prior to a report being issued to the seven HBs for final approval, (3) **Considered** and **approved** that the WHSSC Joint Committee will fulfil the CEO reporting function for the programme with immediate effect, prior to a report being issued to the seven HBs for final approval, (4) **Recommended to HBs for approval of** an in year funding uplift of £347k and a recurrent full year funding of up to £506k by 2025/26 for phase 1 of the implementation of the SARC Regionalisation Programme, prior to a report being issued to the seven HB's for final approval; and (5)

Recommended to HBs for approval of a continuation of funding for Phase 2 at the current level prior to a report being issued to the seven HBs for final approval.

A separate note will follow to HBs clarifying the financial arrangements for Phase 1.

8. Welsh Government National Commissioning Review Update
Members received a verbal update on progress with the Welsh Government national commissioning programme commissioned by the Minister for Health & Social Services.

Members noted that the National Commissioning Review Implementation Board meeting was taking place immediately after the WHSSC Joint Committee meeting.

Members **noted** the verbal update.

9. Single Commissioner for Secure Mental Health Service Project Initiation Document (PID)
Members received a report presenting the Project Initiation Document (PID) for the Single Commissioner Model for Secure Mental Health Services.

Members (1) **Noted** the report; and (2) **Supported** the recommendation to initiate the project to develop a Single Commissioner Model for Secure Mental Health Services.

10. Revision to Financial Delegated Limits
Members received a report requesting changes to the financial limits for Individual Patient Funding Request (IPFR) approvals.

Members (1) **Noted** the report, and (2) **Approved** the requested changes to the financial limits for Individual Patient Funding Request (IPFR) approvals.

11. WHSSC Model Standing Orders – Governance and Accountability Framework
Members received a report providing an update on the WHSSC Model Standing Orders and Governance and Accountability Framework.

Members (1) **Noted** the report, (2) **Approved** the proposed changes to the WHSSC Standing Orders (SOs), prior to being issued to the seven HB's for approval and inclusion as schedule 4.1 within their respective HB SOs, (3) **Approved** the proposed changes to the WHSSC Standing Financial Instructions (SFIs) prior to being issued to the seven HBs for approval and inclusion as schedule 4.1 Annex 2.1 within their respective HB SOs; and (4) **Noted** that there are no changes to the Memorandum of Agreement (MoA).

12. WHSSC Performance Report Month
Members received a report providing a summary of the performance of WHSSC's commissioned services. Further detail including splits by resident Health Board (HB) was provided in an accompanying Power BI Dashboard report.

Members **noted** the report.

13. Financial Performance Report – Month 4 2023-2024
Members received the financial performance report setting out the financial position for WHSSC for month 4 2023-2024. The financial position was reported against the 2023-2024 baselines following approval of the 2023-2026 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2023.

The year to date financial position reported at Month 4 for WHSSC was a forecast overspend of £2.164m against the ICP financial plan and a forecast year-end underspend of £4.202m.

Members **noted** the contents of the report including the year to date financial position and forecast year-end position.

14. South Wales Neonatal Transport Delivery Assurance Group Report (April 2023 - June 2023)
Members received a report providing a summary of the South Wales Neonatal Transport Delivery Assurance Group (DAG) quarterly report for 1 April 2023 – 30 June 2023.

Members (1) **Noted** the highlights of the Q1 Neonatal Transport DAG report, (2) **Noted** that the full report was being shared In-Committee due to potential patient identifiable data; and (3) **Received** assurance that the Neonatal Transport service delivery and outcomes were being scrutinised by the Delivery Assurance Group (DAG).

15. South Wales Trauma Network Delivery Assurance Group Report (Q1)
Members received a report providing a summary of the Quarter 1 2023/24 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN).

Members **noted** the full South Wales Major Trauma Network (SWTN) DAG Report and highlights contained in the cover report.

16. Specialised Paediatric Services Strategy – Implementation Board Highlight Report
Members received a report providing a progress update on the implementation of the Specialised Paediatric Services Strategy.

Members **noted** the report and the progress made.

17. All Wales PET Programme Progress Report
Members received a report providing an update on the progress made by the All Wales Positron Emission Tomography (PET) Programme.

Members **noted** the progress made by the All Wales Positron Emission Tomography (PET) Programme and its associate projects and workstreams.

18. 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.

19. Other reports
Members also **noted** update reports from the following joint Sub-committees:

- Audit and Risk Committee (ARC),
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel,
- Integrated Governance Committee (IGC); and
- Quality & Patient Safety Committee (QPSC);

20. Any Other Business

- **Cheshire & Wirral Mother and Baby Unit (MBU) –** Members noted that a contractor had been identified and a start on site was expected before Christmas. Recruitment to the posts was expected to start in April 2024 with view to new unit being operational by 1 October 2024; and
- **WHSSC Annual Report –** members noted that the WHSSC Annual Report would be circulated via email for approval and brought back to the November meeting for ratification.

CYFARFOD BWRDD IECHYD PRIFYSGOLN ANEURIN BEVAN
ANEURIN BEVAN UNIVERSITY HEALTH BOARD

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	EMERGENCY AMBULANCE SERVICES COMMITTEE (EASC) Update Report – November 2023
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Nicola Prygodzicz, Chief Executive Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rani Dash, Director of Corporate Governance

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the Emergency Ambulance Service Committee as a Joint Committee of the Board.

Cefndir / Background

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).

Asesiad / Assessment

The Joint Committee met on 19th September 2023 since the last report to Board. The papers for this meeting are available at Meetings and Papers - Emergency Ambulance Services Committee (nhs.wales) . A summary of the business discussed at the September meeting that included:

- Performance report noted the following:
  - 999 call volumes are around 12% lower than the same period last year.
  - 10.3% reduction in incidents in July 2023 compared with July 2022
  - Hear and Treat rates were 2.3% (460 incidents) higher in July 2023 compared with July 2022
  - Delivery of red performance remains challenging.
  - Amber, median, 65th, 95th and the longest Amber waits remain lower than 2022.
  - The volume of incidents transported to a Tier 1 site (Major ED) has increased, being 20% higher in July 2023 compared with July 2022
  - Ambulance handover times are stabilizing on a number of metrics, including total lost hours, % handed over in 15 minutes and handovers over 4 hours.

