Aneurin Bevan University Health Board

Wed 25 May 2022, 09:30 - 14:30

Agenda

1. Opening Business/Governance Matters

1.1. Chair's Introductory Remarks

Verbal *Chair*

1.2. Apologies for Absence for Noting

Verbal *Chair*

1.3. Declarations of Interest for Noting

Verbal *Chair*

1.4. Draft Minutes of the Health Board Meeting held on 23rd March for Approval

Attachment *Chair*

1.4 Draft Board Minutes 23 March 2022.pdf (14 pages)

1.5. Board Action Log for Review

Attachment *Chair*

1.5 Action Log 23.03.22.pdf (2 pages)

1.6. Report on Sealed Documents and Chair's Actions

Attachment *Chair*

1.6 Report on Sealed Documents and Chair's Actions March 2022.pdf (14 pages)

1.7. Chair's Report

Verbal *Chair*

2. Patient Experience and Public Engagement

2.1. An update in respect of Maternity Services Provision

Attachment *Director of Nursing*

2.1 Midwifery Staffing and Impact for Service Provision - May 2022.pdf (6 pages)

2.2. Long COVID - Adferiad Programme - to include patient story

Attachment *Director of Therapies and Health Sciences*

2.2a Adferiad Board Briefing Cover Paper.pdf (5 pages)
2.2b Adferiad Programme Board Briefingce PC.pdf (20 pages)
2.2c Adferiad Programme.pdf (20 pages)

3. Items for Decision

3.1. Satellite Radiotherapy Unit Full Business Case

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

3.1a RSC FBC Cover Report.pdf (3 pages)
3.1b SRU FBC V 6 17.5.22.pdf (83 pages)

4. Items for Discussion/Assurance

4.1. Learning and Reflections from Business Continuity (Black Escalation Status)

Attachment *Interim Chief Executive/Director of Nursing*

4.1 Learning and reflections from declaring BC May 2022.pdf (9 pages)

4.2. Board Governance: Annual Review of Effectiveness 2021/22

Attachment *Chair/Director of Corporate Governance*

4.2 Board Self Assessment Report 2021-22.pdf (7 pages)

4.3. ABUHB's People Plan

Attachment *Director of Workforce and OD*

4.3a People Plan 2022 - 2025 Board cover report (002).pdf (5 pages)
4.3c PEOPLE PLAN 2022 - 2025 v2.pdf (39 pages)
4.3 c Appendix 3 People Plan A3 Poster Landscape (002).pdf (1 pages)

4.4. Nurse Staffing Levels Wales Act Annual Assurance Report

Attachment *Director of Nursing*

4.4a NSLWA Board Report.pdf (3 pages)
4.4b Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act April 2022.docx - FINAL.pdf (21 pages)
4.4c Appendix A - Summary of Establishments.pdf (4 pages)

4.5. Trade Union Partnership Forum, Annual Report

Attachment *Chair, TUPF*

4.5 TUPF Annual Report 2021-22 (1).pdf (6 pages)

4.6. Strategic Partnerships Update Report

Attachment *Director of Planning and Strategic Partnerships/Interim Director of Primary, Community and Mental Health Services*

4.6 Strategic Partnerships .pdf (25 pages)

4.7. An Overview of Joint Committee Activity:

a) WHSSC Update Report, Including Integrated Commissioning Plan
b) EASC Update Report, Including IMTP 2022-25

4.7a1 WHSSC Update Report - May 2022.pdf (4 pages)
4.7a2 Chairs Summary Report Jnt Cmt 15 March 22.pdf (4 pages)
4.7a2.1 WHSSC Joint Committee Briefing (Public) 10 May 2022.pdf (5 pages)
4.7a3 WHSSC Integrated Commissioning Plan.pdf (145 pages)
4.7a4 Chairs Summary WHSSC QPSC 30 March 22.pdf (14 pages)

- 4.7b1 EASC Update Report - May 2022.pdf (4 pages)
- 4.7b2 Chairs Summary of Joint Cmt held 15 March 2022.pdf (8 pages)
- 4.7b3 EASC IMTP 202225v7 Final.pdf (52 pages)
- 4.7b4 Confirmed Mins 18 Jan 22.pdf (10 pages)

4.8. Financial Performance, Month One 2022/23

- 4.8a Finance Report _m1_April 2022 final 13.5.22.pdf (23 pages)
- 4.8b appendices.pdf (18 pages)

4.9. Performance Report, May 2022

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

- 4.9 Performance Report May 2022.pdf (26 pages)

4.10. Strategic Risk Report

Attachment *Interim Chief Executive*

- 4.10 Strategic Risk Report board May2022docx.pdf (13 pages)

4.11. Executive Team Report

Attachment *Interim Chief Executive*

- 4.11 Executive Team Report May 2022_.pdf (8 pages)

4.12. Key Matters from Committees of the Board

Attachment *Committee Chairs*

- 4.12 a Committee and Advisory Assurance Reports.pdf (15 pages)
- 4.12 b SSPC Assurance Report 24 March 2022.pdf (5 pages)

5. Closing Matters

Date and Time of Next Meeting: Tuesday 14th June at 10am (to receive the Annual Accounts), Wednesday 27th July 2022 at 9:30am (To include Annual General Meeting)

6.

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

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

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

Aneurin Bevan University Health Board
Minutes of the Public Board Meeting held on
Wednesday 23rd March 2022,
via MS Teams

Present:

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

In Attendance:

Rani Mallison	-	Director of Corporate Governance
Leanne Watkins	-	Director of Operations
Dan Davies	-	Chief of Staff
Bryony Codd	-	Head of Corporate Governance
Jemma McHale	-	Aneurin Bevan Community Health Council
Neall Hollis	-	Audit Wales (item ABUHB 2303/13)
Nathan Couch	-	Audit Wales
Andrew Doughton	-	Audit Wales (item ABUHB 2303/13)
Richard Harries	-	Audit Wales (item ABUHB 2303/13)
Phil Diamond	-	Torfaen County Borough Council(item ABUHB2303/16)

Apologies:

Cllr Richard Clark	-	Independent Member (Local Government)
Keith Sutcliffe	-	Associate Independent Member (Chair of the Stakeholder Reference Group)

ABUHB 2303/01 Welcome and Introductions

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

The Chair highlighted that this was a national day of reflection, on the second anniversary of the first COVID lockdown, to

remember those lives lost and lives changed. The Board would pause at midday to observe a one-minute silence.

The Chair congratulated Leanne Watkins on her substantive appointment to the role of Director of Operations.

On behalf of the Board, the Chair observed that all thoughts were with the people of Ukraine and those suffering as a result of the conflict at this time.

ABUHB 2303/02 Declarations of Interest

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

ABUHB 2303/03 Minutes of the previous meeting

The minutes of the meetings held on 26th January 2022 were agreed as a true and accurate record.

ABUHB 2303/04 Action Log and Matters Arising

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

ABUHB 2303/05 Governance Matters

The Board noted the use of the Health Board's common seal and RATIFIED the use of Chair's Actions, undertaken between 13th January and 7th March 2022, as set out within the paper.

ABUHB 2303/06 Chair's Report

The Chair expressed her gratitude to Pippa Britton, Interim Vice Chair, for undertaking Chair duties during her absence; and provided an overview of the activities she had undertaken, outside of her routine meetings, since her return, including:

- Chairs Peer Group Meeting, at which a discussion was held regarding the number of learning disabled patients in long term specialist care and how their care was being progressed. Further work was being undertaken with the Vice Chairs on this important issue.
- The Chairs Peer Group had also discussed the requirements for the recovery programme, including system reset.
- Attended a meeting on behalf of Chairs which was focussed on Rebalancing Social Care, and the response of the Welsh Government to the White Paper. The implementation of the actions would have a fundamental consequence for the responsibilities of Health Boards and Local Authorities.
- The Gwent Public Service Board (PSB) had met and agreed the in principal objectives for the next 3 years. The PSB had

also pledged to become a Marmot region and further detail would be brought back to the Board in due course.

The Chair acknowledged the ongoing challenges in respect recovery and reset and expressed her gratitude to staff for the ongoing care provided to communities.

ABUHB 2303/07 Report from the Aneurin Bevan Community Health Council (CHC)

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

The report raised issues in relation to the different aspects of the whole systems pressures including ambulance waits, delays in discharging those who are medically fit and access to primary care. It was recognised that these were whole system issues which require work in partnership with Local Authority partners.

A patient survey had been undertaken in to maternity services. It was acknowledged that visiting restrictions had now been reduced and the action plan from the Health Board was awaited.

The 111/OOH survey which had run for 3 months had had only 17 respondents. Data gathered from national work would therefore be utilised to supplement the report being prepared.

The CHC was receiving feedback from individuals wanting to access dental services; this will be an area that the CHC would investigate further. [confirmed that the Dental Access Project would be undertaken in May/June 2022].

Jemma McHale thanked the Health Board's Communication and Engagement Team for hosting CHC members at the roadshow events, highlighting the benefits of the collaborative approach.

As part of the Winter Survey, the CHC had been providing weekly feedback to senior teams in MIU/ED departments. There were issues regarding waiting times and comfort but positive feedback regarding the approach of staff. A formal report would be received in April.

There had been a poor response to the Stroke Survey and this had therefore been extended until June.

Jemma McHale highlighted the key areas of work over the coming year, including dementia care in the community survey,

a focus on palliative care and the socio-economic factors relating to cancelled operations.

The Chair thanked the CHC for the report which demonstrated an enormous amount of work and provided a helpful insight into services.

Pippa Britton, Interim Vice Chair, asked if, in relation to the 111/OOH survey, it would be possible to speak to people in ED to ask how they arrived there, and if they had been directed by 111. It was agreed that this would be picked up through the winter patient experience programme.

Rhiannon Jones, Director of Nursing, commented that the Health Board was rapidly reviewing visiting restrictions with plans to reduce these from April in line with WG guidance.

Katija Dew, Independent Member, asked if there was information on the impact of delayed discharges on individuals, particularly their needs when they return home. Jemma McHale agreed to include this in a DTOC survey being undertaken later in the year. Rhiannon Jones confirmed that, as part of the test of change for step closer to home pathways, there would be focussed work on assessing patient experience.

Shelley Bosson, Independent Member, asked about the methodology used to communicate with individuals on waiting lists. Leanne Watkins, Director of Operations, explained that validation was underway. All patients were being contacted by text/ and the Health Board was endeavouring to provide the most up to date information regarding the anticipated length of wait. A central validation team was now in place with a central hub for patient queries. It was agreed that this needed to be publicised. **Action: L. Watkins**

In relation to ongoing patient experience in GUH, Leanne Watkins confirmed that interim arrangements were in place for additional ED waiting room space by the end of April. The Chair emphasised that the Board required assurance, via the Patient Quality, Safety and Outcomes Committee, regarding opportunities for patients to provide feedback on experiences at GUH and the outputs of these for improvement and learning. **Action: L. Watkins/R. Jones**

The Board NOTED the update from the Community Health Council.

ABUHB 2303/08 Integrated Medium Term Plan

Nicola Prygodzicz, Director of Planning, Performance, Digital and IT, presented the Integrated Medium-Term Plan (IMTP) 2022/25

seeking the Board's approval for submission to Welsh Government.

She noted that in December 2021 Welsh Government had confirmed the resumption of the formal IMTP process following the decision in 2020 to pause this requirement in the light of the COVID-19 pandemic. It was recognised that this was the first NHS Planning Framework of the new Government term, and that it had been published at a time of extreme pressure on the health and care system. She therefore advised the Board that the Framework required the Health Board to look ahead to the next three years to deliver sustainable services for patients and improve population health.

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

She informed the Board that the draft Integrated Medium-Term Plan 2022/25 represented a natural progression from the Annual Plan 2021/22, which built on the life course approach, adopted last year, whilst recognising the current operational demand and the need to be able to focus on realistic, sustainable recovery.

It was noted that further information would be provided to the Board in relation to monitoring performance against key metrics, with an Outcomes Framework being developed during Quarter 1 of 2022/23. The IMTP provided clear opportunities to drive improvements across the system.

Katija Dew, Independent Member, welcomed the life stage approach to setting priorities and requested further information on the pressing economic circumstances currently faced by the population, which would clearly impact on health inequalities. Katija Dew stated that giving every child the best start in life would become a real challenge, as the health inequalities gap grew.

Sarah Aitken, Director of Public Health and Strategic Partnerships, assured the Board that there was a renewed focus on the Healthy Start Scheme and it would be important to ensure that staff enabled the population to access this Scheme where entitled to do so.

Rhiannon Jones, Director of Nursing, highlighted amendments required to the report:

- ICEBERG – no longer the term used

- Care Aims – now integrated decision making
- A strengthened focus on dementia care was needed.

There was discussion regarding the need to promote care in the community and to support avoidable attendances at Emergency Departments. It was agreed that a Board Briefing Session would be arranged regarding the community model of care, aligned to secondary care pathways.
Action: Chair/Director of Corporate Governance

Phil Robson, Special Advisor, emphasised the need for a risk matrix relating to the delivery of the plan.

Shelley Bosson, Independent Member, asked for confirmation that the plan will deliver improved activity and outcomes for patients in all areas i.e. productivity will be greater than during 20/21 or 21/22. Nicola Prygodzicz explained that the plan would ensure that more activity was undertaken than in 2021/22 but it would be difficult to compare with pre-pandemic levels due to ongoing COVID-19 guidance.

On behalf of the Board, the Chair thanked the Executive Team and respective teams for a clear and concise strategic plan, which demonstrated what our communities can expect in the next three years. A timed Outcomes Framework to underpin the plan would be essential.

The Board APPROVED the Draft IMTP 2022-25 for submission to the Welsh Government by the 31st March 2022.

ABUHB 2303/09 Delegation of Revenue Budgets

Rob Holcombe, Interim Director of Finance and Procurement, presented the Board with a paper which set out the principles and proposed approach to delegating funding at the start of the 2022/23 financial year within total available resources (£1.47bn).

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

Rob Holcombe advised that the IMTP financial plan was based on applying the above principles, thus the focus has been on developing a budget strategy that:

- Ensures budget delegation plan values reconcile with Allocation funding
- Budget allocations were prioritised to making historical/underlying commitments sustainable as part of the 'Core' IMTP plan

- Budget delegation excluded Covid cost estimates and exceptional National Cost pressures – this was a risk but aligns with IMTP assumptions and would be identified as a quarterly budget review
- All allocations were delegated to service delivery - negligible central reserves would be held
- Required budget holders to operate & deliver within delegated budgets
- Reflected that the IMTP was only affordable if £26m savings were delivered to support some of the service costs identified – a budget cannot be allocated for a saving.
- All other risks & pressures would need to be pro-actively managed & mitigated.

He advised that, in addition to the initial budget delegation plan, a quarterly financial budget planning and approval process was recommended for any additional Covid funding. This would ensure that the uncertainties of responding to the pandemic were appropriately mitigated, resourced and managed within the health board's governance framework.

Board members agreed that a hybrid approach was prudent, bearing in mind the current local, national and global challenges.

The Board APPROVED the delegation of revenue budgets, the funding provisions to be held in reserve and contingency and the approach for setting covid related budgets, as set out within the paper. They agreed that the detail of the savings and disinvestment required to balance would need to be strengthened and discussed further by the Board.

ABUHB 2303/10 Capital Programme

Nicola Prygodzicz, Director of Planning, Performance, Digital and IT set out the Capital Programme for 2022/23 for both the All-Wales Capital Funding and the Discretionary Allocation to obtain Board approval to progress the schemes early in 2022/23.

It was highlighted that this year would be particularly challenging with the WG NHS allocation significantly reduced eg there had been a 25% reduction in discretionary funding.

The total Capital Resource Limit for 2022/23 was £31.308m. This included £8.227m discretionary capital.

Board Members noted the schemes that were awaiting WG approval, as set out within the paper.

A comprehensive capital prioritisation exercise had been undertaken against bids from divisions totalling £24m, to develop a shortlist of priority bids, based on prioritisation and

risk, for the proposed opening capital programme of £6.693m. Risks relating to backlog maintenance, IT resilience and equipment resilience were highlighted.

Work had been undertaken to identify and develop priority bids (£5.8m) in readiness for any further opportunities.

The Board NOTED the report and APPROVED the Draft Capital Programme 2022/23 and specified projects within the report.

ABUHB 2303/11 Endoscopy Business Justification Case

Nicola Prygodzicz, Director of Planning, Performance, Digital and IT presented the Business Justification Case to support the proposed redevelopment and expansion of Endoscopy services at Royal Gwent Hospital (RGH). The estimated capital cost of the development was set out as £9.145 million.

It was noted that the two endoscopy suites at RGH did not currently meet JAG Accreditation nor capacity requirements and several temporary, unsustainable solutions were in place.

The key investment objectives were highlighted as:

- To improve and increase Endoscopy infrastructure at RGH and achieve JAG accreditation
- To eliminate /reduce the need for waiting list initiatives and private sector out-sourcing
- To improve access to Endoscopy diagnosis and treatment services.

Helen Sweetland, Independent Member, commented that this was a vital development for diagnostic and therapeutic interventions. This point was supported by Board Members.

The Board APPROVED the BJC for submission to Welsh Government and noted that the utilisation of the facilities would be phased in as revenue becomes clearer.

ABUHB 2303/12 Board and Committee Arrangements 2022/23

Rani Mallison, Director of Corporate Governance, presented a proposed revised committee structure for 2022/23, which would ensure a focus on key priorities and risks would be maintained. The revised structure took into account feedback from Audit Wales and Board members.

Rhiannon Jones, Director of Nursing, welcomed the important addition and strengthening of the Terms of Reference for the Patient Quality, Safety and Outcomes Committee, including a focus on the commissioning arrangements and quality oversight of commissioned services.

The Board APPROVED the revised committee structure for 2022/23, as set out within the paper.

ABUHB 2303/13 Structured Assessment and Annual Audit Report

Andrew Doughton, Audit Wales, presented the External Audit Annual Audit Report, which provided an overview of the work undertaken over the last financial year, noting that this presented a generally positive picture, with some areas identified to address.

The Chair thanked Audit Wales, commenting that the assessments were most valuable and helped the Health Board to improve its arrangements.

Pippa Britton commented that it would be helpful for an induction pack to be developed for Board Members which contained all relevant documentation and information. Rani Mallison confirmed that work was underway at a national level regarding an induction programme which would then be available for local use. In addition, the development of an ABUHB tailored programme was included as a governance priority for the year within the IMTP.

The Board NOTED the Annual Audit Report, Structured Assessment, and associated Action Plans to respond.

ABUHB 2303/14 Clinical Futures and Grange University Hospital: Reflections on the first twelve months

Nicola Prygodzicz, Director of Planning, Performance, Digital and IT, outlined the key developments in the Health Board's system of care over the past 12 months since the Grange University Hospital opened, providing reflections on key areas of progress and the priorities for further work. The difficulty and complexity in evaluating when the GUH had been opened early in the midst of a global pandemic was acknowledged.

The following key areas were highlighted:
- Changes in patterns of demand, with a significant increase in COVID presentations weeks after opening the GUH;
- Record attendances by June 2021;
- Still significant pressure in the system but evidence that the system is stabilising;
- eLGHs – increase numbers attending MIUs and MAUs, routinely seen within the 4 hour target.

High level system reflections were outlined as being:
- Service sustainability for women and children's service;
- More resilient and flexible critical care service;
- Improved infection control management;
- Additional physical space across the system;

- Additional emergency department and resus capacity;
- Areas of improved recruitment;
- Maintain elective activity at RGH and NHH;
- Additional diagnostic resilience.

It was acknowledged that the system remained under significant pressure, particularly urgent care. The impact upon staff and workload in terms of volume and complexity had been significant. There were numbers of inappropriate presentations to Medical Assessment Units and transport delays at eLGHs which were a key issue and area of focus for improvement.

Nicola Prygodzicz noted that the key issues identified would be addressed via the IMTP priorities.

Pippa Britton, Interim Vice Chair, queried whether or not the 4/12 hour targets were appropriate for the GUH. Nicola Prygodzicz commented that the target was suitable at a system wide level, however not appropriate for a hospital that only sees majors. Rhiannon Jones, Director of Nursing, confirmed that work was underway with Welsh Government to explore more meaningful targets which are more outcome focussed.

Paul Deneen, Independent Member, requested that the Board undertook a deep dive with the Community Health Council into patient experience and patient voice and also staff experience and staff voice as the next phase of the evaluation. This was supported.

The Chair thanked the Executive Team for the helpful report, which highlighted the issues that required focus, such as transfers, length of stay, and the community model as the basis for the new system.

The Board NOTED the report.

ABUHB 2303/15 Annual Equality Report/Strategic Equality Objectives

Sarah Simmonds, Director of Workforce and OD, presented the report which set out the work undertaken to meet the Health Board's strategic equality objectives, in the context of multiple challenges highlighted by the pandemic and increased inequalities in some areas, such as in managing the COVID-19 vaccine roll out and COVID workplace risk assessments.