- Annual reports were received in respect of:
  - Emergency Ambulance Service Delivery Assurance Group Emergency Medical and Retrieval and Transfer Service Annual report 2023 and,
  - Non-emergency Patient Transfer Services Delivery Assurance Group

- Quality and Safety report – that detailed the:
  - improving picture for complainants receiving a response within 30 days, with 49% of complainant's receiving a response against a target of 75%. Mitigating actions have been identified to improve response rates in coming months.
  - The theme from all eight 'Serious Case Incident Forums' that remained consistently related to delayed responses and call categorisation.
  - 16 cases identified by WAST as requiring joint investigation in July and,
  - The themes from joint investigations identified the following areas:
    - delays in raising concerns,
    - lack of clinical input and
    - end of life care planning.

    The report noted that work was ongoing with Welsh Risk Pool to explore improvement opportunities for the reporting of joint investigations.

The Assurance report for this meeting is attached.

Argymhelliad / Recommendation

The Board is asked to RECEIVE this report by way of an update on EASC Joint Committee activity.

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

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

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

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	19 September 2023

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/september-2023/
The minutes of the EASC meeting held on 18 July 2023 were approved.

PERFORMANCE REPORT

The Performance Report was received which included the Ambulance Service Indicators and the EASC Action Plan. In presenting the report, Stephen Harrhy highlighted a number of key areas.

Members noted that:

- 999 call volumes were approximately 12% lower than the same period last year although more patients were attending Emergency Departments
- 10.3% reduction in incidents in July 2023 compared to July 2022
- Hear and Treat rates were 2.3% (460 incidents) higher in July 2023 compared to July 2022
- Despite the issues above the volume of incidents (patients) transported to a Tier 1 site (Major ED) had increased, 20% higher in July 2023 compared to July 2022 and the delivery of red performance remained challenging and not where it needed to be.

- In specific health board areas:
  - Swansea Bay (SBUHB), impacts included increasing pressures of handover delays for 4hour and 10hour delays now implementing the Continuous Flow Model to improve patient care
  - Hywel Dda (HDUHB), issue of the reinforced autoclaved aerated concrete (RAAC) on capacity and the impact on services for the population of West Wales.
  - Cwm Taf Morgannwg (CTMUHB), variation remained from site to site and day to day but overall improvements seen.
  - Cardiff and Vale (CVUHB), continued to deliver excellent performance and were meeting their predicted trends as per the Integrated Commissioning Action Plan (ICAP)
  - Aneurin Bevan (ABUHB), remained to have variable performance but some signs of improvement seen.
  - Betsi Cadwaladr (BCUHB), stabilisation underway although variation between hospital sites and ongoing learning.

The ICAP plans for SBUHB and HDUHB appeared to be focusing on the right areas, but these remained challenging areas

Members noted:

- The mixed view in terms of the impact of handover delays which was leading to improvements to Amber patients. However, this would need to translate into impacting on improving red performance.
- Ongoing work with WAST (by the EASC Team) to plan the trajectory of improvements required which would be shared with Members (Action Log) and Welsh Government officials; the ICAP process would monitor the impact.
- Need to better understand utilisation and what a good level would be for all resources to be at the right level.
- Amber, median, 65th, 95th and the longest Amber waits remained lower than 2022.
- Ambulance handover times were stabilizing on a number of metrics, including total lost hours, % handed over in 15 min and handovers over 4 hours.

Members raised and noted:

- Their support for the approach in relation to the current position and the level of red response performance which was very concerning and remained at a deteriorating position despite local efforts.
- That the unseasonal weather had also impacted adversely on the performance
- That actions had been agreed in the ICAPs, but the resulting improvement was not always being seen in terms of impacting positively on handover delays
- In some areas, the tolerance remained that 4hour waits were acceptable as a large number of patients were breaching the 4hour target on a daily basis.
- The variability of the WAST ambulance unit hour production (UHP)
- The impact of 'overtime bans' (which were outside of the those identified within the Integrated Medium-Term Plan)
- The importance of getting back to the basics of delivering a responsive ambulance service and the ultimate aim to return to no handovers over 15 mins in line with the statutory targets.

In response, Jason Killens explained that an overtime ban was not in place, although the WAST financial plan had aimed to target areas to control spend. Additional resources had been provided to aid WAST management in a difficult and unanticipated period of demand.

Members noted:

- A deliberate choice had been made to develop the Cymru High Acuity Response Units (CHARU) and this had led to a marginally better performance. The quality of services received by patients had improved including an improvement in the rates of return of spontaneous circulation (ROSC) used as one indicator of patient outcomes.
- The current WAST planning model for resources and geographical location was based on up to 6,000 lost hours; the current rate at 18,000+ was impacting adversely on ambulance performance.
- Returning to a more traditional (dual crewed ambulance) would not improve performance and it would be more costly and would not be efficient or effective for patients.
- WAST answering around 100 calls every day of red calls (which was a small number) and reiterated the need to focus attention on a relatively small number of calls.
- That the impact of the CHARU service had not led to improving performance and it was asked whether this had been the right action for the service. However, although the performance percentages had not increased the quality of the service had improved for patients.

Members welcomed the additional work to target frequent callers and asked how the additional 100WTE staff funding had translated into improvements in health board areas and its impact. Further information was requested about capacity and constraints for the next provider report (Action Log).

Members noted:

- The difficulties in recruiting staff in areas across Wales
- Potential issue looming if no improvements in handover delays and the likelihood of difficult conversations where change was not seen.
- Improvements expected in performance in line with reducing handover delays.
- Increased sickness levels at WAST in August and not yet clear if this was a blip or recurring trend.
- Ongoing work in providing different crews to attend incidents where different needs identified (not one size fits all)
- Improvement event planned with WAST in October and further work to do in supporting non-conveyance and alternatives to conveyance to EDs.
- The need to have the alternate blended approaches and help to manage variation and note the risk management approach by WAST.
- The importance of maintaining the ICAP process and holding each other to account; and the cross-reference to the national work such as the Six Goals for Urgent and Emergency Care Programme.

QUALITY AND SAFETY REPORT

The Quality and Safety Report was received.

In presenting the report, Stephen Harrhy highlighted the presentation of the revised quality report in light of the requirements of the Duty of Candour and Duty of Quality.

Noted:

- The importance of the quality of services being paramount
- National Reportable Incidents (NRIs) key themes continued to be community response and calls categorisation.

- Coroner requests have remained higher than pre pandemic levels; was 244 then and 450 in the last year; growing concerns for patient care.
- High numbers of patients receiving 'no send' although not as high as previously but had remained at around 900.
- 195 people presented at Emergency Departments who were categorised at Category 1 – immediately life threatening which was concerning; could have benefited from earlier treatment interventions by skilled well trained WAST staff.
- Actions to be taken in relation to the Ambulance Service Indicators (ASIs) and work underway to review in line with the Duty of Quality and therefore provide evidence how compliance is assured through the commissioning lens.
- Importance of patient story for the next meeting.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received.

- EASC Commissioning Frameworks - in line with the Commissioning Cycle and the discussion at the previous meeting work had commenced to review the Non-Emergency Patient Transport Service (NEPTS) Commissioning Framework, this included the development of a long-term strategy for the service. Further updates would be provided at future meetings.
- An update on Integrated Commissioning Action Plans (ICAP)
  - the on-going commitment from health boards and WAST to the process
  - an outline of the work undertaken by health boards was provided in an appendix which included the impact of the ongoing work.
  - further work plans included the validation of data relating to immediate release requests and the further development of remote clinical triage and signposting opportunities.
- EASC Integrated Medium Term Plan (IMTP) – Formal approval by Welsh Government was awaited. Members noted the IMTP Tracker which reflected the progress made against the agreed performance ambitions. The IMTP Tracker would be updated monthly, and updates would be provided at future meetings.
- EASC Commissioning Intentions 2023-24 – Members noted that the Quarter 2 update would be presented the EASC Management Group in October.

Members noted that WAST had not committed to achieving the ambition set within the EASC IMTP that sickness levels should be maintained below 5.5% (WASTs internal target was noted at 6% at the end of the year). It was also noted that the trajectories within the IMTP were multi-factorial, some actions for WAST, some for health boards and some joint actions across WAST and health boards.

The CASC also suggested that the approach towards developing the legacy statement for the IMTP would continue as in previous years despite the work to create a new Joint Committee for national commissioning. The plan going forward would be clear for WAST and would dovetail into the new arrangements.

UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW

The update report on the EMRTS Service Review was received. Lee Leyshon presented the report and gave an overview of work to date in the phased approach.

Noted:

- Previous information shared at the 'Focus on' session.
- In 2nd Phase and seeking public and stakeholder comments on the work started afresh following the EASC decision on 8 November 2022
- The approach adopted was previously outlined at EASC.
- Emerging themes identified in Phase 1
- External supplier stakeholder and representative sample feedback
- Remit of the external supplier and highlighted key areas received.
- Note that the work of the CASC and External Supplier (Picker Institute) was independent of each other to capture as much public feedback as possible.
- Themes identified to date to be part of the core engagement materials for Phase 2
- Data modelling planned in addition to the issues raised in Phase 1 and detail for the approach taken.
- Phase 1 listened to comments and Phase 2 would present the independent review but would also continue to listen to stakeholders and the public in order to arrive at a recommendation for presentation to EASC.
- Phase 2 in person / face to face meetings taking place between 12 Oct to 20 Oct and the timetable developed.
- Window to respond for the public allowing 4 weeks until 5 November 2023
- Focused listening opportunity for the Commissioner – based on the learning from Phase 1
- Plan to arrive at a recommendation and potentially a preferred option by the Chief Ambulance Services Commissioner to present to EASC.
- Concerns remain highest for the members of the public who live closest to the affected bases.

Members thanked the CASC and the EASC Team for the work undertaken to date and noted:

- the 4week public engagement window – 9 October to 5 November 2023 (subsequently increased to 12 November)
- Llais and the interface to check that they are content with the continuing approach.
- The rapid opportunity to work through the modelling work and early heads up for HBs to be alongside for any events and be fully apprised of the work to date.

Members also noted; -

- A meeting took place with Llais in July which generally accepted the extent and the nature of Phase 1. The initial advice from the then Community Health Councils had been to undertake formal engagement for 6-8 weeks followed by a break and then a further 2 weeks and this timescale had been extended based on the public response and the need for sufficient time to consider the complex work involved.
- Ongoing dialogue across NHS Wales and with key stakeholders
- Information would be shared with Members before it was made public.
- At the time, some areas of modelling were still outstanding.

The CASC thanked Members and welcomed that all HBs were supportive of the approach taken to date but particularly of Powys and BCU health boards.

The Chair explained that he had deliberately not engaged in the process to maintain an impartial approach for the Joint Committee. The important matter for the work was to provide an improved EMRTS service across Wales utilising the highly specialist critical care service.

WELSH AMBULANCE SERVICES NHS TRUST REPORTS

The Welsh Ambulance Services NHS Trust (WAST) Provider Report was received. In presenting the report, Jason Killens highlighted:

- the work undertaken by WAST to maximise opportunities to improve response to red calls.
- Sickness trajectory had been on a downward trend except for August which was being analysed further to identify key reasons.
- As part of the Demand and Capacity work and the Roster Review utilising the Cymru High Acuity Resource Units (CHARUs) to improve outcomes, Members noted that WAST was starting to see a month on month improvement particularly in the return of spontaneous circulation (ROSC) as an important outcome measure for patients and last month was the highest ever recorded. Initially only half of the CHARU was 'funded' but WAST had assessed the available resources to get the best response, mindful of the quality and performance issues. Members noted that this was an overall improvement in quality outcomes for patients.
- The revised overtime profile and the capacity for the coming winter
- Although not contained within the report, as provider of the 111 service Members noted the ongoing work with the 'new' software provider SALUS and that the contract would soon be terminated by the Programme. Jason Killens raised the question of who would own the re-procurement required for the new call handling system and this would be raised at a future meeting as this was time sensitive (Action Log).