It was noted that the breakdown of staff profiles at March 2021 demonstrated increased trends regarding ethnic minority, registered disabled, aged 20 and under.

Pippa Britton, Interim Vice Chair, welcomed the report, commenting that it was positive to see improvements in ethnic backgrounds; however disability numbers remained much lower

and it would be excellent to see the Health Board as an employer of choice for people with disabilities. Sarah Simmonds recognised there was further work to do in this area and noted that the Health Board had achieved the level 2 award for being a disability confident employer, with action underway to achieve level 3.

Katija Dew, Independent Member, noted that in light of the current challenges at a local, national and global level, a breakdown of staff by income would be helpful as a number of staff would be affected by current economic circumstances. It was confirmed that this would be picked up as part of the work programme.

The Board APPROVED the Annual Equality Report.

ABUHB 2303/16 Gwent Regional Partnership Board Population Needs Assessment 2022-27

Sarah Aitken, Director of Public Health and Strategic Partnerships, explained that the Social Services and Wellbeing (Wales) Act 2014 set out a duty on local authorities and local Health Boards to produce one collective Population Needs Assessment (PNA) report per local government electoral cycle. She presented the PNA 2022-27, which had been developed in collaboration by the regional PSB to provide a consistent regional assessment of need linked to the Gwent Wellbeing Assessment, previously presented to the Board in January 2022.

It was noted that between 2019 and 2043 there could be an extra 37,263 people over the age of 65 in the Gwent area coupled with an increase in the numbers suffering from dementia. Care for older, frail people and keeping people well at home was therefore a key priority.

Paul Deneen, Independent Member, welcomed the report, which outlined the interconnectivity of people's needs which cross organisational boundaries, highlighting the need for whole system solutions.

Phil Diamond explained that the Area Plan would be the regional representation of the action plan which will highlight key actions across key partners, emphasising that the PNA focuses on the needs that require partnership working, such as for dementia care services and represent a balance between prevention and care. The PNA will identify the key outcome measures to take forward as a region.

It was noted that the concerns about looked after children were a priority. The Board APPROVED the Population Needs Assessment.

ABUHB 2303/17 Financial Performance

Rob Holcombe, Interim Director of Finance, Procurement and VBHC, presented the previously circulated report outlining financial performance to the end of Month 10. It was noted that the Health Board continued to forecast a breakeven position for both revenue and capital.

It was noted that the risks outlined in the report did not reflect the global consequences of the current crisis in Ukraine.

It was highlighted that variable pay remained high due to implications of the pandemic and recovery activity continued to be delivered.

Paul Deneen, Independent Member, asked what advice and support was available to staff in terms of HMRC, travel costs, work from home (WFH) etc. Sarah Simmonds confirmed that HMRC and WFH guidance had been shared with staff and would be shared again. In relation to travel expenses, it was noted that the rates reimbursed were linked with the overarching UK based calculation.

It was agreed that this information would also be shared with Independent Members.
Action: S. Simmonds

Katija Dew, Independent Member, raised concern that staff would be seeing significant increases in fuel costs for travel to work and at home and asked if there were plans to look at the Health Board's current estate to offer local hubs etc. Sarah Simmonds advised that the team was discussing these issues actively and learning from others across Wales and the UK. The Chair requested that this be raised with WG, via all Wales Directors of Workforce, as a matter of urgency. **Action: S. Simmonds.**

The Board NOTED the financial performance to the end of January 2022, as outline in the report.

ABUHB 2303/18 Performance Report

Nicola Prygodzicz, Director of Planning, Performance, Digital and IT, presented the Board with the Performance Report, which provided a high-level overview of activity and performance at the end of January 2022, with a focus on delivery against key national targets as included in the performance dashboard.

It was noted that many of the outlined themes had been discussed throughout the meeting, and a high level overview of the position was provided, including:

- RTT – 111,000 on the waiting list, 76,000 of which were at the outpatient stage. 34,500 waiting over 36 weeks. Risk based prioritisation continued.
- Diagnostics – reduced in January, with 5,500 waiting over 8 weeks. This position has improved again in February with improvements in endoscopy and cardiology due to insourcing.
- Unscheduled Care – pressures in the system continue, including impact of Omicron on staffing.
- Cancer access - continued increase in referrals, particularly for breast and colorectal cancers.

The Board RECEIVED the Performance Report, recognising the significant pressures and acknowledged the improvements and continued areas of concern. An update would be provided in response to the required recover plan.

ABUHB 2303/19 Strategic Risk Report

Glyn Jones, Interim Chief Executive, presented the Board with the Strategic Risk Report, noting that many of the strategic risks had been considered throughout the Board meeting.

There were 22 principal risks, of which 15 were categorised as high risk. Detailed assurance had been provided to relevant committees.

Glyn Jones noted that it was important that the Board's risk management arrangements remain a dynamic process as the Health Board continues to operate in significant uncertainty.

Shelley Bosson, Independent Member, raised a query in relation to CRR008 – Health Board Estate not fit for purpose – highlighting that in a previous report the funding agreed had been reduced due to other pressures, and asked what impact this would have on the risk. It was confirmed that, as a result of the Executive Team no longer being able to support the £820k allocated. There would be no increased risk for the Health Board fulfilling agreed schemes; however it would mean that the maintenance backlog would increase.

The Board NOTED the report.

ABUHB 2303/20 Executive Team Report

Glyn Jones, Interim Chief Executive, presented the Executive Team report, which reflected the service issues in delivering the plans agreed by the Board during the year, along with work underway in respect of ensuring the best available workforce; and a focus on mental health and family services, with positive examples of delivering alternative services included within the report.

The Board RECEIVED the report of the Executive Team.

ABUHB 2303/21 Committee and Advisory Group Chair's Assurance Reports

The Board RECEIVED Assurance Reports from the following Committees:

- Audit, Finance and Risk Committee – 3rd February 2022
- Patient Safety, Quality and Outcomes Committee – 8th February 2022
- Mental Health Act Monitoring Committee – 1st March 2022
- Charitable Funds Committee – 3rd March 2022

The Board also noted reports from:

- Welsh Health Specialised Services Committee – 18th January and 8th February 2022. *Glyn Jones highlighted that there had been a number of meetings in the past few months trying to agree the plan for specialised services, working through priorities in terms of what could realistically be delivered.*
- Shared Services Partnership Committee – 20th January 2022

ABUHB 2303/22 Date of Next Meeting

The next scheduled meeting of the Board, to be held in public, is to be held on Wednesday 25th May 2022 at 09:30.

Aneurin Bevan University Health Board Meetings –
Wednesday 23rd March 2022

ACTION SHEET

Minute Reference	Agreed Action	Lead	Progress/ Outcome
ABUHB 2303/07	**Report from the Aneurin Bevan Community Health Council (CHC):** A central validation team was now in place with a central hub for patient queries. It was agreed that this needed to be publicised.	**L. Watkins**	Staff have been appointed to the central team and an email address and telephone line set up, initially for outpatient queries in stage 1, with a plan to roll out for treatment in stage 2. The team commenced patient contact/validation in quarter 4, 21/22, any patient queries to be responded to within 48 hours. The patient contact to continue during 22/23. Long waiting patients on the new outpatient waiting lists and some patients on appropriate follow-up waiting lists are being contacted to establish if they still wish to receive their appointment. There is a robust, clinically agreed process in place. Reasons for removal are recorded and directorate teams are informed of outcomes and letters sent to GPs so they are aware. The second stage is for the team to serve as single point of contact for outpatient queries and the programme/resource requirements are being reviewed to determine the launch date for this second element.
	The Chair emphasised that the Board required assurance, via the Patient Quality, Safety and	**L. Watkins / R. Jones**	Patient experience for GUH will be built into the scheduling of reporting to PQSOC. To include assurance that the Health Board

Minute Reference	Agreed Action	Lead	Progress/ Outcome
	Outcomes Committee, regarding opportunities for patients to provide feedback on experiences at GUH and the outputs of these for improvement and learning.		methodology to collect patient feedback was accessible and comprehensive.
ABUHB 2303/08	**Integrated Medium Term Plan:** It was agreed that a Board Briefing Session would be arranged regarding the community model of care, aligned to secondary care pathways.	**R. Mallison**	Following the establishment of Informal Board Strategic Planning Sessions (as set out in a paper to Board in March 2022), this item has been scheduled for the first session to be held on 29th June 2022.
ABUHB 2303/17	**Financial Performance:** It was agreed that information regarding HMRC and WFH guidance would also be shared with Independent Members.	**S. Simmonds**	Information circulated to members. In addition, the Chair sought clarification in relation to the guidance applying to Independent members and this has been circulated.
	Issues relating to increased fuel costs, to be raised with WG, via all Wales Directors of Workforce, as a matter of urgency.	**S. Simmonds**	Update provided to members – Review undertaken via all Wales Directors of Workforce with NHS Wales Employers.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 25th May 2022 Agenda Item:1.6

Aneurin Bevan University Health Board

Governance Matters:

Report of Sealed Documents and Chair's Actions

Purpose of the Report

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

The Board is asked to: (please tick as appropriate)			
Approve/Ratify the Report			✓
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Rani Mallison, Board Secretary			
Report Author: Bryony Codd, Head of Corporate Governance			
Report Received consideration and supported by :			
Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**N/A**
Date of the Report: 9th May 2022			
Supplementary Papers Attached: None			

Executive Summary

This paper presents for the Board a report on the use of Chair's Action and the Common Seal of the Health Board between the 9th March and 9th May 2022.

The Board is asked to note that there has been one (1) document that required the use of the Health Board seal during the above period.

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

During the period between the 9th March and 9th May 2022, five (5) Chair's Actions have been agreed. This paper provides a summary of the Chair's Actions taken during this period, which are appended to this report.

Background and Context

1. Sealed Documents

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

2. Chair's Action

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

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

3. Key Issues

3.1 Sealed Documents

Under the provisions of Standing Orders the Chair or Vice Chair and the Chief Executive or Deputy Chief Executive must seal documents on behalf of the Health Board. One document was sealed between the between the 9th March and 9th May 2022, as outlined below.

Date	Title
14/04/2022	Service Level Agreement between TCCB and ABUHB – Early Years Services

3.2 Chair's Action

All Chair's Actions undertaken between 8th March and 9th May 2022 are listed below. All of which were approved by the Vice Chair, in the absence of the Chair.

Date	Title
11/03/2022	Insourcing of Endoscopy Procedures
17/03/2022	'Careflow' Contract Extension
24/03/2022	Support Services for Voice Network
28/03/2022	Robotic Process Automation Platform
06/04/2022	Endoscopy and MRI Outsourcing

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

Description of Request:	
To consider as Chairs Action the approval of a Single Tender Action (STA) to continue existing service.	
Financial Value	£2,071,650.00

Situation

Request to approve the Single Tender Action (STA) contract for the extension to continue the commissioning arrangements with Remedy Healthcare Solutions in their insourcing capacity until March 2023 to manage current endoscopy demand and existing backlogs from 1st April 2022 to 31 March 2023.

Background

It is noted that this is a short term, interim solution as the cycle of non-recurrent solutions is not considered sustainable in the long term. In addition, a capital proposal for the RGH site has been considered by the Executive Team as a priority for investment as part of the IMTP/annual planning process, with the endoscopy unit relocating from floor 3 to the old main delivery unit at RGH (B4) this will create more capacity within the existing service provision.

In the context of A Healthier Wales, the Welsh Government announced in September 2018 a new nationally directed approach for endoscopy service improvement. The National Endoscopy Programme (NEP) provides a framework to deliver improvement against four key work streams by 2023. At a local level, this sets the direction for the transformation of endoscopy services across Gwent and is aligned to the Health Board's IMTP priorities 2022 - 2025.

Endoscopy services play an essential part in diagnosing and staging of suspected/confirmed cancer and positive bowel screening results, providing follow up for patients with prior diagnosis and delivering interventional treatment thus delivering both therapeutic and diagnostic services. The service covers several modalities of diagnosis and treatment with waiting lists being subject to an 8 week diagnostic target.

Furthermore, in September 2021 the Executive Team approved the insourcing of endoscopy services by Remedy Healthcare Solutions until March 2022, acknowledging the increased demand on the service and in particular the risk to patient outcomes. This increase in demand has continued over the last few months and the Gastroenterology Directorate is currently facing an extremely challenging situation in terms of meeting waiting times for endoscopy diagnostics, Bowel Screening Wales (BSW) and repeat/surveillance procedures.

Signatures: Chair / Vice Chair	Date:
	10/3/22.
Signature: Chief Executive	**Date:**
	11/3/2022
Signature: Board Secretary	**Date:**
	4th March 2022
Signature: Independent member	**Date:**
Shelley Bosson - Approved by separate email 11/3/22	11/3/22
Signature: Independent member	**Date:**
Pippa Britton - Approved by separate email 13/3/22	13/3/22

---- End ----

Description of Request:	
To consider as Chairs Action a request for an extension for the 'CareFlow' contract.	
Financial Value	£559,020 (Inclusive of VAT)

Situation

Approval request to an extension of the 'CareFlow' project.

Background

The two options for the Health Board are:

1. Do Nothing - This is not an option as the project continues and to ensure return on investment and benefits set out in the business case, ongoing commitment is required.
2. Commit financial support to extend the 'CareFlow' contract into Year 4, to 03/23, to support ongoing project activities and benefits realisation.

Option 2 is recommended to mitigate the risk of the 'CareFlow' system end of contract in March 2023.

Request:

This request is for Approval of the contract extension.

An extension to the contract to March 2024 will allow the project to complete roll out and evaluate the system ahead of any re-procurement exercise. This is aligned to the Informatics and divisional IMTPs.

Accompanying documents:

PPD 1164 - Careflow Extension

Chairs Action PPD 1164 .doc

Approval:

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

Signatures: Chair / Vice Chair	**Date:**
	14/3/22

Signature: Chief Executive

Date:

17/03/2022

Signature: Director of Corporate Governance

Date:

17th March 2022

Signature: Independent member

Paul Deneen – Approved by separate email

Date:

18th March 2022

Signature: Independent member

Shelley Bosson – Approved by separate

Date:

17th March 2022

---- End ----

Description of Request:	
To consider as Chairs Action the approval of a Request for Approval (RFA) for support services for Voice Network.	
Financial Value	2 years with the option to extend by 1 + 1 years – contract start 1st April 2022 Total value of new contract £431,987.92 ex VAT and; Total value of new contract (including extensions) £863,975.84 ext VAT (maximum cost)

Situation

Request to approve the Request for Approval (RFA) for a two-year contract, with an option to extend, for support services for Voice Network.

Background

The Health Board operates an AVAYA/Nortel environment for both Voice and Data Network. The Voice manage approximately 9,000 telephony handsets, multiple high available telephony systems and older legacy devices. Uptime monitoring, and availability is vital in keeping clinical services operational in a 24x7 organisation.

To deliver voice telephony to the Health Board, ICT must pay licence and support costs to the hardware manufacturer, AVAYA. AVAYA does not deal directly with end users and a third-party vendor is required to provide the licence and support services, as well as to provide other value added services.

The market of skilled engineers that are able to support AVAYA technology is substantially smaller than that of other vendors. Fournet Technologies currently provide 24/7 support to the AVAYA and Nortel estate within the Health Board.

The Health Board is currently completing a migration to a CISCO network across various sites therefore, the value of this contract will decrease as the kit is decommissioned.

During the evaluation the Health Board's ICT Procurement team has negotiated the costs of this contract providing a saving of £5790.04 ex VAT per annum. In comparison to the current contract, there is a cost avoidance saving of £ 35,711.82 ext VAT per annum.

Request:

Providing the support services to the Voice Network using the supplier Fournet Technologies will support the service during the migration to a different network.

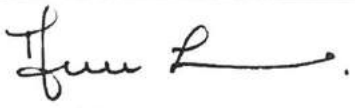
Accompanying documents:

RFA 775 Contract.pdf

RFA 775 Letter.pdf

Approval:

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

Signatures: Chair / Vice Chair	**Date:**
	23/03/2022
Signature: Chief Executive	**Date:**
	23/03/2022
Signature: Director of Corporate Governance	**Date:**
	15th March 2022
Signature: Director of Planning, Digital & IT	**Date:**
	24.03.2022
Signature: Independent member	**Date:**
Paul Deneen – Approved by separate email	24th March 2022
Signature: Independent member	**Date:**
Shelley Bosson – Approved by separate email	24th March 2022

---- End ----

Description of Request:

To consider as Chairs Action the approval of a Request for Approval (RFA) for the procurement of a Robotic Process Automation (RPA) Platform.

Financial Value	£683,280.00 ex. VAT
	Additional draw down costs =
	Year 2 = £80,640.00 ex. VAT
	Year 3 = £80,640.00 ex. VAT
	Total contract value (including draw down) £763,920.00 ex. VAT

Situation

Request to approve the Request for Approval (RFA) for a three-year contract.

Background

Robotic process automation (RPA) is a software technology that makes it easy to build, deploy, and manage software robots that emulate humans actions interacting with digital systems and software.

Blue Prism Cloud combines proven intelligent automation technology, digital workers with built-in artificial intelligence and seamless integration capabilities, and access to Azure cognitive services to bring a fully managed platform delivered from the Microsoft Azure cloud.

Intelligent automation in the cloud is the fastest path to digital transformation and allows the Health Board to focus on exceeding goals and transforming the organisation.

This contract will provide:

- 11 Production Digital Workers
- 2 Development Digital Workers

There will be the option for an additional 4 production workers in Years 2 and 3 of the contract.

Blue Prism is the only supplier which can provide this platform with the processes ABUHB require.

Request:

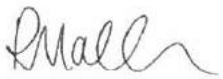
Approval of the request will enable the procurement of the platform conducted through the SBS Framework as a direct award.

Accompanying documents:

RFA938.docx Letter%2093 ABUHB.Softc

Approval:

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

Signatures: Chair / Vice Chair	**Date:**
	29/3/22
Signature: Chief Executive	**Date:**
	28/3/2022
Signature: Director of Corporate Governance	**Date:**
	28th March 2022
Signature: Director of Planning, Digital & IT	**Date:**
	28th March 2022
Signature: Independent member	**Date:**
Shelley Bosson - Approved by separate email	28/3/22
Signature: Independent member	**Date:**
Paul Doreen - Approved by separate email	28/3/22

---- End ----

Description of Request:	
To consider as Chairs Action the approval of a Request for Approval (RFA) for Endoscopy and MRI Outsourcing.	
Financial Value	£958,800.00

Situation

Request to approve the Request for Approval (RFA) for the period 11th April 2022 to 31st March 2023.

Background

The COVID-19 outbreak has presented a significant challenge to the Health Board and to ensure the delivery of essential / urgent non-COVID clinical services are maintained external providers will be utilised by the Radiology and Endoscopy Directorates of Aneurin Bevan University Health Board (ABUHB) for the undertaking of selected Radiology and Endoscopy activity.

Request:

Approval of the request will enable:

- Provision of endoscopy room and facilities, provision of all required equipment and consumables, and provision of all non-medical endoscopy staff, (ABUHB will provide endoscopists).
- Provision of MRI services, (static site with minimum magnet strength of 1.5T), with images available within 24 hours of scanning, (fully staffed service by provider). HIW registration required. Preference for one provider for both services.

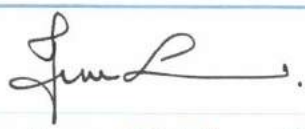
Following an e-tender process the contract for Endoscopy and MRI Outsourcing will be awarded to St Joseph's Hospital Limited via the NHS Wales framework for Outsourcing/Insourcing.

Accompanying documents:

RFA 945 Amended.pdf

Approval:

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

Signatures: Chair / Vice Chair	Date:
	6/4/22
Signature: Chief Executive	**Date:**
	6/4/2022
Signature: Director of Corporate Governance	**Date:**
	6th April 2022
Signature: Independent member	**Date:**
Paul Deneen – Approved by separate email	6/4/22
Signature: Independent member	**Date:**
Shelley Bosson – Approved by separate email	6/4/22

---- End ----

Aneurin Bevan University Health Board

Midwifery staffing and impact for service provision

Purpose of the Report

This report is to update the Board on the temporary changes agreed by the Executive Team, on the 5th May 2022, based on the current staffing challenges across Midwifery Services across Aneurin Bevan University Health Board. There are circa 21 WTE vacancies for Band 6 and 7, together with 12.4 WTE maternity leave (5.3%) and sickness absence is at 10%.

The workforce gaps, in addition to the increased workload, present a risk to quality, safety and experience as well as staff well-being. It is important to note the decision made to adapt service provision was an anticipatory approach to minimise risk. There have not been any discernible patient safety incidents, to date, despite the staffing gaps and demand but it was deemed important to take action to reduce the risks. Decisions, not dissimilar, have been made previously for Midwifery services during Covid surge. It is important to note Midwifery Team Leaders have formalised their concerns in a detailed letter to the Divisional Leadership Team reinforcing the needs for decisive action.

The Board is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			✓
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			
Executive Sponsor: Rhiannon Jones, Director of Nursing			
Report Author: Jayne Beasley – Head of Midwifery			
Report Received consideration and supported by :			
Executive Team	**5th May 2022**	**Committee of the Board [Public Partnerships & Wellbeing Committee]**	
Date of the Report: 16th May 2022			
Supplementary Papers Attached: Nil			

Background and Context

Context:

The GUH maternity model was based on 6000 births per annum with a caesarean section rate of 25% and induction rate of 22%.

The caesarean section rate is currently running at 36% (national standard 28%). The induction of labour rate is currently running at 26% (national standard 20%-22%). These rates reflect an increase in the complexity of pregnancies and women's health, which increases the acuity, length of stay and impacts on bed capacity and flow.

The Birthrate Plus® (BR+) is an acuity tool to support the delivery of maternity staffing in relation to demand and capacity of the population. A review of Birthrate Plus is ongoing and the Health Board has previously been compliant. The BR+ acuity tool has been procured and implementation is in progress to align staffing to acuity on the labour ward, the antenatal and postnatal wards. This will help support the ratio of Midwives to women for increased numbers of complex births. It will also strengthen the ability to demonstrate a consistent, auditable approach to monitoring and promoting safety within the unit.

The 2021 births for GUH were 4979. It is the complexity of the births combined with the increased intervention rate that leads to a longer length of stay for mother and baby, exacerbating the pressure. Baby length of stay is increasing as they are requiring a longer period of observation and antibiotic medication. There is work ongoing with neonates to improve pathways to aid timely and seamless discharge processes, including the development of Midwives administering neonatal IV antibiotics in transitional care. This also increases the workload; however, it is of paramount importance to keep mother and baby together and avoid unnecessary admissions to the Neonatal Intensive Care Unit. Neonatal examination (baby check) is frequently undertaken by trained midwives rather than neonatal doctors in an attempt to improve flow.

Promotion of births outside GUH has been affected by staffing levels. Additionally, the escalation of the ambulance service to 3a, 3b and level 4 is adding additional safety risk and concern to women requiring transfer for intrapartum care. When WAST escalate there is a delay in transferring women from Midwifery-led care to the GUH maternity unit.

For context, births outside of the GUH hospital for the first three months of this calendar year are as follows:

	January 2022	February 2022	March 2022
YYF	11	8	12
RGH	1	1	0
NHH	1	1	1
YAB	3	1	3
Home	14	14	16

Workforce Assessment

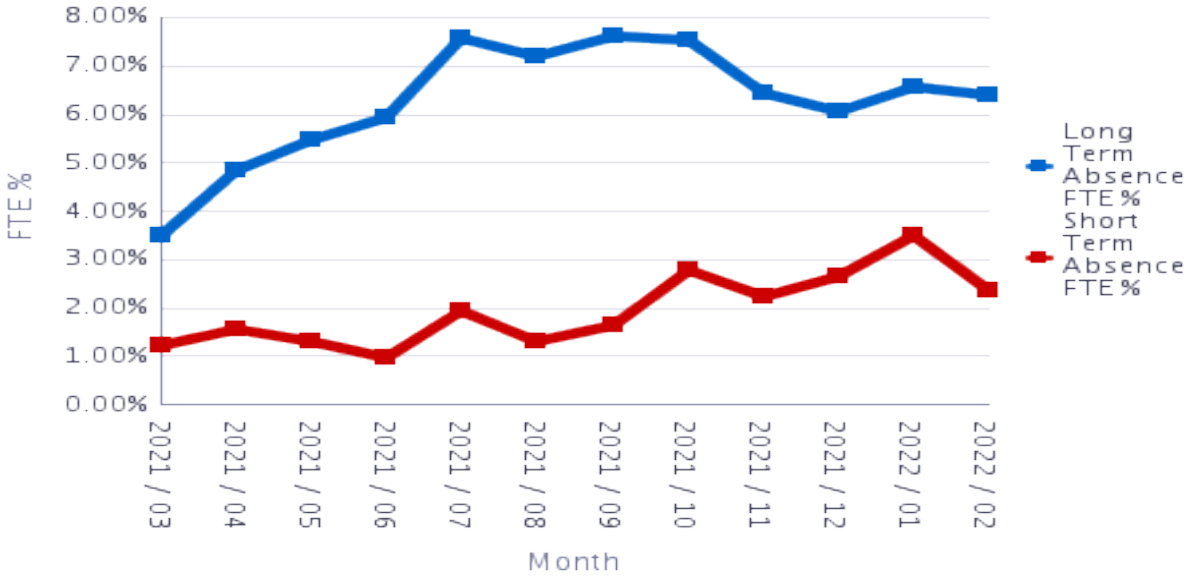
Vacancies:

From May 2022, the vacancy rate will increase to 21.8 WTE Midwife hours for Band 6 and 7.

As part of the All-Wales recruitment process (called Student Streamlining), the service has requested 21 band 5 Midwives. 56 Midwives have selected ABUHB through streamlining, but these newly qualified staff will not take up a post until September/October 2022, when they will have completed their course and registered with the Nursing and Midwifery Council. Upon appointment, there is also requirement to support band 5 Midwives though their preceptorship period with additional training. This will be completed within the first 2 weeks of appointment, when they are supernumerary. A recent advertisment has been placed for Bank-only work trying to increase availability of casual workers to support rosters.

Sickness:

The following table illustrates long term and short term sickness absence from March 2021 to February 2022, showing long term absence is predominant and high, with stress/anxiety (26%) the top reason (mirrored in other Divisions).



Top 5 Sickness reasons:

Absence Reason	%
S10 Anxiety/stress/depression/other psychiatric illnesses	26.2
S27 Infectious diseases	13.3
S98 Other known causes - not elsewhere classified	8.8
S28 Injury, fracture	7.1

S11 Back Problems	6.5

To support the workforce gaps a number of actions have been taken:

- Divisional support for the payment of specialist bank rates until August 2022
- The Head of Midwifery has reviewed GUH Midwife roles
- A roster creator has been assigned to reduce Band 7 and 6 time
- 2 HCSW apprentices in post
- A pending advertisement of fixed term HCSW hours, backfilling maternity leave.
- Band 5 out to advert (beyond streamlining)
- Band 6 Community post out to advert
- Ward Assistant out to advert

In order to further support safe staffing it is proposed the service:

- Utilise bank nurses to support theatre scrub
- Explore utilisation of agency Midwives (not previously undertaken)
- Utilise HCSWs to support staffing levels in GUH and Community (maternity backfill)
- Utilise specialist Midwives to support gaps in rotas
- Engage WOD to introduce targeted recruitment exercises
- Ensure annual leave is managed robustly
- Consider prudent recruitment (over-recruit) for 10 WTE Midwives to minimise gaps and effectively manage turnover

From May 2022 there will be Midwife vacancies of 21.8 WTE (9%) and the service is actively out to recruit band 5, band 6 and band 7 Midwives. There is high maternity leave 12.4 WTE (5.3%) and a high level of short and long term sickness for Midwives and HCSW (9%).

Midwives are currently receiving incentivised pay rates which is supporting deficits and gaps within rosters. Incentivised pay is considered essential to staff all clinical areas as a temporary measure. Despite actions, shifts remain unfilled presenting a risk.

The Executive Team discussed the gaps and risks and made a decision to temporarily reduce services, enabling centralisation, to ensure quality, safety and patient experience and staff well-being, whilst also maintaining women's choice of birth place.

It was agreed to continue births at YYF birth centre with staffed opening during the hours of 9-5 pm Monday to Sunday, as opposed to a 24/7 service. Overnight the birth centre will retain its birthing status as a pod, which is unstaffed and where the named midwife will attend with the women to support birth. The midwifery-led units at Nevill Hall (NHH) and Royal Gwent Hospitals (RGH) will be closed to births. Home birth services and birthing at YAB, which is a pod, will remain unchanged, for now, with regular review.

This enables a proportion of women to continue to attend a birth centre and have a home birth if desirable but will facilitate the release of Midwives and HCSWs to support the increased activity in GUH and support community services. Importantly the decision made enables birth choices for women, which is important. The GUH has the capacity, in the along-side birth unit, to accommodate the demand associated with the temporary closures of RGH and NHH birth units.

Coupled with notification to the Chair of the Health Board and Independent Members, the decision has been communicated to the Community Health Council, Welsh Government via the Chief Nursing Officer, Senedd Members and Health Inspectorate Wales. Additionally, the Communication Team has worked with the Family and Therapies Division to ensure effective communication with the public, utilising the Maternity Facebook Page.

As part of the programme of visits across the Health Board for Board Members, Maternity Services and Neonates have been prioritised and the Executive Director of Nursing has planned visits to the GUH and YYF to meet with the midwifery staff.

The situation will remain under regular review.

Recommendation
The Board is asked to **NOTE** and **DISCUSS** the precarious midwifery staffing, which will impact until at least September, and the actions being taken to maintain service-user safety, quality, experience as well as staff well-being. The situation is subject to regular review, with an initial evaluation of impact scheduled for six weeks or sooner if there is a further deterioration in the staffing picture.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework. Staffing deficits are included in the Corporate Risk Register.
Financial Assessment, including Value for Money	There is a financial impact which is unavoidable due to agency use and specialised and flexible rates of pay as well as the plan to over-recruit.
Quality, Safety and Patient Experience Assessment	This is an anticipatory approach to mitigate potential risks to QPS.
Equality and Diversity Impact Assessment (including child impact assessment)	Equality and diversity are key elements of the impact assessment and evaluation.
Health and Care Standards	• Safe care • Effective care • Timely care • Staff and resources
Link to Integrated Medium Term Plan/Corporate Objectives	Linked to Priority 1 – Every child has the best start in life and strategic enablers: • EQS • Workforce & OD • Partnership First

The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Aligned to: • Balancing short term needs with long term goals and safeguarding • Involvement • Diversity & engagement • Working collaboratively • Prevention
Glossary of New Terms	
Public Interest	Important for the public to understand the situation and rationale for decision-making, as this is a welfare issue. This report is written for the public domain.

Aneurin Bevan University Health Board

Adferiad Programme Board Briefing

Executive Summary

The Post-COVID Recovery Service was developed in response to the experience of a cohort of patients with prolonged and frequently unpredictable symptoms following COVID-19 infection. Often described as 'long covid' the presentations have similarities with other post viral conditions, but the experience is unique for every individual. No single service existed that could respond to the wide range of symptom presentations or the need for ongoing support, either for adults or for children and young people.

The ABUHB service was delivered with £940,000 of funding from the Welsh Government *Adferiad* programme in the year 2022/23. We have received £880,000 of funding for the current financial year. ABUHB was the first Health Board in Wales to deliver a post-ICU covid rehabilitation programme and this service was highly valued by patients. It is estimated that at least 10% of patients will experience prolonged symptoms, after a less acute infection and this often has a debilitating effect on patients' quality of life. We worked with patients to understand their experience and this knowledge guided the development of our care pathways, building upon the clinical experience developed in the first phase of the response.

Our model is holistic, person centred and rehabilitative, with a focus on recovery rather than a diagnostic label. We established a multi-disciplinary team comprising expertise in psychology, respiratory physiotherapy, occupational therapy and exercise assessment and management, with access to expertise across secondary care services. Appendices A and B summarise our pathways and treatment and support options. Appendix C highlights our Plan on a Page, setting out the aims and objectives of the programme.

The pathway was established by a team hosted in neurology services though we have only recently been able to secure dedicated sessions within the neurology service (to commence mid-July). We have been able to establish links with a wide range of teams to provide advice and guidance via email or written advice and this has enabled us to support patients without ongoing referral to those services.

It has been noticeable that over-exertion can be a critical determinant for regression for many patients with Long COVID, and education and pacing have been key aspects of our approach. We are the first Health Board in Wales to be introducing a purpose-built, two-way, smartphone application to support patients in their recovery from covid-19. We have also recently finalised our paediatric pathway for children and young people, which Welsh Government has advocated for all-Wales use.

The service is funded by non-recurrent monies from Welsh Government through the Adferiad programme which will cease on 31st March 2023. Welsh Government announced on the 31st March 2022 an extension of funding to the end of 2023. We have provided information in the paper about the potential for an ongoing model for a needs-based rehabilitation approach that would continue to support COVID recovery which will also benefit patients with similar needs. This could include conditions such as fibromyalgia/ME and chronic pain and fatigue. Colleagues in liver, endocrinology and rheumatology services have highlighted needs in their patient groups that would also benefit from the service. A business case will be developed to support the continuation of the service.

The service is currently responding to rising referrals. However, as COVID rates decline we anticipate a plateau and gradual reduction as we move through the year.

The Pathway

The Post COVID pathways developed for adults and children and young people, are designed on the principle of a holistic recovery model based on individual need. Many patients with chronic symptoms interact with a range of services. The use of an Impact Assessment has ensured that a holistic approach is taken and that the individuals concerns, and priorities guide their recovery plan. Regular follow up monitors the delivery of care and support and allows adjustments as needed. The COVID Recovery Team is testing the use of an APP or telephone follow up to ensure continuity. We believe that this approach would be of value for patients who have completed diagnostic tests but require recovery support who otherwise would need to seek advice through GP or outpatient clinic appointments.

Through our supported self-management approach, we empower patients to manage their health proactively, and to manage and maintain engagement with work, school or other commitments. Many patients have recognised an opportunity to review health behaviours and we are seeking to support these valuable 'teachable moments'. The National Exercise Referral Scheme (NERS) has been a critical aspect of the programme and has shown improvements in physical activity and mental wellbeing. Our model provides the bridge from medical investigation and treatment through supported self-management to independent self-care.

The principles of the Adferiad programme have relevance for our approach to service provision for other care pathways, such as ME/CFS, Fibromyalgia and Chronic Pain, especially where this model may contribute to a reduction of 'over-medicalisation'. Our experience with patients suggests that ongoing support can be critical to ensure that patients have the capacity to engage effectively with advice. Group work (such as the Educating Patients Programme) has been highly valued and provides patients with shared experience and support.

This report updates the Board on the achievements of the Post-COVID Recovery Service and the learning gained which may inform future service development.

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

Executive Sponsor: Peter Carr, Director of Therapies and Health Science			
Report Author: Charlie Evans, Programme Manager, Post COVID Recovery Service and Karen Gully, Professional Advisor, Post COVID Recovery Programme			
Report Received consideration and supported by:			
Executive Team	**X**	**Committee of the Board**	
Date of the Report: 11th May 2022			
Supplementary Papers Attached: • Adferiad Programme Board Briefing • The Adferiad Programme			

Purpose of the Report
The purpose of the report is to update the Board and the public on the work completed in the Adferiad Recovery from COVID Programme in 2021/22 and engage the Board on the plans for the programme for the year ahead. We also share our future ambitions for our services beyond the end of 2022/23.

Background and Context
The Post-COVID Recovery Service was developed in response to needs of patients with prolonged symptoms that can be unpredictable in nature and severity following COVID-19 infection. Often described as 'long covid' the presentations have similarities with other post viral conditions, but the experience is unique for every individual. No single service existed that could respond to the wide range of symptom presentations or the need for ongoing support either for adults or for children and young people.

Recommendation
The Board is asked to support the plans of the Adferiad programme and to endorse the proposed use of Welsh Government funding to maintain and mainstream the multidisciplinary rehabilitation model for the year 2022/23

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework. **Clinical-** a growing waiting list with demand exceeding capacity. Proceeding with pace to improve capacity. **Organisational –** short-term funding means recruitment and retention of staff is challenging, as staff look for secure employment through permanent contracts. Looking at secondment opportunities for staff to support our programme. **Financial-** due to staffing shortages at the beginning of the financial year, we have slippage. We are partnering with other divisions and third-party organisations to deliver care and the slippage will therefore be addressed.

Financial Assessment, including Value for Money	The programme is directly funded by Welsh Government, through its national Adferiad Programme so presents no immediate financial risks to the Health Board.
Quality, Safety and Patient Experience Assessment	Risks: Staffing pressures could lead to treatment being delayed, however this would not breach any Health Board targets for routine and urgent care. Patient Experience, Quality and Safety is regularly monitored with a robust process to collate patient reported outcome and experience measures as well as facilitating regular engagement events. Quality improvement is discussed by the Programme Board on a monthly basis, and actions and risk registers are monitored by the Programme Manager.
Equality and Diversity Impact Assessment (including child impact assessment)	 longcovidequia1.docx
Health and Care Standards	Our services meet Health and Care Standards. We have adopted a treatment approach that is whole person centred and multidisciplinary, which underpins all health and care standards. We deliver care that is safe; timely; effective; dignified; and individualised, where we respond to individual need properly and consider all the feedback that we receive.
Link to Integrated Medium Term Plan/Corporate Objectives	*The programme is currently not linked to the IMTP; however we are proactively looking at avenues to mainstream our services from 2023/24 onwards.*
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*Long Term – The long term needs of this population has been considered as well as a broader population group- for people with conditions such as fibromyalgia and CFS/ME.* *Integration – Our work is aligned for WG's Healthier Wales; ABUHB's Clinical Futures and national NICE guidelines. We are collaborating with colleagues across divisions to ensure integration is at the heart of our agenda.* *Involvement – We have involved patients and clinicians from the beginning of the programme's lifecycle. Moreover, we have engaged with Ceri Harris, ABUHB's Equality, Diversity, Inclusion specialist to ensure we are reaching out to disadvantaged and marginalised groups.* *Collaboration – We have collaborated with a broad range of divisions internally, as well as partnered with third party organisations such as the Gwent Association of Voluntary Organisations; National Exercise Referral Scheme and Martin*

	Hopkins, a communications provider. *Prevention – By having a separate programme for long covid patients has ensured this new caseload does not impact on existing services. The core of our team has seen people recruited into the NHS therefore not disrupting workforce elsewhere. Moreover, we have developed self-management resources to assist wider population health.*
Glossary of New Terms	Post Covid Syndrome/Long COVID- Post Covid Syndrome and Long COVID are used synonymously to explain a condition where a person experiences symptoms 12 weeks following an infection of covid19.
Public Interest	The pandemic remains at the forefront of people's minds, as well as the fear that as we transition to the status of an endemic, people with long covid will be left behind. Our programme and services are in the public interest.

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

adferiad o COVID-19 recovery from COVID-19

THE ADFERIAD PROGRAMME

A recovery and support model building upon the COVID-19 Recovery Service.

Document Title:	**The Adferiad Programme Board Briefing**		
Date of Document:	**04.05.2022**		
Executive Sponsor:	PETER CARR		
Purpose: **Exec. Team is asked to:**	Approve change		Comment:
	Approve funding		
	Provide a view	X	

Summary / Situation:

The Post-COVID Recovery Service has been provided with funding by Welsh Government until March 2023. This paper updates the Board on the programme and its evaluation. This may inform the future development of a generic rehabilitation programme for a wider cohort of patients whose care and recovery needs are not currently provided as a single programme.

Background:

The Post-COVID Recovery Service was developed in recognition of the needs of some patients who experience prolonged symptoms, following COVID-19 infection that can be unpredictable in nature and severity. Often described as 'long covid' the presentations have similarities with other post viral conditions, but the experience is unique for each individual. No single service existed that could respond to the wide range of symptom presentations or the need for ongoing support either for adults or for children and young people.

Assessment

The ABUHB Adferiad model, developed for Post COVID recovery, has responded to the needs of a cohort of COVID 19 patients but would be suitable to use to address unmet needs in other patient groups. A significant proportion of patients referred to specialist services have medically unexplained symptoms or require a period of support for rehabilitation when diagnostic processes have been completed. This approach is aligned to the strategic aims of ABUHB to respond more effectively to patient needs and experience by developing new ways of working. Use of an Impact Assessment at an early stage in many clinical pathways would help to personalise care. With respect to long covid, early access to physical assessment and a managed exercise programme could play an important role in minimising deconditioning.

The Adferiad Programme is responding to a high-profile public concern about the investigation and treatment of Post COVID sequalae. This is also an important issue for health and social care partners, whose workforce was particularly affected by the pandemic.

Recommendation & Conclusions:
The Board is asked to note the alignment of the Adferiad programme, within the organisation's strategic plans and the use of WG funding to establish a multidisciplinary rehabilitation model.

Contents

1. Executive Summary

The Post-COVID Recovery Service was developed in response to the experience of a cohort of patients with prolonged and frequently unpredictable symptoms following COVID-19 infection. Often described as 'long covid' the presentations have similarities with other post viral conditions, but the experience is unique for every individual. No single service existed that could respond to the wide range of symptom presentations or the need for ongoing support, either for adults or for children and young people.

The ABUHB service received funding of £940,000 from Welsh Government's *Adferiad* programme in the year 2021/22. We have received £880,000 of funding for the current financial year. ABUHB was the first Health Board in Wales to deliver a post-ICU covid rehabilitation programme and this service was highly valued by patients. It is estimated that at least 10% of patients will experience prolonged symptoms, after a less acute infection and this often has a debilitating effect on patients' quality of life. We worked with patients to

understand their experience and this knowledge guided the development of our care pathways, building upon the clinical experience developed in the first phase of the response.