Members noted (in relation to 111)

- the impact on 999 call handling (or call taking) and the need for EASC to be aware
- Resilience would be an issue, although WAST did not feel this would be a significant matter in the first instance.
- The opportunity emerging to bring 111 and 999 together particularly in the clinical advice area.
- The importance of agreeing the approach and where the 111 work would be best dealt with until the new Joint Committee was in operation.
- The importance of the provider procuring the right software to support service delivery.
- WAST would want to procure the right software/system as part of the provision of the service but this had not yet been finalised by the programme.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received. In presenting the report, Stephen Harrhy highlighted key areas which included:

- Meetings with Welsh Ambulance Services NHS Trust (WAST)
- Meeting with Health Boards
- Review of remote clinical support
- Six Goals for Urgent and Emergency Care Programme
- Connected Support Cymru (previously known as Night Sitting Service)
- Transfer, Discharge and Repatriations
- Review of National Commissioning
- Data linking.

Members noted:

- The report by Healthcare Inspectorate Wales (HIW) on system flow and the impact on WAST and on the EASC Team who would be leading the work to respond

- The continuous flow model and the ongoing work with three health boards to implement; Aneurin Bevan, Betsi Cadwaladr and Swansea Bay University Health Boards
- That the Escalation Policy had been approved by the NHS Leadership Board a while ago and it would need to be updated to get the right balance for the ask between urgent and emergency care, cancer and scheduled care.
- New normal to be described to update to the current position.
- The link to Goal 5 in the Six Goals for Urgent and Emergency Care Programme and bring together.
- Visits to health boards undertaken with a focus on local matters and performance within a more bespoke session.
- Regular meetings with WAST; the Review of the Clinical Support Desk which would be presented at a future meeting (Action Log)
- The Six Goals for Urgent and Emergency Care Programme in particular Goal 4 – work with ED colleagues and out of ED; 'what does a good ED look like?' and frailty at the front door
- In relation to Connected Support Cymru, how to better use IT and remote IT; noted that some patients presented when the service they needed was not available and the work on how to support the patient until the service they needed was available; an evaluation report had just been finalised and would be circulated to Members (Action Log)
- Transfer, discharge and repatriation – a holding response had been sent to the Deputy Chief Medical Officer (DCMO) and work was continuing by the EASC Team to plan how to progress and identify the potential resource implementation.
- Data linking; consultant paramedic would be identifying better links to the data within the Emergency Communication Nurse System (ECNS) and an update would be provided.
- Fire Service – potential for fire services to respond to some red calls and act as the first responder, analysis undertaken (to be shared – Action Log) utilisation of fire services at 15% could link to work with volunteers. Fire Service staff are already trained and have access to defibrillators which could improve red response by 5% (approx.) this could have a big impact in rural areas and could also support non-injury falls.

Members highlighted; -

- Opportunities within the report;
- Additional information and create an eco-structure of out of hospital services and build a system from the start to cross cover and increase system resilience.
- Describing inverting the triangle and what could be done within commissioning intentions.
- Opportunity to discuss further what the WAST offer could be in terms of rapid response, remote clinical assessment and 24/7 urgent response to help keep patients at home – consider for a 'focus on' session (Action Log).

EASC FINANCIAL PERFORMANCE REPORT MONTH 4 2023/24

The EASC Financial Performance Report at month 4 in 2023/24 was received. James Leaves presented the report and Members noted no variances within the plan. Discussion had taken place earlier in the meeting in relation to the 100wte staff. All additional funding was being utilised to support the additional overtime costs.

SUMMARY OF THE EASC MANAGEMENT GROUP MEETING HELD IN AUGUST 2023

The meeting had been cancelled due to the number of apologies and the meeting would not have been quorate.

EASC SUB-GROUPS CONFIRMED MINUTES

Approved:

- Non-Emergency Patient Transport Services Delivery Assurance Group notes 1 June 2023

EASC GOVERNANCE

The report on EASC Governance was received which included the:

- EASC Risk Register
- EASC Assurance Framework
- EASC Key Organisational Contacts
- Welsh Language Commissioner – Final Report and Decision Notice
- Letter to host in relation to the statutory Duty of Quality and Candour.

Noted that:

- The Risk Register had five red risks in total, three scoring the highest level at 25.
- The EASC Assurance Framework had been updated in line with the changes above to the risk register, the framework utilised the host body's risk management approach and assurance framework.
- The updated Model Standing Orders were received, Members noted the changes in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020 which included working with 'Llais Cymru', previously known as Community Health Councils. Once approved the Standing Orders would form part of the schedule for Health Boards.
- Work remained ongoing in relation to the investigation by the Welsh Language Commissioner, supported by the host Cwm Taf University Health Board. The work involved changes to the website software and involved Digital Health and Care Wales. Further updates would be provided at future meetings.
- The latest EASC Key Organisational Contacts report was presented, and Members asked to review their organisational representatives at EASC and its sub groups.
- There were no governance concerns to raise in relation to the Annual Reports prepared by the Emergency Medical Retrieval and Transfer Service (EMRTS) Delivery Assurance Group or the Non-Emergency Patient Transport Services (NEPTS) Delivery Assurance Group.
- The short summary (for assurance) of the latest Audit and Risk Committee meeting which took place on 16 August 2023

FORWARD LOOK AND ANNUAL BUSINESS PLAN

The Forward Look and Annual Business Plan was received and approved.

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) and the impact on services provided to HB local communities and to WAST.