Our model is holistic, person centred and rehabilitative, with a focus on recovery rather than a diagnostic label. We established a multi-disciplinary team comprising expertise in psychology, respiratory physiotherapy, occupational therapy and exercise assessment and management, with access to expertise across secondary care services. Appendices A and B summarises our pathways and treatment and support options. Appendix C highlights our Plan on a Page, setting out our aims and objectives of the programme.

The pathway was established as a team hosted in neurology services though we have only recently been able to secure dedicated sessions within the neurology service (to commence mid-July). We have been able to establish links with a wide range of teams to provide advice and guidance via email or written advice and this has enabled us to support patients without ongoing referral to those services.

It has been noticeable that over-exertion can be a critical determinant for regression for many patients with Long COVID, and education and pacing have been key aspects of our approach. We are the first Health Board in Wales to be introducing a purpose-built, two-way, smartphone application to support patients in their recovery from covid-19. We have also recently finalised our paediatric pathway for children and young people, which Welsh Government has advocated for all-Wales use.

The service is funded by non-recurrent monies from Welsh Government through the Adferiad programme which will cease on 31st March 2023. Welsh Government announced on the 31st March 2022 an extension of funding to the end of 2023. We have provided information in the paper about the potential for an ongoing model for a needs-based rehabilitation approach that would continue to support COVID recovery but also benefit patients with similar needs. This could include conditions such as fibromyalgia/ME and chronic pain and fatigue. Colleagues in liver, endocrinology and rheumatology services have highlighted needs in their patient groups that would also benefit. This would need to be the subject of a business case for consideration.

The service is currently responding to rising referrals. However, as COVID rates decline we anticipate a plateau and gradual reduction as we move through the year.

The Pathway

The Post COVID pathways developed for adults and children and young people, are designed on the principle of a holistic recovery model based on individual need. Many patients with chronic symptoms have interactions with a range of services. The use of an Impact Assessment has ensured that a holistic approach is taken and that the individuals concerns, and priorities guide their recovery plan. Regular follow up monitors the delivery of care and support and allows adjustments as needed. The COVID Recovery Team is testing the use of an APP or telephone follow up to ensure continuity. We believe that this approach would be of value for patients who have completed diagnostic tests but require recovery support that would otherwise be sought through GP or outpatient clinic appointments.

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recognised the opportunity to review health behaviours and we are seeking to support these valuable 'teachable moments'. The National Exercise Referral Scheme (NERS) has been a critical aspect of the programme and has shown improvements in physical activity and mental wellbeing. Our model provides the bridge from medical investigation and treatment through supported self-management to independent self-care.

The principles of the Adferiad programme have relevance for our approach to service provision for patients historically underserved by the system. This model may also contribute to a reduction of 'over-medicalisation'. Our experience with patients suggests that ongoing support can be critical to ensure that patients have the capacity to engage effectively with advice. Group work (such as the Educating Patients Programme) has been highly valued and provides patients with shared experience and support.

This report updates the Board on the achievements of the Post-COVID Recovery Service, and the learning gained, which may inform future service development.

2. Strategic Context

2.1 Need

The COVID-19 pandemic has had a significant impact on the Aneurin Bevan University Health Board population and the workforce. At the time of writing, ABUHB has had **163,555** confirmed cases. (Public Health Wales, 2022). Cases have been highest in Caerphilly however per population head it is Blaenau Gwent and the lowest is Monmouthshire which reflects the economic inequalities of Gwent.

With respect to Long COVID, the Office for National Statistics estimates 2% of people living in the United Kingdom have prolonged symptoms following an infection of COVID-19. (Office for National Statistics , 2022).

Post-COVID syndrome is defined as prolonged symptoms 12 weeks after infection. (NHS, 2022). On confirmed cases alone this would translate to 11,220 people in Gwent living with post-covid syndrome however we know that during the early months of the pandemic, access to testing was limited so that figure may represent an under-estimate. **121 patients** who had received inpatient care in the intensive care unit attended a multidisciplinary team of which 83 were invited to a rehabilitation programme. 70 patients completed this programme.

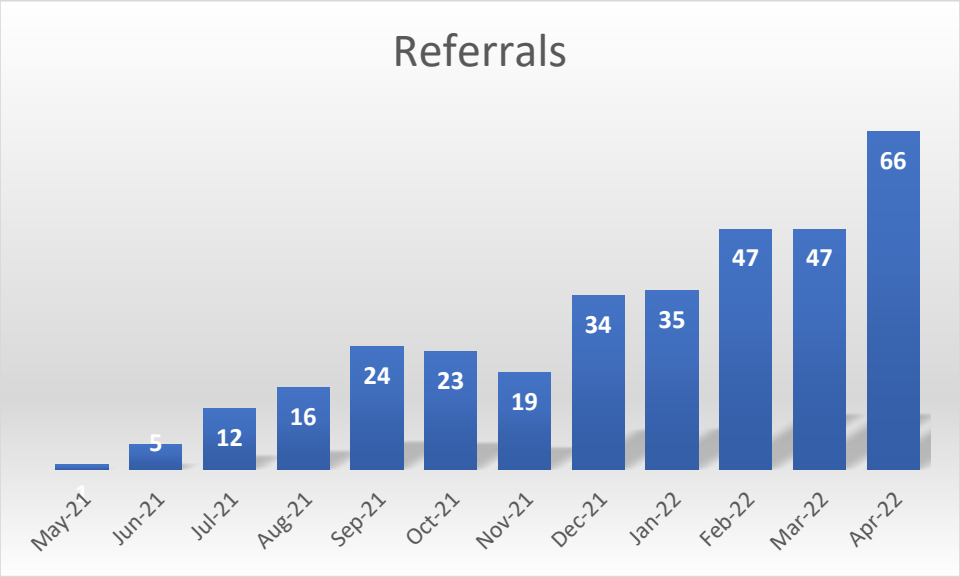
Many patients have been investigated and managed in primary care, supported by the development of clinical guidance and patient information resources. However, since the use of Read Codes for 'Long COVID' symptoms has been inconsistent, it is not currently possible to quantify that need.

From a period of May 2021 to April 2022, **278 people** have been referred into the Post COVID Recovery

Service. This includes 23 children in our recently launched paediatric service. **231 patients have accessed our Education Programme for Patients** which we have delivered in collaboration with GAVO.

14 members of staff have been supported directly by Occupational Health Services whilst others have received care from the Post-COVID Recovery team and primary care services.

Demand for our services is increasing. As the visibility of our services rises, we are seeing an increased number of referrals. And following the large Omicron wave during Winter, we have seen that filter through into referrals into our services. We do not yet know how many patients affected during this period will experience prolonged symptoms and concerns, but we anticipate a continuing demand during 2022.



In our service, we have seen patients with a high prevalence of obesity, anxiety and depression. Long Covid and other chronic conditions have many overlapping symptoms. Patients benefit from a needs-based approach which supports their personal experience.

2.2 Strategic Context

On Tuesday 8th February 2022, the Health Minister made a statement to the Senedd on long covid services. She committed to a further six-month review of the Adferiad programme to September 2022. From April to September 2022, Health Boards are expected to continue to meet the needs of our communities and patients with post covid syndrome, and HBs are expected to plan to mainstream long covid management into existing long-term condition pathways. On Monday 7th March, Welsh Government published a document setting out its plan to transition from managing covid as a pandemic to an endemic condition. In doing so, it reaffirms a commitment to supporting people with long covid, as well as supporting people's return to work. (Welsh Government , 2022).

We have developed service pathways that are aligned with both Welsh Government's "A Healthier Wales" and Aneurin Bevan University Health Board's Clinical Futures strategy. As set out in our Executive Summary,

we have established a service that is holistic, whole person centered with appointments delivered close to home.

3. Current Service Provision

3.1 Background

Work to develop this service began in November 2020. The Health Board did not have an established model for post viral recovery support and services for patients with symptoms such as those for prolonged covid-19 recovery were fragmented.

The post COVID service pathways have been designed and implemented to be aligned to NICE and Welsh Government guidelines. The aims of the Post COVID Planning Group at the time were:

- An evidence-based approach informed by patient experience
- Service provision is mapped to ensure that new developments are aligned with existing services which can be expanded or adapted to meet the needs of the identified post covid 19 sequelae
- Services for people with post covid-19 syndrome are delivered in a way that is equitable with other health or care issues; services should neither advantage nor disadvantage people post covid-19
- Service provision in communities based upon tiers of service provision so that only those with specific needs are seen by highly specialist services.
- Opportunities are taken to actively engage and participate in relevant trials and research.

We established a **Clinical Practice Group** to ensure that clinical experience and the latest research was reflected in our planning. A multi-disciplinary approach was used to ensure that each aspect of an individual's needs could be supported, and we identified at an early stage the need for a service for children and young people.

Appendix A summarises our adult pathway

Appendix B summarises our pathway for children and young people

3.2 Support

We established our workforce from the end of 2020 to the middle of 2021. We wanted to ensure our team was truly multidisciplinary and we added to our team as the year progressed. We paid for sessions by reimbursing directorates for clinical time, and we also drew on support from wider clinical networks for advice . We were unable to recruit to some vacancies, such as a GP with Special Interest, and it has taken some time to secure medical input from secondary care teams

Role	Band	WTE
Paeds		
Consultant (Paed's)	Consultant	0.1
Clinical Psychologist	8d	0.2
Physiotheraphy	7	0.2
Assistant Psychologist	5	0.2
Trainee Psychologist	6	0.2
Assistant Prac	4	1

Programme		
Assistant Director (SRO)	8d	0.2
Programme Manager (Nov 2021)	8a	1
Administrator (Nov2021-Jan2022)	3	1
Advisor	Consult	0.3

Adult		
Psychologist	8d	0.3
Psychologist	7	0.1
Physio	8a	0.4
OT-MH	7	0.4
Exercise Referral	6	0.5
OT-OH	7	0.5
OT-OH	7	0.5
Assistant Prac (Jan 2022)	4	1

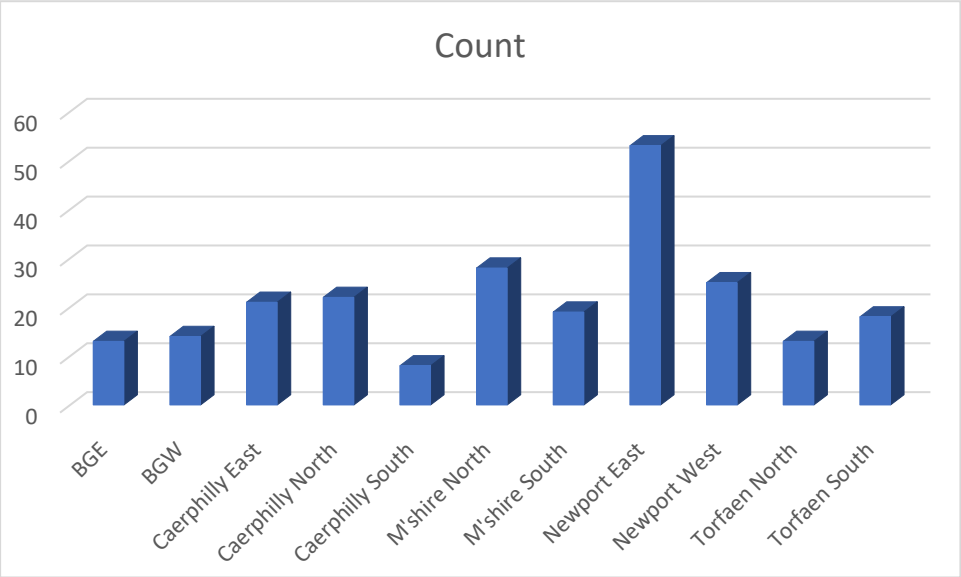
3.3 Service Evaluation

278 patients were referred into our core post COVID Recovery service between June 2021 and May 2022. This excludes the post-ITU COVID patients that were seen in 2020. We have a comprehensive record of demographic information and the health profile of our patients. Patient Reported Outcome Measures (PROM) and Patient Reported Experience Measures (PREM) information is being collected and collated currently.

3.3.1 Demographics

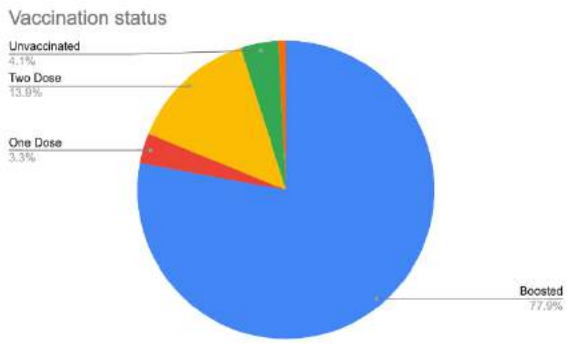
More than two thirds of referrals are female (69.23%). Most of the patients attending the post COVID Recovery service self-reported as White (69%) however clinical workstation data is incomplete. The mean age of patients is 49 years.

During the beginning of our programme, we saw an overrepresentation of patients from GP clusters in Newport and Monmouthshire and an underrepresentation from Blaenau Gwent and Torfaen, which was pointing to socioeconomic factors impacting upon patient access to our services. However as the visibility and awareness of the programme has improved, these problems have been rectified. The table below indicates the number of patients who have been referred to our services by GP cluster area:



Vaccination

Most patients have been fully vaccinated, with a minority (4.1%) unvaccinated. Some patients reported their long covid symptoms worsened following vaccination whilst others reported an improvement.



Comorbidity

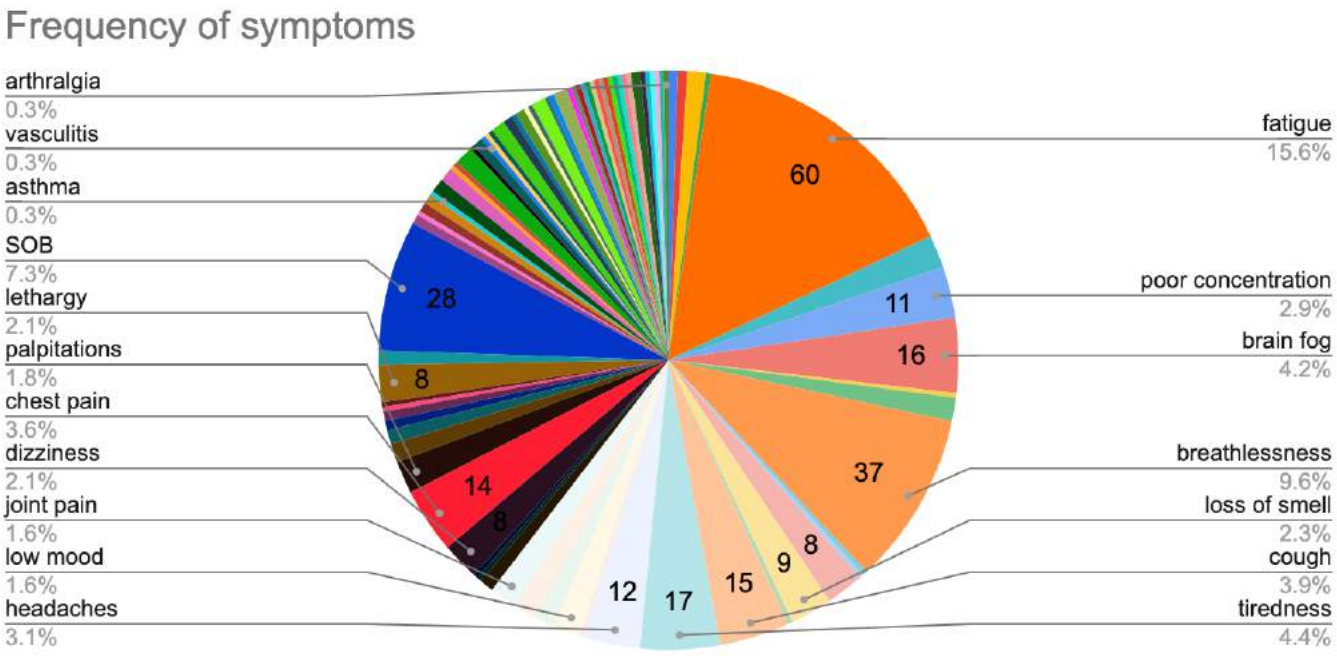
The most frequently reported co-morbidity has been anxiety and depression (15.3%).

Asthma and shortness of breath were present in 10.5% of patients and

Pre-existing symptoms of Chronic Fatigue Syndrome and Fibromyalgia are reported frequently. Morbid obesity has also been a common finding.

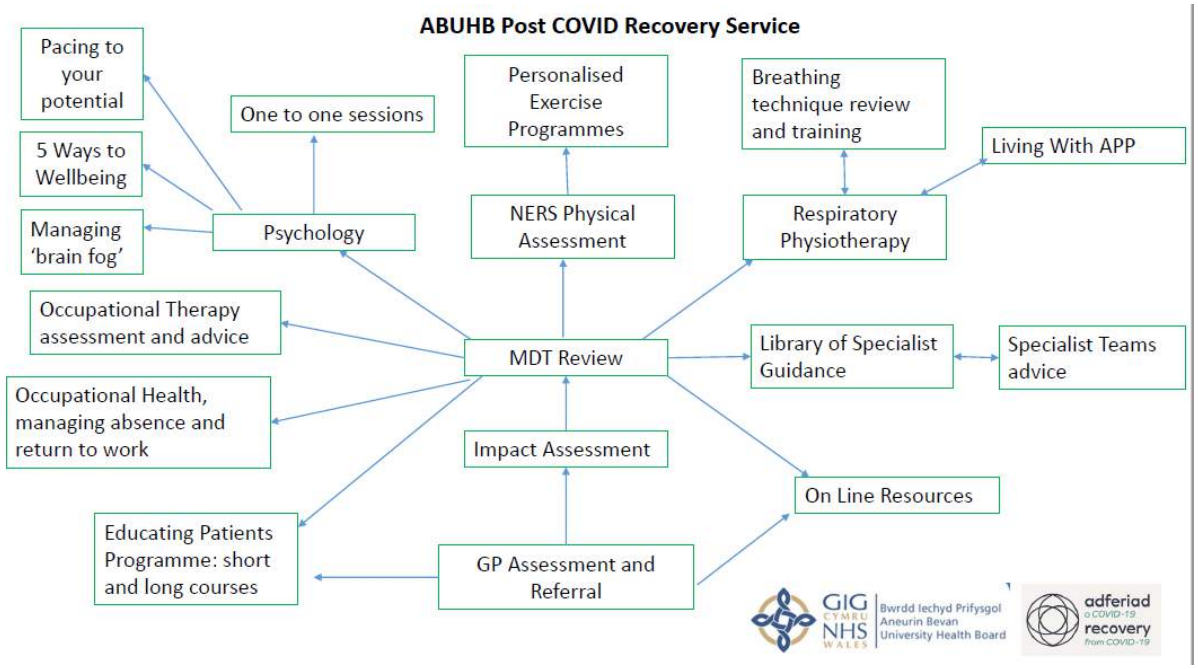
Patient symptoms of long covid

22.1% of patients reported fatigue-like symptoms and 17.2% reported shortness of breath. The graph demonstrates the broad range of symptoms presented.



3.3.2 Interventions

Each patient was contacted to complete an Impact Assessment which was taken to the MDT for discussion with review of the GP referral and any ongoing management through other services. The MDT agreed suitable treatment and support options, and these were discussed with the individual to agree a personalised plan. The interventions varied from supported self-management; partner programmes such as an Educating Patients Programme; respiratory rehabilitation; physiotherapy and exercise referral (NERS),



and psychological support.

Respiratory rehabilitation

A range of interventions have been customised according to patient needs. These include breathlessness management exercises, Pilates for breathing, and acapella for breathing. Incentive Spirometry has proved popular with patients as a motivational tool.

Physiotherapy and exercise support

30% of patients have been assigned physical programmes that included weight management, exercise programmes and physiotherapy.

Partner programmes

46.67% of patients have enrolled into partner programmes such as the National Exercise Referral Service (NERS) and EPP.

Self-management

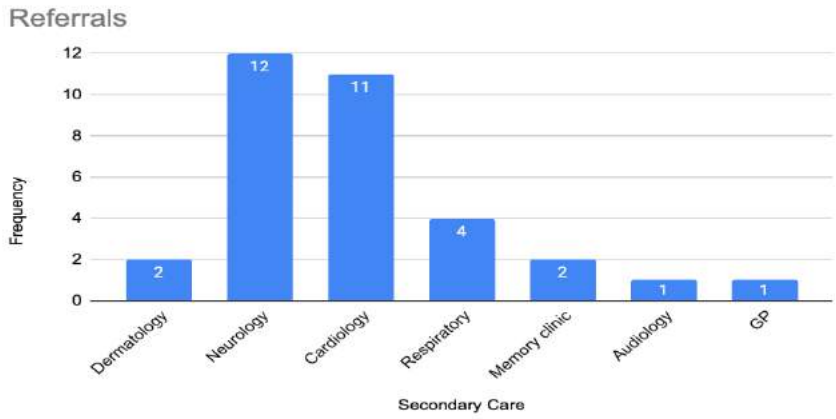
43.3% of patients have been provided guidance including World Health Organisation (WHO) guidance, 5 Ways of Wellbeing, Menopause guidance and other NHS resources. However, all patients are advised about the ABUHB self-management resources.