• The ongoing formal engagement process for the EMRTS Service Review, the closure of Phase 2 and the potential recommendation to the December meeting of EASC.				
Matters requiring Board level consideration				
• To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours – especially in relation to the quality of services patients receive				
Forward Work Programme and Annual Business Plan				
Considered and agreed by the Committee.				
Committee minutes submitted	Yes		No	✓
Date of next meeting	**21 November 2023**			

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	22 November 2023
CYFARFOD O: **MEETING OF:**	Board
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	**Committee and Advisory Group Update and Assurance Reports**
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Rani Dash, Director of Corporate Governance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Michelle Jones Head of Board Business

Pwrpas yr Adroddiad
Purpose of the Report

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In line with the Health Board's Standing Orders, a number of Board Committees and Advisory Groups have been established. This report provides, for assurance, an overview of the business undertaken by these committees during the reporting period, and highlights key matters for Board consideration, where required.

Cefndir / Background

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

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

Assurance Reporting

The following Committee assurance reports are included:

- Audit, Risk and Assurance Committee – 12th September 2023
- Patient Quality. Safety and Outcomes Committee -11th October 2023
- People and Culture Committee – 19th October 2023
- Population Health and Planning Committee - 1st November 2023.

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 the EASC and WHSSC the work of these sub committees is covered separately at agenda item 4.11. In respect of Shared Services Partnership Committee, the Assurance report in respect of the meeting held on 21 September 2023 is shown at Appendix 1.

Asesiad / Assessment

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

Argymhelliad / Recommendation

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

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

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

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	Committee Chairs as part of the assurance process for those Committees that have met during this period.

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

Name of Committee:	Audit Risk and Assurance Committee
Chair of Committee:	Iwan Jones
Reporting Period:	12th September 2023
Key Decisions and Matters Considered by the Committee:	

Single Tender Action
The Committee noted the report and agreed that future reports on the use of STA would need to include whether- or not there was sufficient budget in place to support the expenditure.

Financial Governance, Reporting and Control Procedures
The Committee was presented with two financial control procedures. The Procurement Policy and the Prepayment of goods and services.

The Committee approved the Procurement Policy and approved the permanent removal of the Prepayment Policy, which was specifically created due to COVID-19.

Review of Committee Programme of Business
The Committee noted the committee programme of Business.

Committee Effectiveness 2023/24
The Committee approved the self-assessment template and timeframe for completion.

Audit Recommendations Tracking
The committee welcomed the progress being made in the management of recommendations while acknowledging that greater detail in the progress updates was required to enable the Committee to take enhanced assurance that the recommendations were being managed effectively and progressing towards completion.

The Committee also noted its concern in respect of the long-standing recommendations (pre-2022) that had not progressed and agreed that these would be escalated to the Board. (As shown below in Matters requiring Board level section.)

The Committee noted and endorsed the revised deadline requests.

Risk and Assurance Report
The Committee received the Risk and Assurance Report and noted the refreshed approach to risk management.

Internal Audit
The Committee noted the following Reasonable Assurance Reports from the Audit Plan for 2023-24.

- Bank Office and Temporary Workers Final Internal Audit Report.
- IMTP
- Safeguarding.

External Audit

The committee noted the progress report and was assured that all planned audits would meet scheduled deadlines.
Matters Requiring Board Level or other Committee Consideration or Approval:
Following recent press reports about the adequacy of whistleblowing arrangements and that the most recent internal audit review had been undertaken a few years ago, the Committee proposed that this issue be referred to the People and Culture Committee to obtain its view on whether or not Internal Audit should consider commissioning a follow-up review to support the Welsh Government's request to conduct an organisational self-assessment of the Speaking Up Safely processes within the Health Board The Committee agreed to escalate the number of legacy (pre-2022) internal and external Audit Recommendations that remained active to the Board to encourage the need to drive improvements and close longstanding recommendations. The position reported to the Committee was that there were 75 legacy recommendations that were overdue at the end of Q1 2023/24; however, the Audit Committee will receive an updated position as of the end of Q2 2023/24 at its meeting on November 28th, 2023, before escalating further to the Board.
Key Risks and Issues/Matters of Concern:
Planned Committee Business for the Next Reporting Period: Workplan to be added
Date of Next Meeting: Tuesday 28th November 09:30-12:30 via Microsoft Teams

Name of Committee:	**Patient Quality, Safety and Outcomes Committee**
Chair of Committee:	**Pippa Britton**
Reporting Period:	**11th October 2023**
Key Decisions and Matters Considered by the Committee:	
Patient Quality and Safety Outcomes Performance Report, October 2023 The Committee received the Patient Quality & Safety Outcomes Committee Performance Report for October 2023. The report provided an update and assurances on the work being undertaken relating to: • Patient Experience and Staff feedback. • Civica implementation plan. • Patient Experience and Involvement Strategy. • Patient Experience and Staff Feedback. • PALs update and including plans for implementation in October 2023 • Incident reporting and severity of harm. • Duty of Candour, Falls, Thematic reviews, and learning. • Next steps - pressure ulcers, RAMI, and mortality. • Health, Safety and Security.	

- Infection Prevention and Control.
- Safeguarding.
- Urgent and Emergency Care.
- Planned Care.
- Cancer Pathways.
- Complaints and concerns.
- Implementation of the Pressure Ulcer Faculty 2023.
- Escalated risk concerns, including the Framework for Speaking Up Safely in the NHS and COVID-19 investigations.
- Overview of the Health Inspectorate Wales (HIW) Inspection of Cedar Parc, Ysbty Tri Chwm.
- Quality Outcomes Framework.

Mental Health and Learning Disabilities, including NHS Wales Delivery Unit Review of Mental Health Crisis & Services for Older Adults, and the Health Inspectorate Wales (HIW) Mental Health Discharge Review
The Committee received the reports, noting the contents.

Members noted delays in receiving the updates due to Mental Health and Learning Disabilities system pressures.

Recommendations arising from the All-Wales Delivery Unit Assurance Review of Crisis and Liaison Psychiatry Services for Older Adults in March 2023 were noted. Members were provided with an overview of the current provision of mental health crisis and liaison services for older adults, identified actions and associated action plan.

Committee Risk Report
The Committee received an overview of the revised risk reporting for assurance. This included a summary of current, new, and updated strategic risks delegated to the Committee for monitoring, and a summary of significant operational risks which were being monitored by the Executive Committee via the Corporate Risk Register.

Maternity Services Update, including Maternity Services Organisational Improvement Plans, Maternity and Neonatal Safety Support and MBBRACE
The Committee received the overview of maternity and neonatal services for assurance.

The report outlined the Health Boards response to the *Improving Together for Wales Maternity Neonatal Support Programme Cymru Discovery phase* report, released in July 2023, maternity and neonatal actions, areas for consideration, resource challenges and risks.

Pharmacy Robot
The Committee received the report for assurance. Members were updated on the progress of the business case for a new Pharmacy robot and associated risks, in response to a previous committee action.

Members noted the high patient and staff risk associated with the current system and were assured that the efforts to replace the Pharmacy robot were continuing and that plans were in place in the event of failure.

Committee Self-Assessment
The Committee discussed the report, outlining the Health Boards statutory requirement for an annual self-evaluation of committee effectiveness.

The Committee endorsed the Self-Assessment template and agreed the timescales for completion.

National Incident Reporting Policy
The Committee discussed the report, providing an overview of the revised *Health Board Patient Safety Incident Reporting & Management Policy*. The policy had been revised to align with the expectations set out in the *NHS Wales National Policy on Patient Safety Incident Reporting & Management* published in May 2023.

The Committee endorsed the report for presentation to the Board.

Highlight Reports:
The Committee received the following Highlight Reports for Information: - Clinical Effectiveness and Standards Committee Report.

WHSSC QPS Committee Annual Report
The Committee received the report for information, outlining the key matters discussed at the August 2023 meeting of the Quality Patient Safety Committee.

Organ Donation Committee Annual report
The Committee received the report for information, highlighting the NHSBT Annual Report regarding Actual and Potential Deceased Organ Donation for Aneurin Bevan University Health Board between 1 April 2022 - 31 March 2023.

PSOW Press Release 09/08/2023- Annual Report
The Committee received both the letter from the Ombudsman and the Health Boards response for information**.**

Matters Requiring Board Level Consideration or Approval:

None Noted.

Key Risks and Issues/Matters of Concern:

There were no issues or matters of concern.

Planned Committee Business for the Next Reporting Period:

Development of Committee Annual Programme of Business 2022/23.
Review of Committee Programme of Business.
Patient Quality and Safety Outcomes Performance Report, December 2023.
Safeguarding Annual Report.
Infection Prevention and Control Report.
Annual Clinical Audit Plan.
Clinical Audit Activity Report.

Committee Risk Report. Learning Disabilities. Internal Audit Review - Quality Governance arrangements for the commissioning of NHS Continuing Care within the Mental Health & Learning Disabilities (limited assurance) – Action Plan Update. Internal Audit Review – Medical Devices – Action Plan Update. Overview of Audit Recommendation Tracking. HIW Report/ Stroke Assurance.
Date of Next Meeting: Wednesday 13th December 2023 at 09:30

Name of Committee:	**People & Culture Committee**
Chair of Committee:	**Louise Wright**
Reporting Period:	**19th October 2023**
Key Decisions and Matters Considered by the Committee:	

Review of Committee Programme of Business
The Committee received an overview of the Committee Programme of Business. A request was made for Education Training Matters to be reported on an annual basis in future.

The Committee was assured by the report and requested further Education Training Matters be included in continue reporting to the committee.

Committee Risk Report.
The Committee received an overview of the Committee Risk Report. The Committee was assured by the report and acknowledged that risks were being managed appropriately.

People Plan 2022/25, Quarterly Review
The Committee received an update on the progress made in the quarterly review of the Health Board's People Plan 2022/25. The update included the key achievements and objectives for the following areas:

- Staff Health & Wellbeing
- Occupational Health Service
- Employer Choice
- New hybrid recruitment initiative
- Sustainable Workforce
- Talent Management

The Committee sought clarification on key aspects contained within the report and was assured by the information provided.

Report from the Director of Workforce & OD, Including Employee Relations & Suspensions over 4 Months
The Committee received an update on the progress being made against Welsh Government targets. In particular, the following matters were highlighted:

- Employee relation activity
- Tupe Transfers
- NHS Staff Survey
- Vacancy Scrutiny Panel

The Committee was informed that a refreshed agile working programme had been agreed at Executive Committee and were assured with the information provided within the report.

Retention Update
The Committee received an update on the work completed to date on retention, which included:

- Reprofiling of the approach to corporate induction.
- Revised approach to the leaving questionnaire for staff
- New questions within the staff wellbeing survey.
- Reduction in the turnover of members of staff.

The Committee was informed that a high-level action plan had been created, and a Retention Group set up to progress the implementation of the plan.

The Committee received the report for assurance and was content with the information provided.

Staff Wellbeing Survey – Results and Action Plan
The Committee received an update on the results from the Staff Wellbeing Survey that had taken place this summer and was assured by the information provided.

Committee Self-Assessment
The Committee received the self-assessment form for this current year and agreed that the form should be circulated to members for completion in November 2023.

Reverse Mentorship and Staff Diversity Networks
The Committee was provided with an overview of the work that had been completed. It was highlighted that a robust framework had been developed to ensure the Health Board was aligned with the EDI agenda.

The Committee was assured with the work that had been undertaken to date and noted the progress made.

Workforce Medical E-Systems/Work Plan
The Committee received an update on the above and noted the current position and an associated implementation plan for this work.

The Committee was informed that contacts had been awarded to the following companies; -

- L2P Box Limited – Job planning
- Patchwork – E rostering and Locum bank.

It was noted that the implementation plan would be piloted within Families and Therapies in December 2023 and, if successful would be rolled out to other Divisions. The Committee was advised that the Audit Risk and Assurance Committee would monitor the implementation of this area of work.

The Committee was assured with the update received and the next steps for implementation.