Psychological support

26.67% of referrals have received psychological interventions to manage symptoms such as brain fog, anxiety, depression and post-traumatic stress from recent or previous events. This has been a critical aspect of care in many cases to enable individuals to engage with a wider range of advice and support.

3.3.3 Secondary Care

Up until the end of 2021, there were a number of secondary care referrals. Below shows the distribution of these referrals, with a majority going to Neurology and Cardiology.



3.3.4 Feedback

The service sends out PROM and PREM forms for patients newly referred into our services and patients who are undergoing ongoing treatment and patients who have been discharged. The findings are as follows:

Positive comments

"I have an amazing relationship with my physiotherapist from the covid rehabilitation team who has been supporting me in person & virtually since February. She got me referred to cardiology & has told NERS what I need to do in the next stage of my recovery, she has also been at the end of an email if I need support. The mixture of face to face & virtual appointments have been a benefit."

"Even though a huge strain on the NHS I always had a doctor contacting me back with help even if it isn't the same one as I normally have, I will always have a response which is reassuring that you will get better."

"The support I have received from your service has supported my recovery. I cannot thank the staff enough for their care and understanding during a very difficult period for me and my family."

"Speaking to Sarah Flowers was so helpful. She was kind and considerate. She listened and gave me some really encouraging advice guidance and support."

Negative comments

"I haven't received anything for long covid. Actually, contact people instead of just a survey."

"Quicker access to long covid clinics – I still have not been contacted."

"Focus has been on rehabilitation/pacing without identifying biomedical causes first. Lack of access to neurology assessment. It would be helpful to be seen in person for some appointments."

Data

We have received mixed results in our experience measures:

	Listened to?	Provided with right information?	Involved in care?
Always	25%	19%	27%
Usually	23%	25%	17%
Sometimes	42%	38%	33%
Never	10%	18%	23%

With respect to an overall satisfaction score, we score an average of **5.67** out of 10.

3.3.6 Performance

Our current waiting time is 6.4 weeks which has risen significantly after a reduction to 3.19 weeks. Our demand is currently exceeding capacity significantly.

3.3.7 Children and Young People

We launched our Paediatric Service in November 2021. At the time of submission of this paper, 23 children and young people have received an assessment and a further 17 are on the waiting list.

3.3.8 Occupational Therapy within Occupational Health Workstream

Since November 2021, we partnered with Occupational Health to deliver a pilot, with Occupational Therapists working in the OH team to deliver long covid rehabilitation. 14 patients have been seen. A full review of the pilot will take place at the end of the fiscal year which will include outcome measures. There is agreement that an explicit referral route from Occupational Health services into the Post COVID recovery team would be beneficial for our workforce.

3.4 SWOT Analysis

A team meeting was held to review the development and delivery of the Post COVID recovery service.
A SWOT analysis revealed the challenges faced by many patients when navigating services and when seeking flexible rehabilitative support. It was noted that many services have barriers to access which hinder a multi-disciplinary approach. Where services have engaged to develop patient advice resources, we have been able to minimize onward referrals.

It was also noted that communication of the new service offer has been challenging but that engagement of an external team has been useful for developing communication tools and patient advice resources. The MDT approach has been welcomed by many team members as a supportive work environment.

Strengths	Weaknesses

Empowered self-management- we encourage our patients to be directly involved in the management of their recovery	**Communications-** difficult to engage GP partners and wider public about the services we have on offer. Moreover, due to the pandemic, we have a tsunami of information for the public to work through
Patient-focused and whole-person centred- patients are often surprised we want to know the whole patient experience- as it is all important.	**Access to medical advice-** accessing time to secondary care specialists has been challenging, meaning patients are on long waiting lists and unable to proceed with treatment.
Positive and engaging- we are positive with our patients because we believe recovery is possible. And we are positive as a team as we have developed a truly innovative service model.	**Short-term monies** have meant it is hard to recruit for key positions and there is a retention risk with current staff. Moreover, Adferiad funding only landed in July 2021 and has such made it difficult to spend monies.
Truly multidisciplinary expertise- every discipline within our team is important and valued. Essential for multisystem issues.	**Scepticism about physical therapy.** Physical therapy is not always recognized to have an equivalent esteem to the medical model- hard to engage with public about role of physical therapy.
Cost-saving- decentralized and local services, but contains expertise, can be a far more cost-effective model than a centralized team with long waits for assessment. Fragmented long-term condition management pathways may not ensure access the most appropriate interventions	**Traditional biomedical model** has often meant patients are encouraged to expect a series of tests despite most tests returning negative results.
Digital and innovative- the Living With UCL App is forward thinking and could revolutionise the way we do healthcare.	**Research on Long COVID continues** with regular research papers being published. It is possible our service model will need to adapt to reflect new research.

Opportunities	Threats
Cost-Saving- reducing number of inappropriate referrals and take more targeted interventions.	**Attention diverted following transition to endemicity of covid,** as we as a system tackle mainstream service backlog.
Development of pathways for areas with unmet needs- we have seen this service model work- there is a wider population group who might benefit from this model	**Retention of staff is time-critical** with a March 31st deadline as staff look for roles elsewhere to ensure they stay in employment.
A whole lifespan model, where patients seamlessly transition from CYP, to adult, to older adult services.	**Poor existing chronic condition pathways-** if the service is discontinued, we still have patients that need treating within existing and already full services.
Strengthening collaboration between and within services- whole-person centred modelled ensures different divisions collaborate with each other for the needs of patients- from CYP to adults; physical health to mental health services.	**Funding-** difficult to build long-term continuity.

Partnership working has been enhanced, working with partners delivering services not directly by us but for the benefit of our patients.	**Politics-** messaging from interest groups has often presented a distorted picture of what support exists for patients. An innovative approach is required.
Expert and community-led, delivering the priorities of Welsh Government and ABUHB.	

4.Our Plan for the Adferiad Programme 2022/2023

4.1 Outline

As requested by Welsh Government we have developed a proposal to maintain the current service from April to September 2022 and to mainstream the service from then onwards.

Phase 1- April 2022 – September 2022

- Continue to respond to the prevalence of long covid in our communities
- Increase the whole-time equivalent clinical time to maintain the current waiting time and to offer an increased range of individual follow-ups and interventions
- Offer more group-based interventions to establish community among our patients.
- Increase uptake of the self-management APP
- Improve our rate of discharge with self-management advice and safety netting guidance.
- Improve access to our service by reaching underrepresented communities, working with our primary care partners.
- Consult with stakeholders delivering existing long term condition management pathways
- Finalise the design for an integrated rehabilitation model
- Agreed a referral pathway from Occupational Health referrals into our service.

Phase 2- October 2022 – March 2023

- Transition to an integrated Adferiad Recovery Service
- Continuation of the communications campaign to raise awareness of our services
- Develop a programme approach to articulate how an offer of personalized assessment and rehabilitation management could be extended to a wider patient cohort which may include:
- - Fibromyalgia
  - Chronic Fatigue/ME
  - Chronic Pain
  - Liver

- Rheumatology
- Endocrinology

- Conduct a full-service evaluation at the end of the budget year
- Report back to the Executive team and the Board on plans for 2023/24

Conclusion

COVID 19 has provided extreme challenges but has also provided the opportunity to rapidly develop new solutions. The value of rehabilitation is more widely recognised, and we have been able to design a model that could benefit a wide cohort of patients and relieve pressure on medical services. This approach aligns with the organisations strategic aims to inform and enable the public to achieve the best outcomes. Networking across service boundaries is critical to meet individuals' complex needs.

The Board is asked to note the achievements of the Adferiad Programme for the financial year 2021/22, the plans for the year 2022/23 and the organisational learning that will inform future service development proposals.

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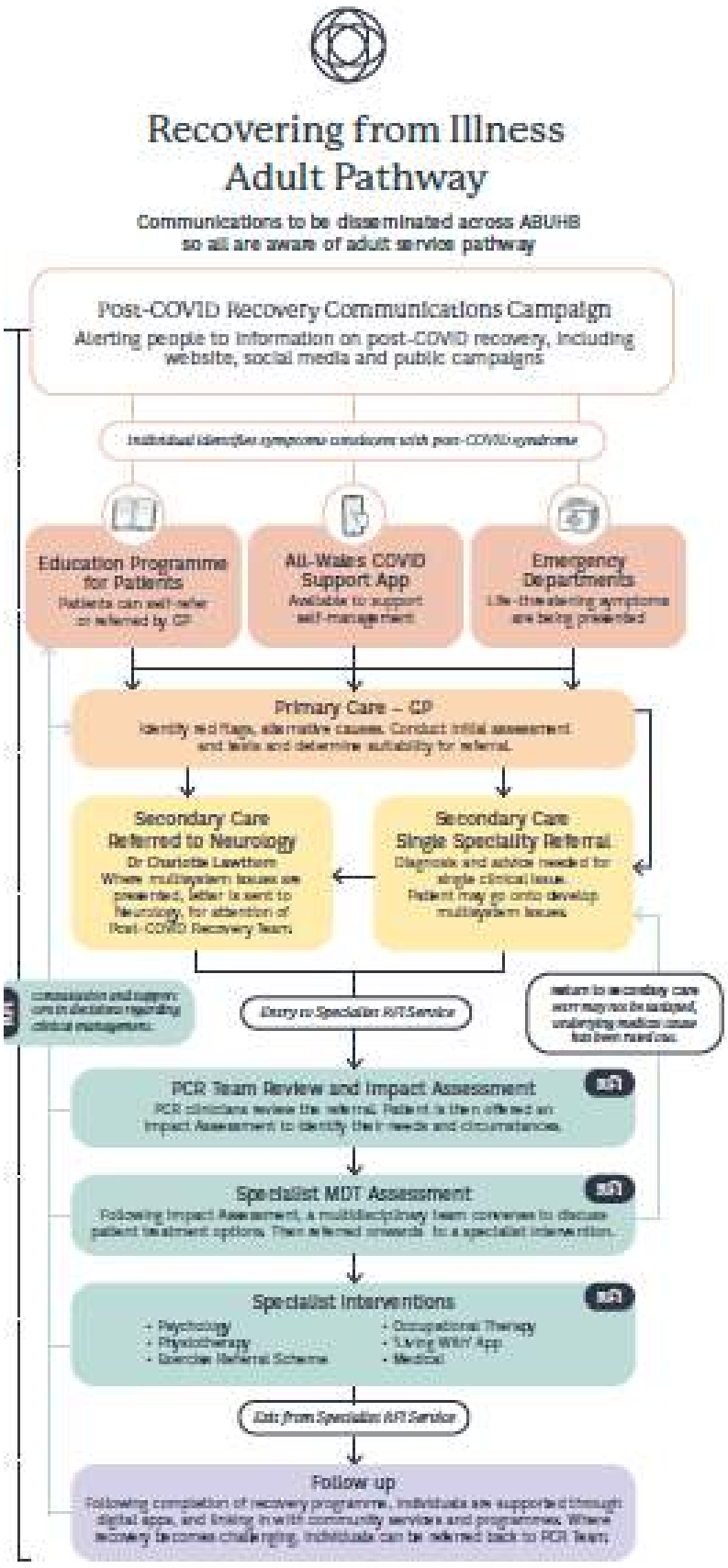


Appendix A- Pathway for Adults

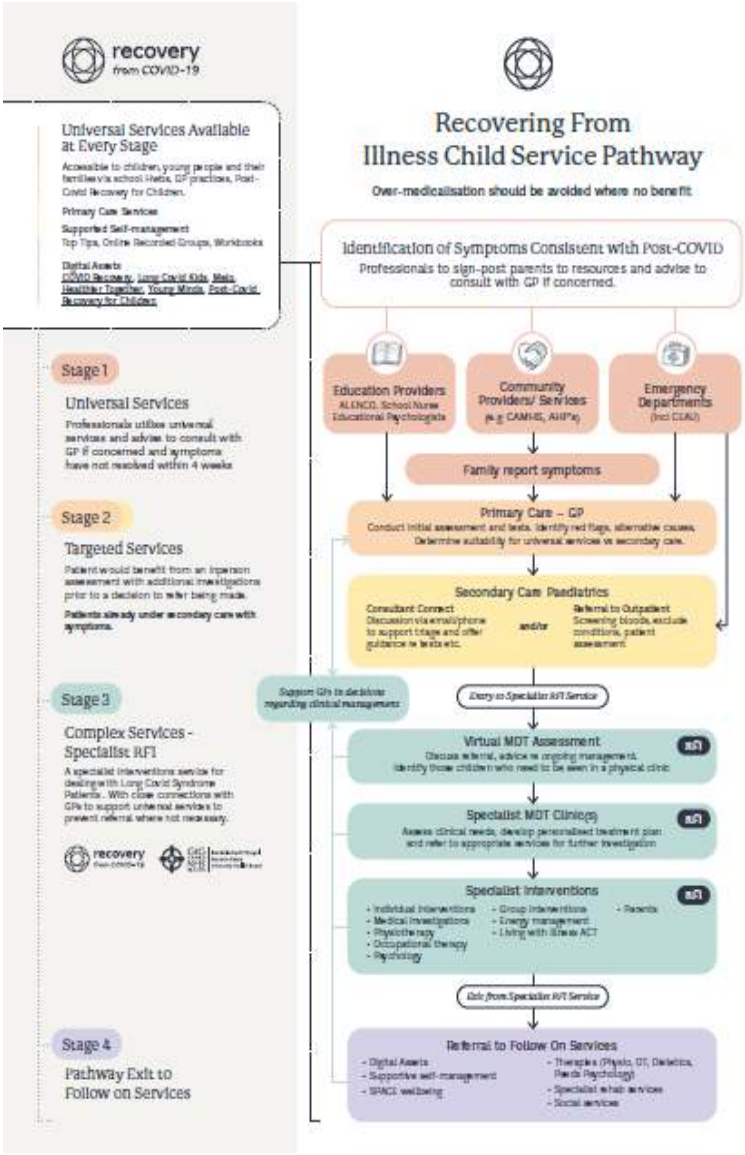
Each person referred to the service is offered an Individualised assessment by a member of a multi-professional team. The assessment focuses on the impact of the symptoms you are experiencing and your specific concerns and worries.

The Impact assessment and the referral information from your GP are reviewed by the whole team to identify options for a treatment or rehabilitation support where required.

Options after assessment may include:

- Individualised advice and guidance to self-manage the issue
- Specific further assessments where indicated
- Individualised rehabilitation programme – related to single or multiple issues, such as fatigue/ breathlessness/ palpitations, mood changes
- Group interventions for people with similar symptoms, such as brain fog.
- Remote rehabilitation support via the **University College London Long Covid App**
- Referral to an Activity or Exercise Professional to increase stamina and energy
- Links to local services that can support specific goals

Appendix B- Pathway for Children and Young People



In establishing our Pediatric Service, we established the following principles:

- All CYP should be offered personalised care that meets their physical, social, psychological, and educational needs. For all CYP, the impact of the illness on the child and family as a whole unit should be assessed, including day-to-day functioning and access to education.

-All CYP and the adults in their proximal life should be able to access information, resources (including digital assets) and services necessary to support the CYP with Post-Covid Syndrome's needs, facilitating self-care and management.

-General practice plays a key role in supporting CYP with long term symptoms of COVID-19

-GP's will adopt a gatekeeping function to ensure CYP's receive appropriate treatment and conduct an appropriate screening before referral to specialist services.

-CYP's can access further therapeutic input, rehabilitation, psychological support, specialist investigation or treatment once they have been assessed, and patients should be referred to existing services as needed.

-CYP should have access to multi-disciplinary teams, accounting for the multi-system nature of the disease.

-Multidisciplinary support and rehabilitation should be available to tailor personalised care plans, provide interventions and be able to escalate to more specialist services for an assessment.

-Local Paediatric Services should be involved in the CYP's care if clinically indicated.

-Post-Covid Assessment Clinics should be available to all affected CYP, and services should be available locally where possible.

-Rapid access to the Recovering from Illness MDT is enabled

Attached below is our full clinical guidance document on our Paediatric Service.

Clinical Guidance
for the Post COVID S

Appendix C- Plan on a Page

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

adferiad o COVID-19 recovery from COVID-19

THE ADFERIAD PROGRAMME

A recovery and support model building upon the COVID-19 Recovery Service.

Document Title:	**The Adferiad Programme Board Briefing**		
Date of Document:	**04.05.2022**		
Executive Sponsor:	PETER CARR		
Purpose: **Exec. Team is asked to:**	Approve change		Comment:
	Approve funding		
	Provide a view	X	

Summary / Situation:

The Post-COVID Recovery Service has had funding provided by Welsh Government until March 2023. This paper updates the Board on the programme and the learning gained. This may inform future development of a generic rehabilitation programme for a wider cohort of patients whose care and recovery needs are not currently provided as a single programme.

Background:

The Post-COVID Recovery Service was developed in recognition of the needs of some patients who experience prolonged symptoms, following COVID-19 infection, that can be unpredictable in nature and severity. Often described as 'long covid' the presentations have similarities with other post viral conditions, but the experience is unique for each individual. No single service existed that could respond to the wide range of symptom presentations or the need for ongoing support either for adults or for children and young people.

Assessment

The ABUHB Adferiad model, developed for Post COVID recovery, has responded to the needs of a cohort of COVID 19 patients but would be suitable to address unmet needs in other patient groups. A significant proportion of patients referred to specialist services have medically unexplained symptoms or require a period of support for rehabilitation when diagnostic processes have been completed. This approach is aligned to the strategic aims of ABUHB to respond more effectively to patient needs and experience by developing new ways of working. Use of an Impact Assessment at an early stage in many clinical pathways would help to personalise care. Early access to physical assessment and a managed exercise programme could play an important role in minimising deconditioning as the backlog of care on waiting lists is addressed.

The Adferiad Programme is responding to a high-profile public concern about the investigation and treatment of Post COVID sequalae. This is also an important issue for health and social care partners, whose workforce was particularly affected by the pandemic.

Recommendation & Conclusions:
The Board is asked to note the alignment of the Adferiad programme, within the organisation's strategic plans and the use of WG funding to establish a multidisciplinary rehabilitation model.

Contents

1. Executive Summary

The Post-COVID Recovery Service was developed in response to the experience of a cohort of patients with prolonged and frequently unpredictable symptoms following COVID-19 infection. Often described as 'long covid' the presentations have similarities with other post viral conditions, but the experience is unique for every individual. No single service existed that could respond to the wide range of symptom presentations or the need for ongoing support, either for adults or for children and young people.

The ABUHB service was delivered with £940,000 of funding from the Welsh Government *Adferiad* programme in the year 2022/23. We have received £880,000 of funding for the current financial year. ABUHB was the first Health Board in Wales to deliver a post-ICU covid rehabilitation programme and this service was highly valued by patients. It is estimated that at least 10% of patients will experience prolonged symptoms, after a less acute infection and this often has a debilitating effect on patients' quality of life. We

worked with patients to understand their experience and this knowledge guided the development of our care pathways, building upon the clinical experience developed in the first phase of the response.

Our model is holistic, person centred and rehabilitative, with a focus on recovery rather than a diagnostic label. We established a multi-disciplinary team comprising expertise in psychology, respiratory physiotherapy, occupational therapy and exercise assessment and management, with access to expertise across secondary care services. Appendices A and B summarises our pathways and treatment and support options. Appendix C highlights our Plan on a Page, setting out our aims and objectives of the programme.

The pathway was established as a team hosted in neurology services though we have only recently been able to secure dedicated sessions within the neurology service (to commence mid-July). We have been able to establish links with a wide range of teams to provide advice and guidance via email or written advice and this has enabled us to support patients without ongoing referral to those services.

It has been noticeable that over-exertion can be a critical determinant for regression for many patients with Long COVID, and education and pacing have been key aspects of our approach. We are the first Health Board in Wales to be introducing a purpose-built, two-way, smartphone application to support patients in their recovery from covid-19. We have also recently finalised our paediatric pathway for children and young people, which Welsh Government has advocated for all-Wales use.

The service is funded by non-recurrent monies from Welsh Government through the Adferiad programme which will cease on 31st March 2023. Welsh Government announced on the 31st March 2022 an extension of funding to the end of 2023. We have provided information in the paper about the potential for an ongoing model for a needs-based rehabilitation approach that would continue to support COVID recovery but also benefit patients with similar needs. This could include conditions such as fibromyalgia/ME and chronic pain and fatigue. Colleagues in liver, endocrinology and rheumatology services have highlighted needs in their patient groups that would also benefit.

The service is currently responding to rising referrals. However, as COVID rates decline we anticipate a plateau and gradual reduction as we move through the year.