Matters Requiring Board Level Consideration or Approval:
N.A

Key Risks and Issues/Matters of Concern:
The following items were agreed to come to the next Board Meeting. • Suspension over 4 months • Tupe Transfers
Planned Committee business for the Next Reporting Period: • Mandatory Training Update • Speciality Doctors and Clinical Fellows Framework. • Review of Committee Programme of Business • Annual Review of Committee Terms of Reference 2022/23 • Annual Review of Committee Effectiveness 2022/23 • Committee Risk Report • Assurance on Compliance with the Equality Act 2010, including Equality Impact Assessment • Review and Refresh of ABUHB Values & Behaviours Framework • Assurance on the Development and Delivery of an Agile Working Framework • Annual Assurance Report of Medical Revalidation • Workforce Performance Dashboard incorporating Key Performance Indicators • People Plan 2022/25, Quarterly Review • Report from The Director of Workforce & OD, including Employee Relations & Suspensions over 4 months.
Date of Next Meeting: Thursday 22nd February 2024

Name of Committee:	**Partnerships, Population Health, and Planning Committee**
Chair of Committee:	**Ann Lloyd**
Reporting Period:	**1st November 2023**
Key Decisions and Matters Considered by the Committee:	
Committee Self-Assessment The Committee received the update and endorsed the self-assessment template. **Committee Strategic Risk Report** The Committee received an overview of the revised risk reporting for assurance and noted plans to map risks to inform Committee Workplans. **To receive and discuss the Gwent Marmot Programme, including an update on the Gwent PSB Wellbeing Plan and the Gwent Marmot region Communication and Engagement Strategy** The Committee received the report, noting the contents and a verbal update of the positive engagement at the recent meeting of the PSB and workshop, with a theme of closing the gap between statutory and community services. Members were assured of alignments between Gwent Marmot Region report 'A Fairer Gwent' and the Gwent Public Service Board (PSB) Wellbeing Plan. A delivery plan is being produced. **To discuss work ongoing within the Regional Partnership Board, including an update on Partnership Capital Strategy and Plans, and the RPB Governance Review**	

The Committee received the report, noting the contents. The update included information on the Partnership Capital Strategy and Plan and the RPB Governance Review.

Members were assured that the Health Board had engaged fully in the Partnership Capital Strategy and Plan, and it had been evaluated through the internal capital governance structure. It now needed to be accepted by the Health Board formally.

To receive an update on the Vaccination Programme
The Committee received the report for assurance and endorsed the plans to mitigate the critical risk of failing meeting the vaccination targets for winter flu and COVID vaccinations and the subsequent consequences for increasing pressure on health services.

To provide enhanced assurance, the Committee requested inclusion of value for money comparing mass vaccination centres with primary care vaccination services in future reports.

The Committee was also advised that the Health Protection Report would be received at the next meeting.

To discuss and endorse the approach to developing the Long-Term Strategy
The Committee received the report and endorsed the approach to developing the long-term strategy for Board approval. Members were assured that the reconfiguration of Health Board services would take place in parallel with the development of the strategy. The arrangements proposed for health staff engagement would be amended.

To receive an update on the development of the Integrated Medium-Term Plan 2024-2026
The Committee received the report and discussed proposed approach to developing the plan for 2024/25. The parameters would be amended to reflect the importance of community-based care and prevention. A detailed discussed would take place at the Board Briefing session on Wednesday the 8th of November 2023.

To receive and discuss an update on Regional Planning
The Committee received an update of progress in respect of ongoing regional and South Wales service planning programmes for information.

Members requested further updates on the quantified effects of service delivery delays associated with delivery delays in digital projects provided by DHCW.

To receive an update on the National Commissioning Implementation Programme
The Committee received the report outlining the final Programme Initiation Document (PID) for National Commissioning, noting the recommendation for one joint committee for Commissioned Services in Wales. Concern was expressed about the conflicted approach to the implementation of the Board proposals and the relationship of the future joint subcommittee to Health Boards to whom they account.

To receive an overview of the Clinical Futures Programme including the Planned Care Programme and Decarbonisation

The Committee received an overview of the Health Board's Clinical Futures Programme priorities. Members noted the contents of the report, and requested further details on mental health transformation plans and an extended work programme for community-based care including place-based care.

Members received an update on the Planned Care Programme. To provide enhanced assurance, members requested a detailed update come back for further discussion at the next meeting, to include work undertaken on health pathways across Health Boards.

Members received an annual update on the Decarbonisation Programme, noting that it was now aligned with the National Programme. Members were assured that the risks associated with the sustainability of resources and funding were being closely monitored and tracked.

To receive an update on Capital & Estates

The Committee received an update on Strategic Capital Projects and Estate Rationalisation. Members noted the potential risk of the *Hollow Beam Survey* currently taking place in Nevil Hall Hospital, associated with RAAC. It was agreed that this risk be flagged to the Board.

To provide enhanced assurance, members requested a detailed update come back for further discussion at the next meeting, or before, subject to the outcome of the current survey.

Committee Work Programme 2023/24

The Committee received the forward work programme, noting that amendments would be made to align with Health Board priorities and risks.

Matters Requiring Board Level Consideration or Approval:

Matters to be discussed at Board level were noted as; -

- Potential additional risks associated with RAAC at NHH.
- IMTP
- Strategic and Estates plans.
- Place based Care. Winter Flu and COVID Vaccination Risk

Key Risks and Issues/Matters of Concern:

Critical risk of potentially not achieving the Winter Flu and COVID vaccination targets on the provision services and the population to be discussed at the Board.

RAAC at Nevil Hall.

Planned Committee business for the Next Reporting Period:

- Committee strategic Risk Report
- Annual review of Committee Effectiveness 2023/24
- Annual review of Committee Terms of Reference
- Overview of work of the Gwent PSB, including an update in respect of Developing a Marmot Region
- Overview of discussions at the Regional Partnership Board (RPB)
- Regional Planning Update
- Draft IMTP

- A report on the evaluation of the Vascular Services Network
- Planned Care Programme
- To receive an update on Capital and Estates
- All-Wales Digital Programmes and delivery
- To discuss work ongoing within the Regional Partnership Board
- Public health and Population Health Improvement
- Mental Health Transformation

Date of Next Meeting: Wednesday 31st January 2024

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	21 September 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising

- ***Duty of Quality Update –*** The Medical Director gave a verbal update on progress with the implementation of the Duty of Quality. Good progress has been made but challenges remain in making the Duty fit to non-patient facing services and we are meeting shortly with both DHCW and HEIW to share thoughts on how best to approach this. Reference was also made to two major projects (Laundry and TrAMS) that have quality improvements at their core but being unable to make significant progress due to lack of capital.
- ***Recruitment Modernisation Update –*** A presentation was given by the Deputy Director of Employment Services and the Head of Recruitment on progress in addressing recruitment challenges across NHS Wales. Measures have been implemented that have significantly streamlined the process and members commented favourably on the reduction in the time taken to successfully recruit new members of staff.