The Pathway

The Post COVID pathways developed for adults and children and young people, are designed on the principle of a holistic recovery model based on individual need. Many patients with chronic symptoms have interactions with a range of services. The use of an Impact Assessment has ensured that a holistic approach is taken and that the individuals concerns, and priorities guide their recovery plan. Regular follow up monitors the delivery of care and support and allows adjustments as needed. The COVID Recovery Team is testing the use of an APP or telephone follow up to ensure continuity. We believe that this approach would be of value for patients who have completed diagnostic tests but require recovery support that would otherwise be sought through GP or outpatient clinic appointments.

Through our supported self-management approach, we empower patients to proactively manage their health, and to manage and maintain engagement with work, school or other commitments. Many patients have recognised an opportunity to review health behaviours and we are seeking to support these valuable

'teachable moments'. The National Exercise Referral Scheme (NERS) has been a critical aspect of the programme and has shown improvements in physical activity and mental wellbeing. Our model provides the bridge from medical investigation and treatment through supported self-management to independent self-care.

The principles of the Adferiad programme have relevance for our approach to service provision for patients historically underserved by the system. This model may also contribute to a reduction of 'over-medicalisation'. Our experience with patients suggests that ongoing support can be critical to ensure that patients have the capacity to engage effectively with advice. Group work (such as the Educating Patients Programme) has been highly valued and provides patients with shared experience and support.

This report updates the Board on the achievements of the Post-COVID Recovery Service, and the learning gained, which may inform future service development.

2. Strategic Context

2.1 Need

The COVID-19 pandemic has had a significant impact on the Aneurin Bevan University Health Board population and the workforce. At the time of the writing, ABUHB has had **163,555** confirmed cases. (Public Health Wales, 2022). Cases have been highest in Caerphilly however per population head it is Blaenau Gwent and the lowest is Monmouthshire which reflects the economic inequalities of Gwent.

		Cases	Cases per 100,000 population	Testing episodes	Testing per 100,000 population	Positive proportion
Aneurin Bevan University Health Board	Blaenau Gwent	21,235	30,395.6	121,330	173,671.0	17.5%
	Caerphilly	51,267	28,312.6	287,578	158,817.1	17.8%
	Monmouthshire	19,997	21,140.7	132,298	139,864.7	15.1%
	Newport	44,126	28,528.0	255,780	165,365.0	17.3%
	Torfaen	26,930	28,660.8	150,382	160,047.3	17.9%

With respect to Long COVID, the Office for National Statistics estimates 2% of people living in the United Kingdom have prolonged symptoms following an infection of COVID-19. (Office for National Statistics , 2022).

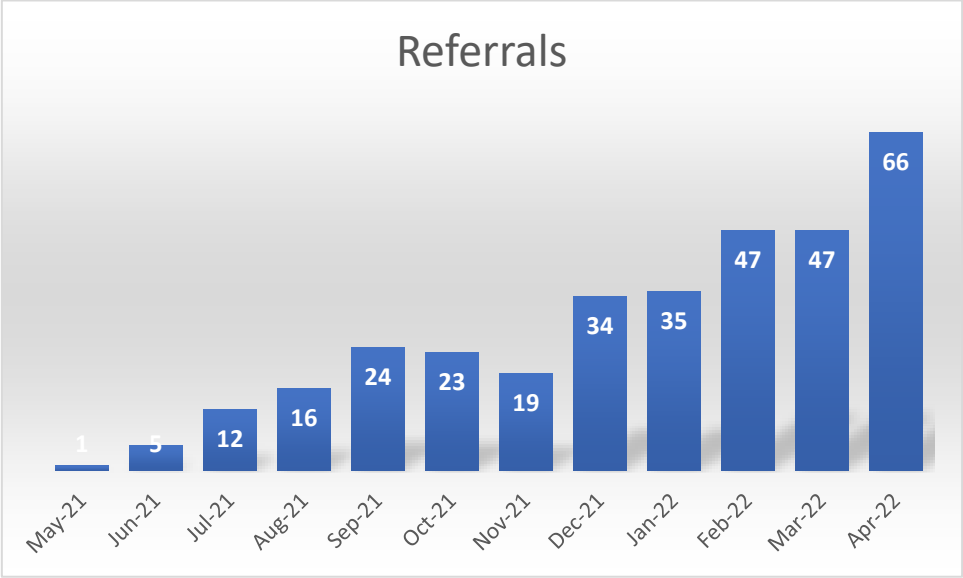
Post-COVID syndrome is defined as prolonged symptoms 12 weeks after infection. (NHS, 2022). On confirmed cases alone this would translate to 11,220 people in Gwent living with post-covid syndrome however we know during the early months of the pandemic, access to testing was limited so that figure may represent an under-estimate of the actual number. Access to our services have been a subset of this wider group. **121 patients** who had received in patient care in the intensive care unit attended a multidisciplinary team of which 83 were invited to a rehabilitation programme. 70 patients completed this programme.

Many patients have been investigated and managed in primary care, supported by the development of clinical guidance and patient information resources. However, since the use of Read Codes for 'Long COVID' symptoms has been inconsistent, it is not currently possible to quantify that need.

From a period of May 2021 to April 2022, **278 people** have been referred into the Post COVID Recovery Service. This includes 23 children in our recently launched paediatric service. **231 patients have accessed our Education Programme for Patients** which we have delivered in collaboration with GAVO.

14 members of staff have been supported directly by Occupational Health Services whilst others have received care from the Post-COVID Recovery team and primary care services.

Demand for our services is increasing. As visibility of our services rises, we are seeing an increased number of referrals. And following the large Omicron wave during Winter, we have seen that filter through into referrals into our services. Current covid infection rates are significantly lower than We do not yet know how many patients affected during this period will experience prolonged symptoms and concerns, but we anticipate continuing demand during 2022.



New referrals

In our service, we have seen a high prevalence of obesity, anxiety and depression. Long Covid and other chronic conditions have many overlapping symptoms. Patients benefit from a needs-based approach which supports their personal experience rather than separate diagnostic categories.

2.2 Strategic Context

On Tuesday 8th February 2022, the Health Minister made a statement to the Senedd on long covid services. She committed to a further six-month review of the Adferiad programme to September 2022. From April to September 2022, Health Boards are expected to continue to meet the needs of our communities and patients with post covid syndrome, and HBs are expected to plan to mainstream long covid management into existing long-term condition pathways. On Monday 7th March, Welsh Government published a document setting out its plan to transition from managing covid as a pandemic to an endemic condition. In doing so, it reaffirms a commitment to supporting people with long covid, as well as supporting people's

return to work. (Welsh Government , 2022).

We have developed service pathways that are aligned with both Welsh Government's "A Healthier Wales" and Aneurin Bevan University Health Board's Clinical Futures strategy. As set out in our Executive Summary, we have established a service that is holistic, whole person centered and appointments are delivered close to home.

3. Current Service Provision

3.1 Background

Work to develop this service began in November 2020. The Health Board did not have an established model for post viral recovery support and services for patients with symptoms such as prolonged covid-19 recovery were fragmented.

The post COVID service pathways have been designed and implemented to be aligned to NICE and Welsh Government guidelines. The aims of the Post COVID Planning Group at the time were:

- An evidence-based approach informed by patient experience
- Service provision is mapped to ensure that new developments are aligned with existing services which can be expanded or adapted to meet the needs of the identified post covid 19 sequelae
- Services for people with post covid-19 syndrome are delivered in a way that is equitable with other health or care issues; services should neither advantage nor disadvantage people post covid-19
- Service provision in communities based upon tiers of service provision so that only those with specific needs are seen by highly specialist services.
- Opportunities are taken to actively engage and participate in relevant trials and research.

We established a **Clinical Practice Group** to ensure that clinical experience and the latest research was reflected in our planning. A multi-disciplinary approach was used to ensure that each aspect of an individual's needs could be supported, and we identified at an early stage the need for a service for children and young people.

Appendix A summarises our adult pathway

Appendix B summarises our pathway for children and young people

3.2 Support

We established our workforce from the end of 2020 to the middle of 2021. We wanted to ensure our team was truly multidisciplinary and we added to our team as the year progressed. We paid for sessions by

reimbursing directorates for clinical time, and we also drew on support from wider clinical networks for advice . We were unable to recruit to some vacancies, such as a GP with Special Interest, and it has taken some time to secure medical input from secondary care teams

Role	Band	WTE
Paeds		
Consultant (Paed's)	Consultant	0.1
Clinical Psychologist	8d	0.2
Physiotheraphy	7	0.2
Assistant Psychologist	5	0.2
Trainee Psychologist	6	0.2
Assistant Prac	4	1

Programme		
Assistant Director (SRO)	8d	0.2
Programme Manager (Nov 2021)	8a	1
Administrator (Nov2021-Jan2022)	3	1
Advisor	Consult	0.3

Adult		
Psychologist	8d	0.3
Psychologist	7	0.1
Physio	8a	0.4
OT-MH	7	0.4
Exercise Referral	6	0.5
OT-OH	7	0.5
OT-OH	7	0.5
Assistant Prac (Jan 2022)	4	1

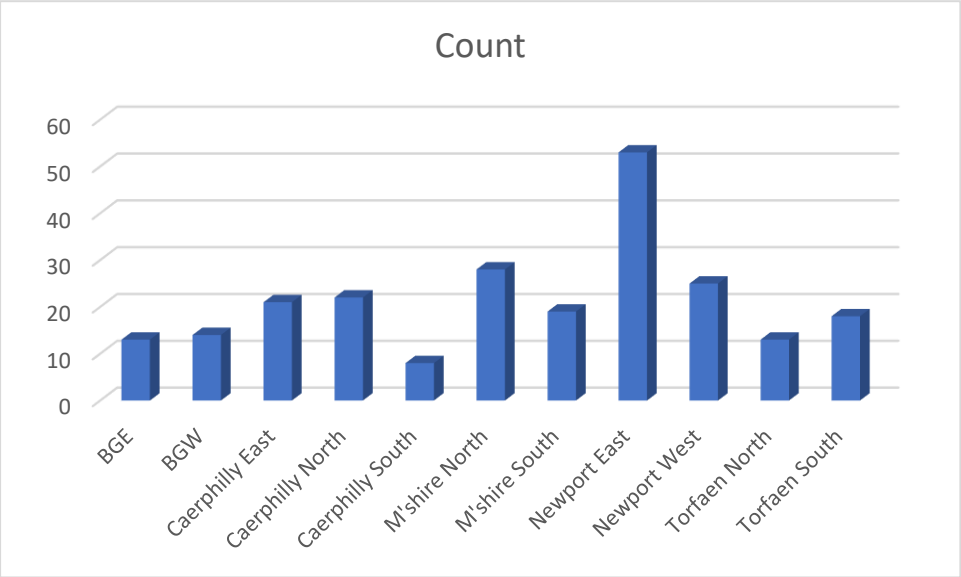
3.3 Service Evaluation

278 patients were referred into our core post COVID Recovery service between June 2021 and May 2022. This excludes the post-ITU COVID patients that were seen in 2020. We have a comprehensive record of demographic information and the health profile of our patients. Patient Reported Outcome Measures (PROM) and Patient Reported Experience Measure (PREM) information is currently being collected and collated.

3.3.1 Demographics

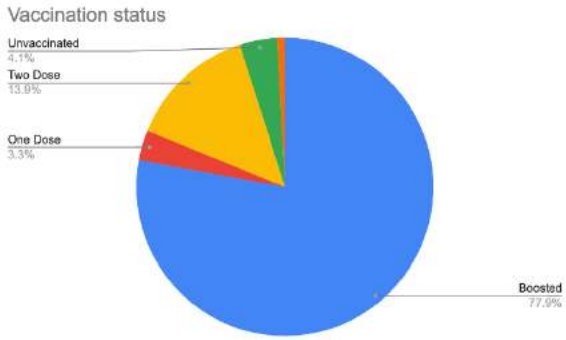
More than two thirds of referrals are female (69.23%). Most of the patients attending the post COVID Recovery service self-reported as White (69%) however clinical workstation data is incomplete. The mean age of patients is 49 years.

During the beginning of our programme, we saw an overrepresentation of patients from GP clusters in Newport and Monmouthshire and an underrepresentation from Blaenau Gwent and Torfaen, which was pointing to socioeconomic factors impacting patient access to our services. However as visibility and awareness has improved, these problems have been rectified. Below you can see how many patients have been referred to our services by GP cluster area:



Vaccination

Most patients have been fully vaccinated, with a minority (4.1%) unvaccinated. Some patients reported their long covid symptoms worsened following vaccination whilst others reported improvement.



Comorbidity

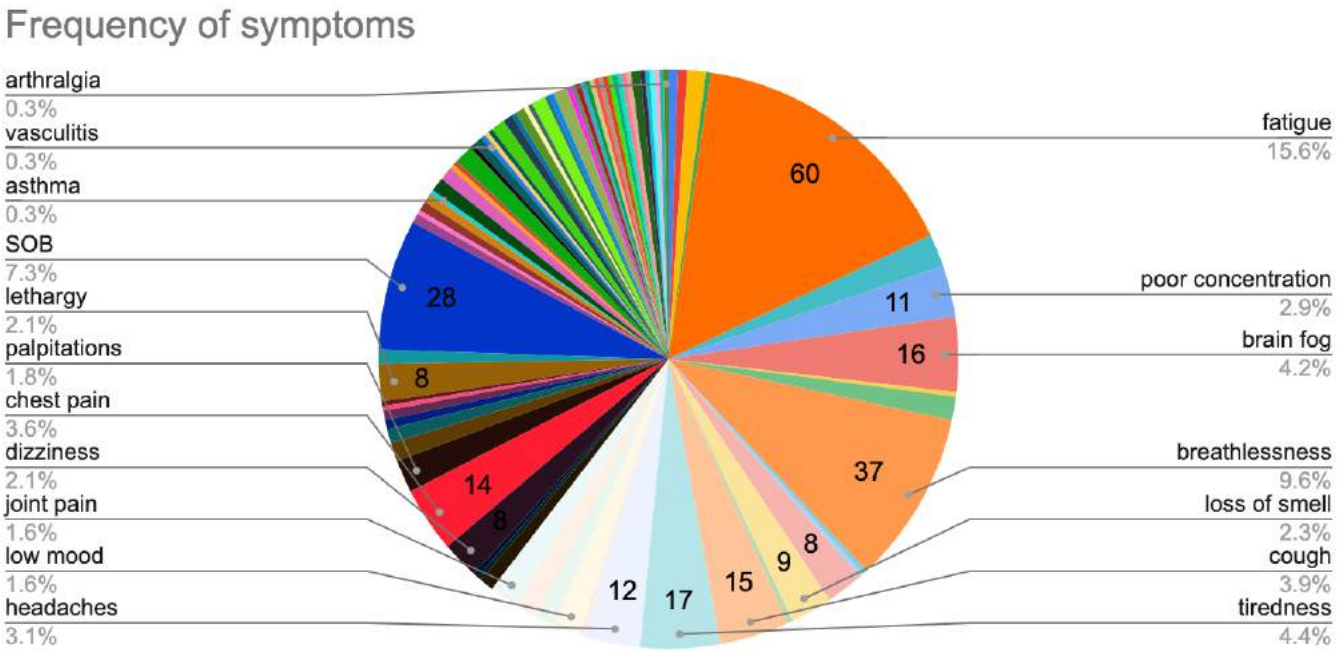
The most frequently reported co-morbidity has been anxiety and depression (15.3%).

Asthma and shortness of breath were present in 10.5% of patients and

Pre-existing symptoms of Chronic Fatigue Syndrome and Fibromyalgia are frequently reported. Morbid obesity has also been a common finding.

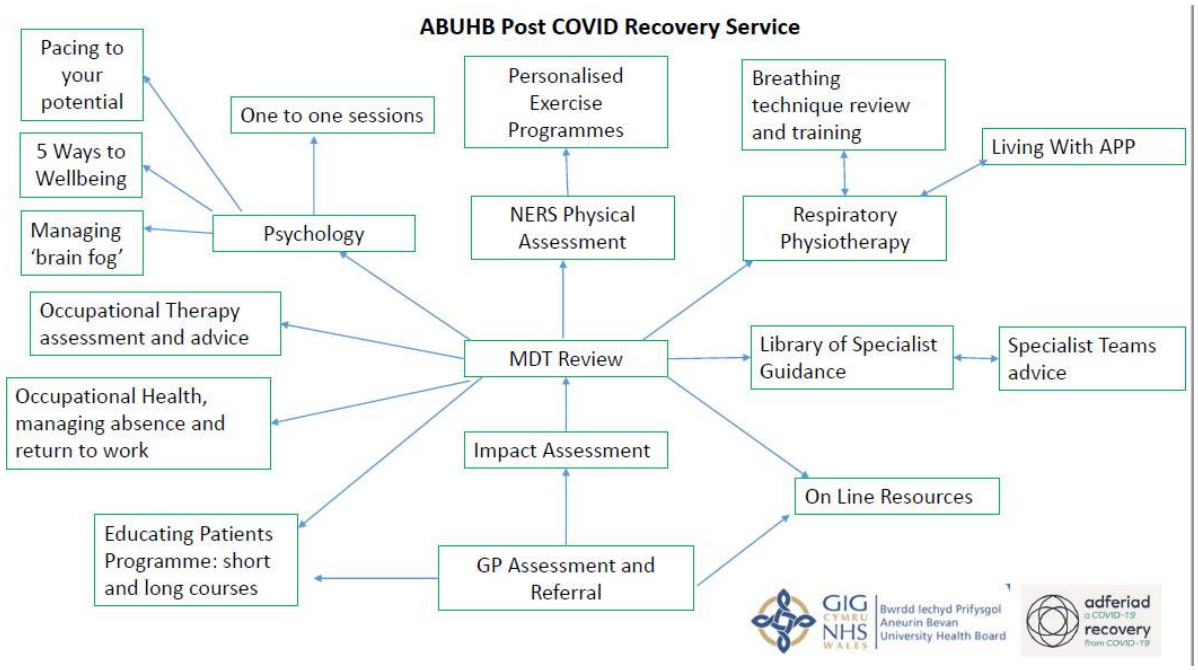
Patient symptoms of long covid

22.1% of patients reported fatigue-like symptoms and 17.2% reported shortness of breath. The graph demonstrates the broad range of symptoms presented.



3.3.2 Interventions

Each patient is contacted to complete an Impact Assessment which is taken to the MDT for discussion with review of the GP referral and any ongoing management through other services. The MDT agrees suitable treatment and support options, and these are discussed with the individual to agree a personalised plan. The interventions vary from supported self-management; partner programmes such as an Educating Patients Programme; respiratory rehabilitation; physiotherapy and exercise referral (NERS), and psychological support.



Respiratory rehabilitation

A range of interventions have been customised according to patient needs. These include breathlessness management exercises, Pilates for breathing, and acapella for breathing. Incentive Spirometry has proved popular with patients as a motivational tool.

Physiotherapy and exercise support

30% of patients have been assigned physical programmes that included weight management, exercise programmes and physiotherapy.

Partner programmes

46.67% of patients have enrolled into partner programmes such as the National Exercise Referral Service (NERS) and EPP.

Self-management

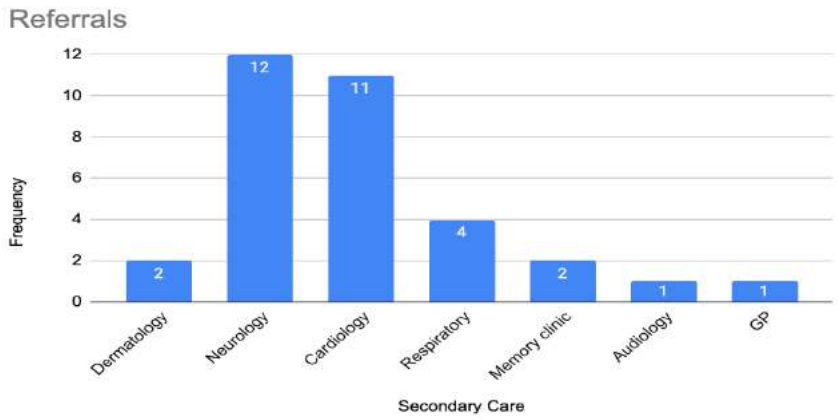
43.3% of patients have been provided guidance including World Health Organisation (WHO) guidance, 5 Ways of Wellbeing, Menopause guidance and other NHS resources. However, all patients are advised about the ABUHB self-management resources.

Psychological support

26.67% of referrals have received psychological interventions to manage symptoms such as brain fog, anxiety, depression and post-traumatic stress from recent or previous events. This has been a critical aspect of care in many cases to enable individuals to engage with a wider range of advice and support.

3.3.3 Secondary Care

Up until the end of 2021, (where this data was captured), we had a number of secondary care referrals. Below shows the distribution of these referrals, with a majority going to Neurology and Cardiology.



3.3.4 Feedback

The service sends out PROM and PREM forms for patients newly referred into our services; patients who are undergoing ongoing treatment and patients who have been discharged. We include some of the findings below:

Positive comments

"I have an amazing relationship with my physiotherapist from the covid rehabilitation team who has been supporting me in person & virtually since February. She got me referred to cardiology & has told NERS what I need to do in the next stage of my recovery, she has also been at the end of an email if I need support. The mixture of face to face & virtual appointments have been a benefit."