Chair's Report

The Chair noted attendance at recent meetings with the Minister largely focused on the financial situation across NHS Wales.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The establishment of a Value and Sustainability Group within NWSSP to drive an organisation wide approach to strengthen cross divisional working,

to co-ordinate and deliver actions to demonstrate value for money as well as continue to innovate and improve quality and consistency for NHS Wales. The Value and Sustainability Group mirrors the national approach and will closely monitor progress in achieving planned savings.

- The negotiations with the landlord on the Mamhilad site for provision of alternative accommodation for the Patient Medical Record service are nearing completion following the discovery of significant Reinforced Autoclaved Aerated Concrete issues in Brecon House. The costs of moving are however substantial with the need to shift 140,000 boxes of records and we are working on how to undertake this in the most cost-effective way.
- The move from the Regional Office in Companies House to Cathays Park has paused as a number of issues have recently arisen in respect of Cathays Park which have caused us to investigate what other options may be available.

The Committee **NOTED** the update.

Items for Approval

Energy April 26 V30 Basket Strategy - The Welsh Energy Group have considered NHS Wales' participation in a longer-term basket strategy for an initial 12-month supply period commencing 1st April 2026. The paper outlined the recommended approach for NHS Wales to confirm participation in the Long-Term Variable (V30) basket strategy for supply of energy for the period. The Committee **APPROVED** participation in the April26 V30 basket strategy.

Laundry Reconfiguration - The paper presented the option of reducing the Laundry Production Units currently utilised in the All-Wales Laundry service from five to four units through the decommissioning of the West Wales unit in Carmarthen and the formation of a storage and distribution hub. The Committee **APPROVED** the proposed decommissioning of the Carmarthen Laundry Production Unit, the creation of a Southwest distribution hub and the subsequent redistribution of volumes across South West and South East Wales.

Changes to the Welsh Risk Pool Risk Sharing Agreement – these had been discussed and agreed at the Welsh Risk Pool Committee on the previous day. The paper set out the Risk Share charges for 2023/24 arising from excess expenditure above the Welsh Government annual allocation for Clinical Negligence and Personal Injury claims. Following the receipt of the 2022/23 annual accounts, the proportions have been reassessed for 2023/24 based on agreed criteria and this has led to some organisations being asked to contribute more, while others will see a reduction in their contributions. The Committee **APPROVED** the updated Risk Share charges to NHS Wales for 2023/24.

Items for Noting

Transforming Access to Medicine (TrAMS)

The original plans for TrAMS have been significantly curtailed by the restrictions on available capital. Accommodation for the service within Southeast Wales is

being urgently sought and there are a number of possible options. The existing Pharmacy Service Technical Units are reaching end-of-life and the need to source alternative accommodation as soon as possible was stressed by a number of members.

The Committee **NOTED** the verbal update.

Finance, Performance, People, Programme and Governance Updates

Finance – The Month 5 financial position is a year-to-date overachievement of non-recurring savings of £0.999m. We continue to forecast a break-even financial position for 2023/24 dependent upon a number of income assumptions relating to pay award funding, energy costs for laundries, continued demand and the costs to support increased transactional activity, IP5 running costs and transitional funding for TRAMS. We are anticipating an element of savings achieved to date will be required to support the transitional and removal costs relating to the transfer of significant volumes of medical records to new premises. Our additional savings submission to Welsh Government on 11th August identified we can make a £1.6m distribution this financial year, in addition to identifying NWSSP supported initiatives that will result in cash releasing savings direct to NHS Wales Organisations and Welsh Government. Following the decision to transfer our utility supplies to the CCS Framework, this gave rise to the opportunity to sell back some small quantities of energy that we had secured the right to forward purchase at lower than current market rates for 2024/25 and 2025/26. The Wales Energy Group (which comprises each Director of Finance or their designated representative) agreed that these tranches of energy will be sold back to British Gas with a net £2.520m one-off windfall gain to NHS Wales to be accounted for in the 2023/24 financial year.

People & OD Update – Sickness absence remains low and statutory and mandatory performance is good. PADR rates are below target and the position has slightly worsened over recent months.

Performance – The in-month July performance was generally good with 37 KPIs achieving the target against the total of 41 KPIs. However, 4 KPIs did not achieve target and are considered Red/Amber. Two of these relate to Recruitment, one to customer satisfaction with the Digital Workforce Team, and one relating to Procurement Savings.

Project Management Office Update – Three projects are currently rated as red, these are the Brecon House relocation where there are issues with the current building being unsafe and the cost of relocation of records, Primary Care Contract reform, and the TrAMS project and particularly the affordability of the proposed solution as part of the wider capital programme.

Corporate Risk Register – There are currently eight red risks on the Corporate Risk Register. These cover energy costs, staffing shortages, the Legal & Risk Case Management System, Brecon House, TrAMs, the impact on the Single Lead

Employer Team of proposed Junior Doctors Industrial action, the limitations imposed by the overall financial climate and the reputational issues for NWSSP relating to the situation at BCUHB. The Committee **NOTED** the above Reports.
Papers for Information
The following items were provided for information only: • Welsh Infected Blood Support Service Annual Report 2022/23; • PPE Stock Report; • Audit Committee Assurance Report; and • Finance Monitoring Returns (Months 4 and 5).
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	Thursday 23rd November 2023 10am – 12pm

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	21 September 2023

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The Committee **NOTED** the update.

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AOB

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Matters requiring Board/Committee level consideration and/or approval

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Date of next meeting	Thursday 23rd November 2023 10am – 12pm