"Even though a huge strain on the NHS I always had a doctor contacting me back with help even if it isn't the same one as I normally have, I will always have a response which is reassuring that you will get better."

"The support I have received from your service has supported my recovery. I cannot thank the staff enough for their care and understanding during a very difficult period for me and my family."

"Speaking to Sarah Flowers was so helpful. She was kind and considerate. She listened and gave me some really encouraging advice guidance and support."

Negative comments

"I haven't received anything for long covid. Actually, contact people instead of just a survey."

"Quicker access to long covid clinics – I still has not been contacted."

"Focus has been on rehabilitation/pacing without identifying biomedical causes first. Lack of access to neurology assessment. It would be helpful to be seen in person for some appointments."

Data

We have received mixed results in our experience measures:

	Listened to?	Provided with right information?	Involved in care?
Always	25%	19%	27%
Usually	23%	25%	17%
Sometimes	42%	38%	33%
Never	10%	18%	23%

With respect to an overall satisfaction score, we score an average of **5.67** out of 10.

3.3.6 Performance

Our current waiting time is 6.4 weeks which has risen significantly after reducing it to 3.19 weeks. Our demand is currently exceeding capacity significantly.

3.3.7 Children and Young People

We launched our Paediatric Service in November 2021. At the time of submission of this paper, 23 children and young people have received an assessment and a further 17 are on the waiting list.

3.3.8 Occupational Therapy within Occupational Health Workstream

Since November 2021, we partnered with Occupational Health to deliver a pilot, with Occupational Therapists working in the OH team to deliver long covid rehabilitation. 14 patients have been seen. A full review of the pilot will take place at the end of the fiscal year which will include outcome measures. There is agreement that an explicit referral route from Occupational Health services into the Post COVID recovery team would be beneficial for our workforce.

3.4 SWOT Analysis

A team meeting was held to review the development and delivery of the Post COVID recovery service.
A SWOT analysis revealed the challenges faced by many patients when navigating services and when seeking flexible rehabilitative support. It was noted that many services have barriers to access which hinder a multi-disciplinary approach. Where services have engaged to develop patient advice resources, we have been able to minimize onward referrals.

It was also noted that communication of the new service offer has been challenging but that engagement of an external team has been useful for developing communication tools and patient advice resources. The MDT approach has been welcomed by many team members as a supportive work environment.

Strengths	Weaknesses
Empowered self-management- we encourage our patients to be directly involved in the management of their recovery	**Communications-** difficult to engage GP partners and wider public about the services we have on offer. Moreover, due to the pandemic, we have a tsunami of information for the public to work through
Patient-focused and whole-person centred- patients are often surprised we want to know the whole patient experience- as it is all important.	**Access to medical advice-** accessing time to secondary care specialists has been challenging, meaning patients are on long waiting lists and unable to proceed with treatment.
Positive and engaging- we are positive with our patients because we believe recovery is possible. And we are positive as a team as we have developed a truly innovative service model.	**Short-term monies** have meant it is hard to recruit for key positions and there is a retention risk with current staff. Moreover, Adferiad funding only landed in July 2021 and has such made it difficult to spend monies.
Truly multidisciplinary expertise- every discipline within our team is important and valued. Essential for multisystem issues.	**Scepticism about physical therapy.** Physical therapy is not always recognized to have an equivalent

	esteem to the medical model- hard to engage with public about role of physical therapy.
Cost-saving- decentralized and local services, but contains expertise, can be a far more cost-effective model than a centralized team with long waits for assessment. Fragmented long-term condition management pathways may not ensure access the most appropriate interventions	**Traditional biomedical model** has often meant patients are encouraged to expect a series of tests despite most tests returning negative results.
Digital and innovative- the Living With UCL App is forward thinking and could revolutionise the way we do healthcare.	**Research on Long COVID continues** with regular research papers being published. It is possible our service model will need to adapt to reflect new research.

Opportunities	Threats
Cost-Saving- reducing number of inappropriate referrals and take more targeted interventions.	**Attention diverted following transition to endemicity of covid,** as we as a system tackle mainstream service backlog.
Development of pathways for areas with unmet needs- we have seen this service model work- there is a wider population group who might benefit from this model	**Retention of staff is time-critical** with a March 31st deadline as staff look for roles elsewhere to ensure they stay in employment.
A whole lifespan model, where patients seamlessly transition from CYP, to adult, to older adult services.	**Poor existing chronic condition pathways-** if the service is discontinued, we still have patients that need treating within existing and already full services.
Strengthening collaboration between and within services- whole-person centred modelled ensures different divisions collaborate with each other for the needs of patients- from CYP to adults; physical health to mental health services.	**Funding-** difficult to build long-term continuity.
Partnership working has been enhanced, working with partners delivering services not directly by us but for the benefit of our patients.	**Politics-** messaging from interest groups has often presented a distorted picture of what support exists for patients. An innovative approach is required.
Expert and community-led, delivering the priorities of Welsh Government and ABUHB.	

4.Our Plan for the Adferiad Programme 2022/2023

4.1 Outline

As requested by Welsh Government we have developed a proposal to maintain the current service from April to September 2022 and to mainstream the service from then onwards.

Phase 1- April 2022 – September 2022

- Continue to respond to the prevalence of long covid in our communities
- Increase the whole-time equivalent clinical time to maintain the current waiting time and to offer an increased range of individual follow-ups and interventions
- Offer more group-based interventions to establish community among our patients.
- Increase uptake of the self-management APP
- Improve our rate of discharge with self-management advice and safety netting guidance.
- Improve access to our service by reaching underrepresented communities, working with our primary care partners.
- Consult with stakeholders delivering existing long term condition management pathways
- Finalise the design for an integrated rehabilitation model
- Agreed a referral pathway from Occupational Health referrals into our service.

Phase 2- October 2022 – March 2023 and ongoing

- Transition to an integrated Adferiad Recovery Service
- Continuation of the communications campaign to raise awareness of our services
- Develop a programme approach to articulate how an offer of personalized assessment and rehabilitation management could be extended to a wider patient cohort which may include:
- - Fibromyalgia
  - Chronic Fatigue/ME
  - Chronic Pain
  - Liver
  - Rheumatology
  - Endocrinology
- Conduct a full-service evaluation at the end of the budget year
- Report back to the Executive team and the Board on plans for 2023/24

Conclusion

COVID 19 has provided extreme challenges but has also provided the opportunity to rapidly develop new solutions. The value of rehabilitation is more widely recognised, and we have been able to design a model that could benefit a wide cohort of patients and relieve pressure on medical services. This approach aligns with the organisations strategic aims to inform and enable the public to achieve the best outcomes. Networking across service boundaries is critical to meet individuals' complex needs.

The Board is asked to note the achievements of the Adferiad Programme for the financial year 2021/22, the plans for the year 2022/23 and the organisational learning which will inform future service development proposals.

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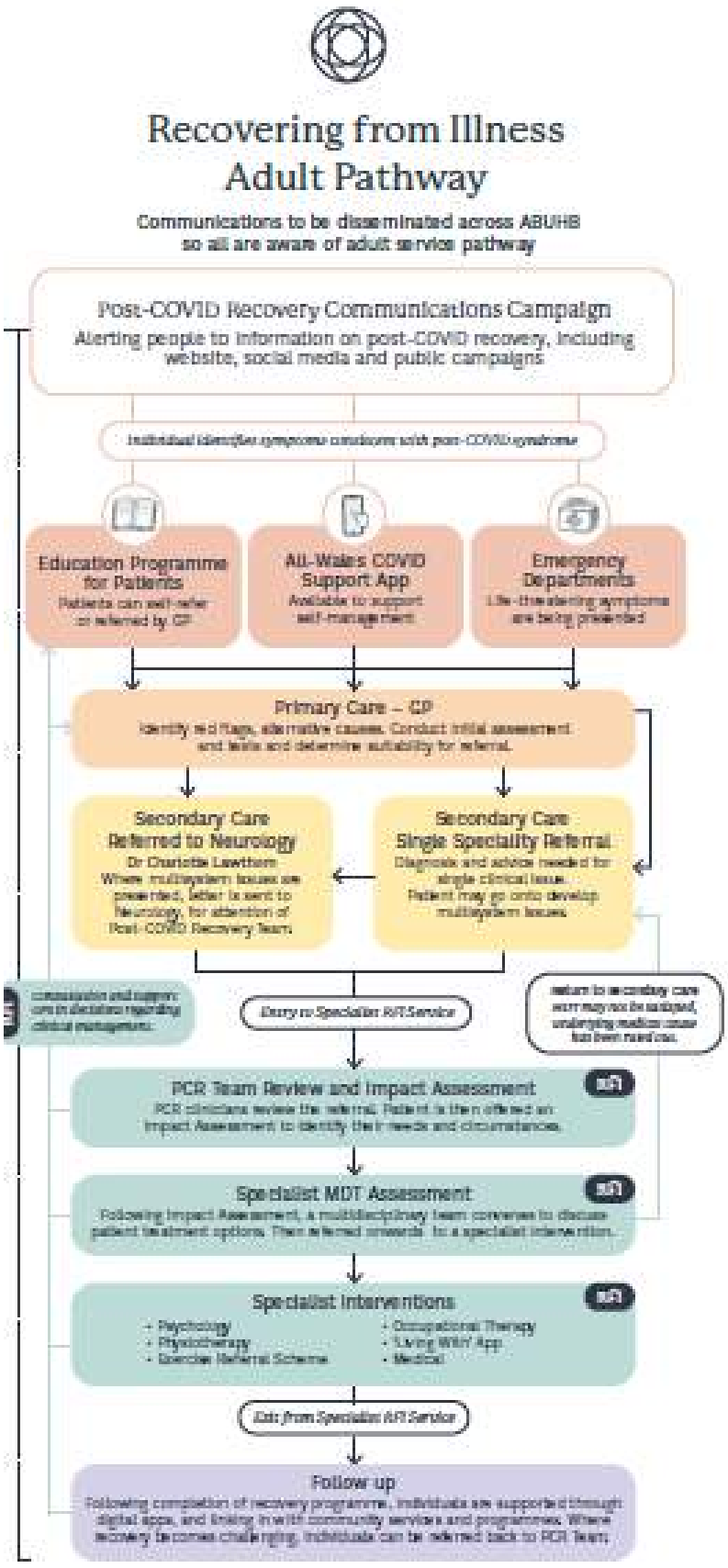


Appendix A- Pathway for Adults

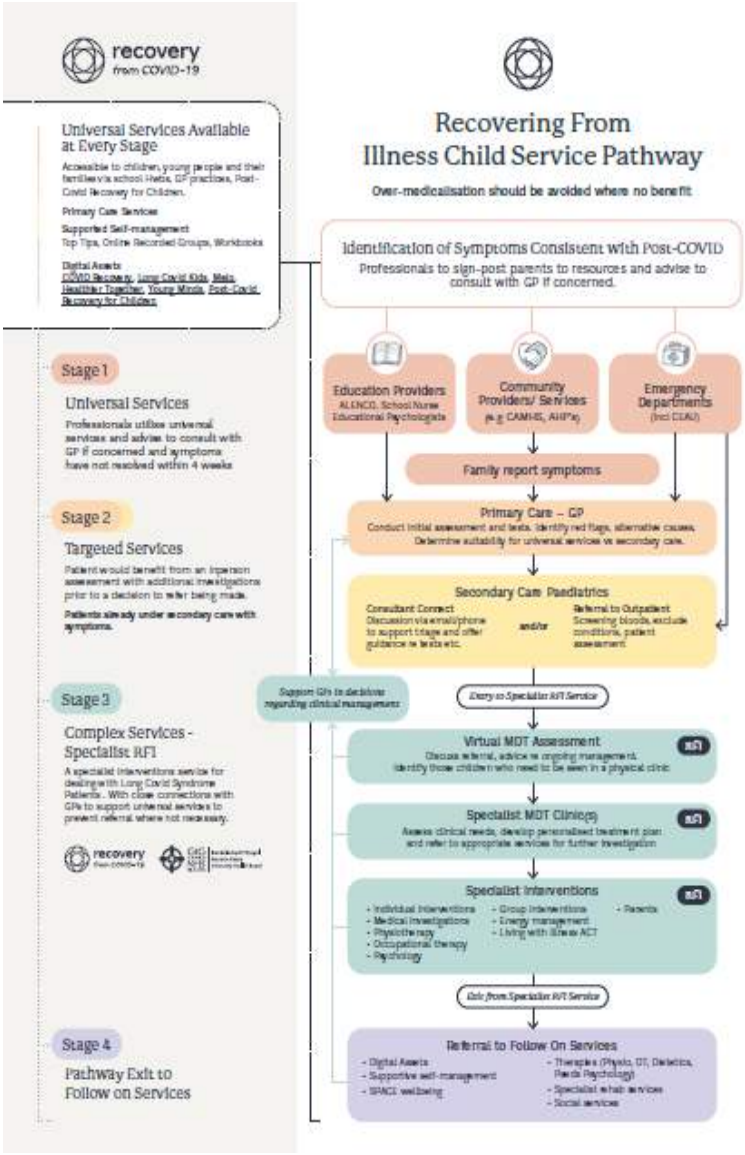
Each person referred to the service is offered an Individualised assessment by a member of a multi-professional team. The assessment focuses on the impact of the symptoms you are experiencing and your specific concerns and worries.

The Impact assessment and the referral information from your GP are reviewed by the whole team to identify options for a treatment or rehabilitation support where required.

Options after assessment may include:

- Individualised advice and guidance to self-manage the issue
- Specific further assessments where indicated
- Individualised rehabilitation programme – related to single or multiple issues, such as fatigue/ breathlessness/ palpitations, mood changes
- Group interventions for people with similar symptoms, such as brain fog.
- Remote rehabilitation support via the **University College London Long Covid App**
- Referral to an Activity or Exercise Professional to increase stamina and energy
- Links to local services that can support specific goals

Appendix B- Pathway for Children and Young People



In establishing our Pediatric Service, we established the following principles:

- All CYP should be offered personalised care that meets their physical, social, psychological, and educational needs. For all CYP, the impact of the illness on the child and family as a whole unit should be assessed, including day-to-day functioning and access to education.

-All CYP and the adults in their proximal life should be able to access information, resources (including digital assets) and services necessary to support the CYP with Post-Covid Syndrome's needs, facilitating self-care and management.

-General practice plays a key role in supporting CYP with long term symptoms of COVID-19

-GP's will adopt a gatekeeping function to ensure CYP's receive appropriate treatment and conduct an appropriate screening before referral to specialist services.

-CYP's can access further therapeutic input, rehabilitation, psychological support, specialist investigation or treatment once they have been assessed, and patients should be referred to existing services as needed.

-CYP should have access to multi-disciplinary teams, accounting for the multi-system nature of the disease.

-Multidisciplinary support and rehabilitation should be available to tailor personalised care plans, provide interventions and be able to escalate to more specialist services for an assessment.

-Local Paediatric Services should be involved in the CYP's care if clinically indicated.

-Post-Covid Assessment Clinics should be available to all affected CYP, and services should be available locally where possible.

-Rapid access to the Recovering from Illness MDT is enabled

Attached below is our full clinical guidance document on our Paediatric Service.

Clinical Guidance
for the Post COVID S

Appendix C- Plan on a Page

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board 25th May 2022 Agenda Item: 3.1

Aneurin Bevan University Health Board
Nevill Hall Hospital Satellite Radiotherapy Unit

Executive Summary

Attached to this paper is the draft Full Business Case (FBC) to support the construction of a new Satellite Radiotherapy Unit on the Nevill Hall Hospital site.

The total cost of the preferred option is £46.180 million which includes the provision of the Integrated Radiotherapy Solution (previously excluded from the OBC) that is being procured by VUNHST as part of their larger proposed Integrated Radiotherapy Solution (IRS). The IRS includes the provision of the two Linear Accelerators that are required for the Nevill Hall satellite unit.

The recurrent revenue cost (All Health Boards) is £2.983m for the delivery of 15,600 fractions associated with prostate, breast and palliative treatments. The ABUHB indicative share of this additional cost is £1.170m.

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

Executive Sponsor: Nicola Prygodzicz, Director of Planning			
Report Authors: Andrew Walker / Phil Meredith			
Report Received consideration and supported by:			
Executive Team	12/5/22	**Committee of the Board [Committee Name]**	
Date of the Report: 16th May 2022			
Supplementary Papers Attached: Draft Outline Business Case (minus appendices)			

Purpose of the Report

To provide the Health Board with the draft FBC for consideration and approval before it is submitted to the Welsh Government.

It should be noted that as this is a joint project in collaboration with Velindre University NHS Trust (VUNHST) the FBC is also going through their own internal governance procedures. The FBC will be submitted to Welsh Government as a joint submission with VUNHST.

Background and Context

The case for change and the preferred option as set out in the approved Outline Business Case (OBC) are still relevant and that no significant changes have occurred since OBC approval. The preferred option is still the construction of a new Satellite Radiotherapy Unit at Nevill Hall Hospital.

The capital "cost not to be exceeded" has been agreed with the Supply Chain Partner in the sum of £29.588 million.

The total cost of the preferred option is £46.180 million which includes the provision of the Integrated Radiotherapy Solution (previously excluded from the OBC) that is being procured by VUNHST as part of their larger proposed Integrated Radiotherapy Solution (IRS). The IRS includes the provision of the two Linear Accelerators that are required for the Nevill Hall satellite unit.

The recurrent revenue cost (All Health Boards) is £2.983m for the delivery of 15,600 fractions associated with prostate, breast and palliative treatments. The ABUHB indicative share of this additional cost is £1.170m.

The planned facility will include two Linear Accelerators and a CT Simulator along with supporting Radiotherapy clinical accommodation. It will be linked to the existing Nevill Hall Hospital via the demolition of the existing Ante-Natal Clinic following its relocation to vacant ward accommodation.

Whilst the building itself will be an ABUHB facility the clinical services will be managed and run by VUNHST staff. A Service Level Agreement will be agreed that will set out exactly which organisation will be responsible for what but put simply VUNHST will be responsible for the clinical services provision and ABUHB will provide soft and hard FM services.

The Investment Objectives for the project are set out below:

Investment Objective 1	To provide access to **quality** and **safe** radiotherapy services that optimises patient **outcomes**
Investment Objective 2	To provide sufficient **capacity** to meet future **demand** for services
Investment Objective 3	To **improve patient, carer** and **staff experience**
Investment Objective 4	To provide **capacity** and **facilities** to support the delivery of high quality **education**, **research**, **technology** and **innovation**

Key project milestones are as follows:

Milestone	**Date**
Submission of FBC to WG	May 2022
WG Approval	July 2022
Start on Site	August 2022
Construction Completion	February 2024
Linac Commissioning Period & Anticipated Beam on Date	February to July 2024

Recommendation
The Health Board is asked to: ▪ Approve the draft FBC for submission to Welsh Government.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The FBC includes an assessment of all risks, service, revenue and capital
Financial Assessment, including Value for Money	The FBC includes a detailed Financial and Economic Appraisal.
Quality, Safety and Patient Experience Assessment	The FBC includes four Investment Objectives and a range of associated Benefits the majority of which are targeted at improving quality, safety and the patient experience
Equality and Diversity Impact Assessment (including child impact assessment)	A separate EDIA will need to be completed and submitted to WG along with the FBC
Health and Care Standards	The FBC had been prepared in the context of the relevant Health Care Standards
Link to Integrated Medium Term Plan/Corporate Objectives	The development is identified in the IMTP and in the associated capital programme
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** This project will significantly influence the longer term delivery and sustainability of radiotherapy services
	Integration – The project has been planned and designed as a fully integrated service with existing services in NHH
	Involvement – There has been extensive engagement with other public sector bodies, staff, users and the wider public.
	Collaboration – The project has been planned and designed with the full collaboration of VUNHST
	Prevention – One of the key aims of the Health and Well Being model is to facilitate, via integrated working, the prevention of ill health
Glossary of New Terms	FBC – Full Business Case, this is the final document in the planning process leading to the approval of capital monies from Welsh Govt.
Public Interest	There is some local, public and political interest in this project. There has already been significant engagement

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

DEVELOPMENT OF A SATELLITE RADIOTHERAPY UNIT AT NEVILL HALL HOSPITAL

FULL BUSINESS CASE

Version No 6 – 17th May 2022

Contents

Appendices: *(not included with this version)*

NB – All capital / construction related information is included in the supporting Estates Annex which is available via a link

FULL BUSINESS CASE - EXECUTIVE SUMMARY

To be inserted

1.0 INTRODUCTION

Purpose of Business Case

1.1 The purpose of this Full Business Case (FBC) is to confirm:

- The case for change and the preferred option as set out in the approved Outline Business Case (OBC) are still relevant and that no significant changes have occurred since OBC approval.
- That the preferred option is still the construction of a new Satellite Radiotherapy Unit at Nevill Hall Hospital.
- That a "cost not to be exceeded" has been agreed with the Supply Chain Partner in the sum of £29.588 million.
- That the total cost of the preferred option is £46.180 million and that this includes the provision of the Integrated Radiotherapy Solution (previously excluded from the OBC) that is being procured by VUNHST as part of their larger proposed Integrated Radiotherapy Solution.

Structure of Document

1.2 This FBC has been prepared using the agreed standards and format for Business Cases, as set out in:

- HM Treasury Guide to Developing the Project Business Case 2018
- NHS Wales Infrastructure Planning Guidance (2015)
- HM Treasury, the Green Book: Appraisal and Evaluation in Central Government: Treasury Guidance (2003).
- Public Sector Business Cases using the Five Case Model: A Toolkit Guidance and Templates (2007)

1.3 The approved format is the 5 Case Model, which comprises of the following key components:

- The **Strategic Case** which sets out the Strategic Context and the Case for Change, together with the supporting investment objectives for the Scheme.
- The **Economic Case** which demonstrates that ABUHB / VUNHST have selected a *preferred way forward,* which best meets the existing and future needs of the Service and is likely to optimise Value for Money (VFM).
- The **Commercial Case** which outlines the potential procurement strategy.
- The **Financial Case** which addresses the capital and revenue implications and the issue of affordability.
- The **Management Case** which demonstrates that the scheme is achievable and can be successfully delivered in accordance with accepted best practice.

2.0 STRATEGIC CASE

2.1 Introduction

2.1.1 The Strategic context and associated case for change has not changed since submission and approval of the OBC and is summarised below for completeness.

2.2 Background

2.2.1 Radiotherapy is the use of ionising radiation, usually high energy x-rays to treat disease and is usually used to treat malignant disease (cancer) and some benign indications. It has an important role in treatment of cancers as 50% of all cancer patients will benefit from receiving radiotherapy as part of their cancer management. Developments in radiotherapy techniques and the increasing incidence of cancer indicate that the demand for radiotherapy will continue to rise and require sufficient and resilient capacity to be made available. Work to date by VUNHST indicates the service will be unable to deliver a high quality, reliable and sustainable service without an expansion in capacity.

2.2.2 This needs to meet the demand of non-surgical cancer services, together with the poor condition of the estate at Velindre Cancer Centre (VCC) led to the Transforming Cancer Services in South East Wales programme (TCS), which developed with partners a clinical model for non-surgical cancer services. This model included a Radiotherapy satellite centre (RSC) and this business case focuses on the RSC and its role to secure radiotherapy capacity for the population of South East Wales. The capacity needs to be in place ahead of the new VCC as demand is already exceeding capacity but also to enable medical physics staff to be available to commission the equipment in RSC but also in the new VCC.

2.2.3 In addition to the lack of capacity, a key factor supporting the case is the benefit of care being delivered closer to home, especially as there is evidence that uptake of radiotherapy in Wales is below best practice and there is evidence that availability of services closer to patients leads to increased uptake of treatments – which in turn will lead to improved outcomes and better experiences for patients.

2.2.4 Following agreement on the TCS clinical model, the process for determining the best site for the RSC was established with partner organisations through an evaluation exercise. This led to the selection of Nevill Hall Hospital as a site for the RSC and as such this is a joint project between the 2 organisations.

2.2.5 The remainder of this Strategic Case will provide more detail on the above issues to support the case for change for this service development.

2.3 Organisational Overview

2.3.1 This section will provide an overview of Aneurin Bevan University Health Board (ABUHB) and Velindre University NHS Trust (VUNHST) and their relevant Service

Hospitals as well as an overview of Cancer Services in South East Wales and the whole system leadership arrangements.

Aneurin Bevan University Health Board (ABUHB)

2.3.2 Aneurin Bevan University Health Board was established in October 2009 and achieved 'University' status in December 2013.

2.3.3 It serves an estimated population of over 639,000, approximately 21% of the total Welsh population.

2.3.4 With a budget of £1.4 billion the HB delivers healthcare services to people in Blaenau Gwent, Caerphilly, Monmouthshire, Newport, and Torfaen and also provide some services to the people of South Powys.

2.3.5 The Health Board covers diverse geographical areas and has to take account of a mix of rural, urban and valley communities. The valleys experience high levels of social deprivation, including low incomes, poor housing stock and high unemployment.

2.3.6 The Health Board employs over 16, 700 (11,972 WTE) staff, two thirds of whom are involved in direct patient care. ABUHB is the largest employer in Gwent.

2.3.7 The Health Board provides a comprehensive range of acute hospital based, Community based, Mental Health and Primary Care services via a large and complex estate consisting of the following:

- The Grange University Hospital (Specialist and Critical Care Centre),
- 3 Local General Hospitals - Royal Gwent, Neville Hall, Ysbyty Ystrad Fawr
- 5 Community Hospitals - County, Ysbyty Aneurin Bevan, St Woolos, Chepstow and Monnow Vale
- 4 Mental Health Hospitals - St Cadoc's, Llanfrechfa, Maindiff Court, Ysbyty'r Tri Chwm
- 8 Locality based Mental Health Units and 1 Residential Unit on LGH site, 4 unoccupied units across Gwent.
- 30 Locality based Community clinics
- Nearly 300WTE General Practitioners and salaried GPs
- 375 General dental practitioners in 79 practices
- 131 Community pharmacies
- 69 Optometry premises

Velindre University NHS Trust (VUNHST)

2.3.8 The Trust is operationally responsible for the management of the following two divisions:

- Velindre Cancer Centre;
- Welsh Blood Service;

- Host for the NHS Wales Shared Services Partnership (NWSSP)on behalf of the Welsh Government (WG) and NHS Wales:

2.3.9 Velindre Cancer Centre located in Whitchurch, Cardiff and is one of the ten largest regional clinical oncology centres in the United Kingdom and the largest of the three centres in Wales. The Trust is the sole provider of non-surgical specialist cancer services to the catchment population of 1.5 million across South East Wales, from Chepstow to Bridgend and from Cardiff to Brecon. Additionally it provides more specialist radiotherapy services across the whole of South Wales. Velindre Cancer Centre employs around 863 (751WTE) members of staff and has approximately 70 volunteers who provide a range of 'added value' roles across the centre. The Trust also works in partnership with a wide range of third sector, charities, Higher Education Institutions (HEIs) and Industry/Commercial Partners to deliver high quality cancer care and undertake clinical research.

2.3.10 Velindre Cancer Centre is responsible for the delivery of non-surgical treatment including Radiotherapy and Systemic Anti-cancer Therapy (SACT), recovery, follow-up and specialist palliative care. These services are provided by specialist teams using a well-established multi-disciplinary team (MDT) model of service for oncology and palliative care, working closely with local HB partners, and ensuring services are offered in appropriate locations in line with best practice standards of care. Following their specialist cancer treatment, Velindre Cancer Centre supports patients during their recovery and through follow up appointments.

2.3.11 The following patient services are delivered in outreach settings in Health Board (HB) locations across South East Wales from Velindre Cancer Centre:

- SACT delivery,
- Outpatient appointments,
- Inpatient reviews; for patients receiving care and treatment in HBs
- Health Board MDTs; and
- Research and Education
- Acute Oncology services.

2.3.12 However, all Radiotherapy activity is currently delivered at the Velindre Cancer Centre.

2.4 Overview of Cancer Services in South East Wales

2.4.1 The planning and delivery of cancer services in South East Wales is the responsibility of the four Health Boards (HBs) (Aneurin Bevan University Health Board, Cardiff ad Vale University Health Board; Cwm Taf Morgannwg University Health Board and Powys Teaching Health Board) as part of their statutory responsibility to meet the health needs of the populations they serve. The HBs are supported by the Welsh Health Specialist Services Committee (WHSSC) which commissions specialist cancer services on their behalf.

2.4.2 VUNHST and the HBs work in partnership with the All Wales Cancer Network, NHS Trusts, Community Health Councils, Voluntary and Charitable Organisations and Public Health Wales.

2.4.3 The four Health Boards, in conjunction with VUNHST and other stakeholders have formed the South East Wales Collaborative Cancer Leadership Group (CCLG). To provide effective system leadership for Cancer Services across South East Wales and deliver improvements in outcome and service experience for the catchment population through Collaborative Cancer Programmes of work within the region The CCLG fully supported the RSC OBC and the development of this FBC is in line with this support from CCLG.

The Cancer Pathway

2.4.4 The delivery of cancer services across Wales generally conforms to a well-defined pathway of care which includes the following five key stages:

Table 2-1: The Cancer Pathway

Cancer Prevention: Enhancing public awareness and education to make informed decisions about lifestyle choices that promote a healthy, cancer free population.
Cancer Diagnosis: Cancer can be identified through a National Screening Programme or where cancer symptoms are identified by the patient/health care professional. If cancer is suspected the patient is assessed by a multidisciplinary team in the Health Board (often supported by Velindre Cancer Centre staff) and cancer may be diagnosed.
Treatment: The treatment options for every patient are discussed and considered by multi-disciplinary teams (MDTs). The treatment options include surgery, non-surgical treatment e.g., Radiotherapy or Systemic Anti-Cancer Therapy (SACT), a combination of these treatments and supportive care. Care often straddles organisational boundaries.
Recovery/Follow Up: Regular follow up appointments are important to monitor recovery, manage and reduce the after-effects of treatment and to ensure any signs of cancer relapse/recurrence are identified at their earliest stage.
End of Life Care: Sadly, not all patients survive cancer – openness about the need to plan end of life care is essential. A focus on living and dying well, early identification of needs and access to fast, effective palliation are important to reduce distress for both the patient and their family.

The Single Cancer Pathway (SCP)

2.4.5 The Suspected Cancer Pathway (SCP) aims to ensure that patients begin a first definitive treatment no later than 62-days after the point of suspicion of cancer. Such an ambition necessarily presents capacity challenges at all points of the patient pathway, not least in relation to treatment delivery.

2.4.6 A direction of travel in the field of radiotherapy is the adoption of a revised suite of time to treatment measures in the near future in Wales. These measures, developed by the Clinical Oncology Sub-Committee (COSC), will replace the extant JCCO measures. The COSC quality measures are supported by definitions which better reflect the ever increasing complexity of radiotherapy planning and will require the great majority of patients referred for radiotherapy treatment to begin their treatment within 21-days of referral. This is in step with the overarching ambition of the SCP, but again will pose significant capacity challenges.

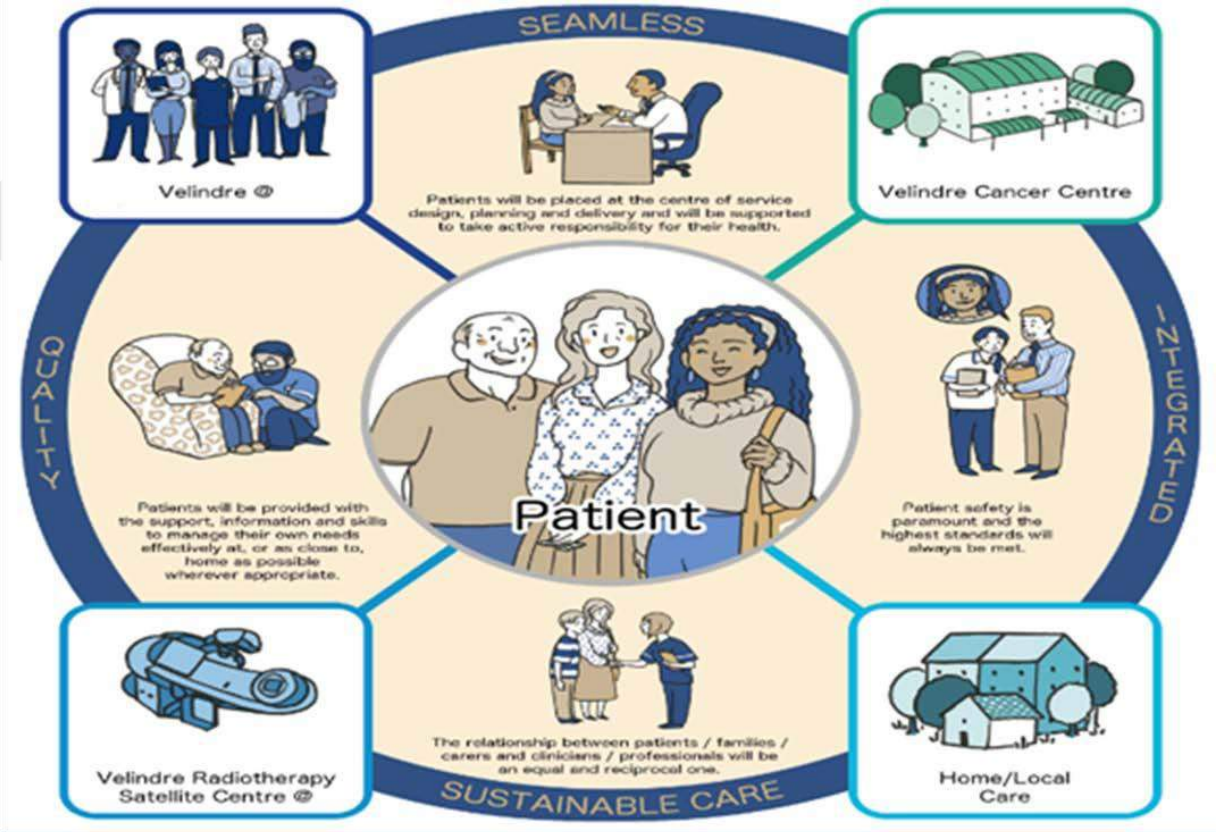
2.4.7 It is obvious that efforts to achieve the SCP timescales and the adoption of the new COSC quality will exacerbate issues associated with the availability of treatment capacity at VCC due to rising demand.

Transforming Cancer Services (TCS) Programme

2.4.8 It is important to understand where this FBC sits in the context of the overall TCS Programme. The TCS Programme is an ambitious Programme which aims to deliver transformed Tertiary non-surgical Cancer Services for the population of South East Wales.

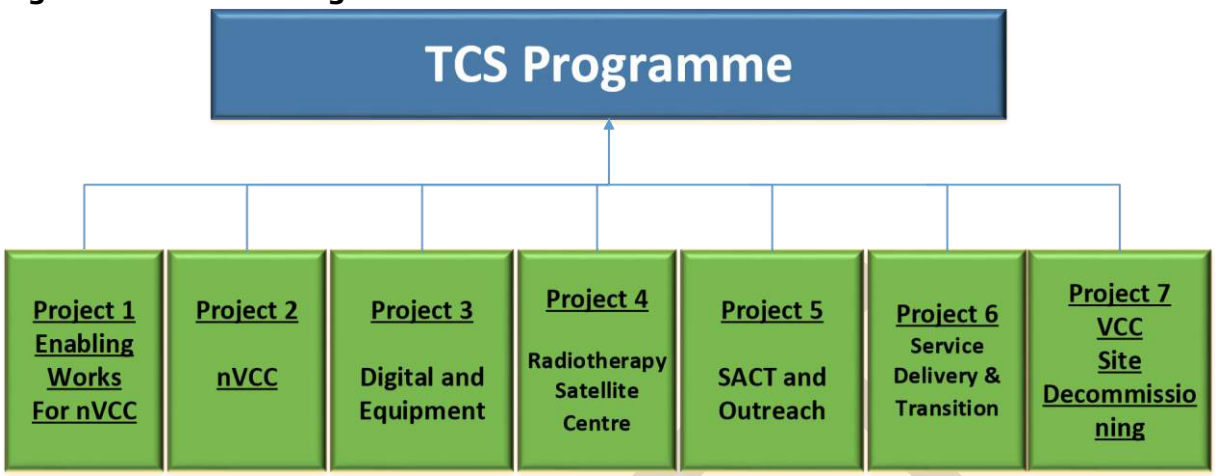
2.4.9 Through detailed stakeholder engagement the clinical model is shown below was developed and approved by HBs.

Figure 2-1: Clinical Model



2.4.10 Following agreement on the proposed clinical model 7 programmes of work/projects were developed to deliver the TCS programme:

Figure 2-2: Seven Programmes of Work



2.4.11 The Strategic Case for the TCS Programme, its links to Welsh Government Strategy and Velindre's own Cancer Strategy, are made in the TCS Programme Business Case (PBC). It is not the intention of this FBC to restate these, more to show alignment with this wider Programme's aims and objectives.

2.4.12 This FBC is also related to the Full Business Case FBC) for the new Velindre Cancer Centre (nVCC) and the FBC for the Integrated Radiotherapy Solution (IRS). The latter project aims to deliver the Trust decision to seek one prime vendor to deliver a fully integrated Radiotherapy solution and move away from the current situation of dual vendors of Radiotherapy equipment. The Integrated Radiotherapy Solution Procurement FBC is being developed from a Digital and Equipment Procurement De-coupling PBC which will be submitted to Welsh Government in May 2022.

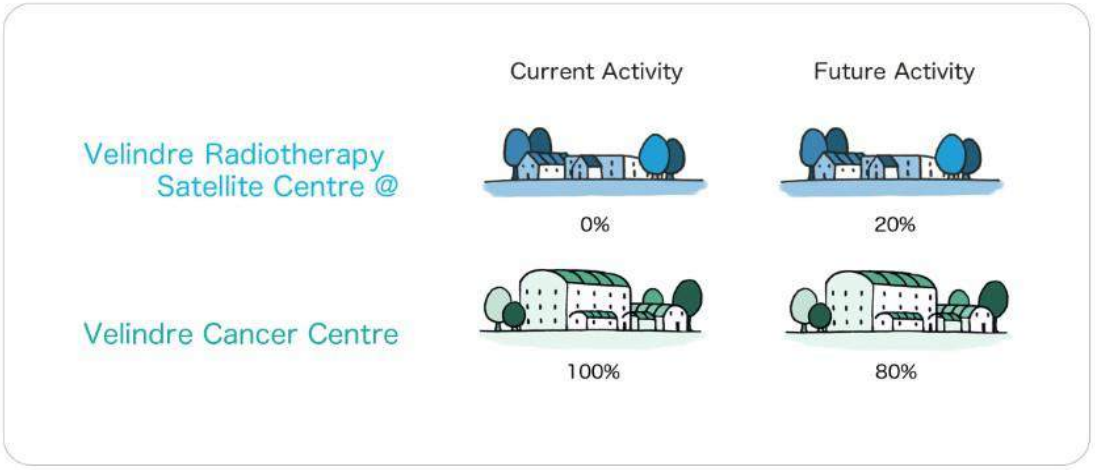
2.4.13 The Clinical Model within the TCS PBC, and as outlined in diagram above describes how services will be delivered in the future and is predicated on the following principles:

- The service model seeks to promote a new set of relationships which work in partnership to improve the way we collectively design and deliver services around patients' needs and to achieve these improvements in a truly sustainable way.
- The patient will be central to plans with an integrated network of services organised around them. The organising principle seeks to 'pull' high quality care towards the patient that is accessible in their preferred location and will support them achieving their personal goals during treatment and subsequently living with the impact of cancer.
- Patient safety is paramount, and the highest standards will always be met.
- The relationship between patients / families / carers and clinicians / professionals will be an equal and reciprocal one.

- Patients will be provided with the support, information, and skills to manage their own needs effectively at, or as close to, home as possible wherever appropriate.
- Patients will be treated at their closest centre where appropriate and safe to do so (removal of HB boundaries).
- Optimising information technology, quality improvement systems, patient involvement, education and embracing innovative approaches to healthcare will all be essential to achieve high levels of service quality in a sustainable way.

2.4.14 To deliver the principles of the new clinical model, care will be delivered differently and at different locations. This will require a number of infrastructure and technology projects as well as service change projects to be established including this business case for a **Radiotherapy Satellite Centre** to provide radiotherapy treatment for approximately 20% of patients (provided by 2 new linear accelerators).

Figure 2-3: Current & Future Activity



2.4.15 This means better access for patients, reduced travel for patients, associated improved outcomes, and less use of transport services. This will mean that fewer patients need to travel to VCC for their radiotherapy. These Benefits are the focus of this business case.

Preferred Operational Model

2.4.16 The TCS Programme undertook an appraisal of a wide range of operational delivery models for all its services and as outlined in the OBC after evaluation (financial and non-financial).

The preferred operating scenario was:

Table 2-2: Preferred Operating Scenario

Radiotherapy Service	5 days a week, 9.5 hours a day at both nVCC and RSC 7-day Radiotherapy service for emergency patients and for urgent palliative patients who are treated at VCC

2.4.17 Following the determination of the clinical model and the preferred operating model it was necessary to determine an appropriate location for the satellite centre.

Process for Identifying a Preferred Site

2.4.18 In 2017 a process was undertaken with HBs and CHCs to determine a preferred location for Velindre's Radiotherapy Satellite Centre. Full details of the process were included in the OBC.

2.4.19 The Evaluation Panel, comprising HB, Trust and CHC representatives:

- Approved the evaluation report;
- Approved the key findings and results outlined within the report;
- Approved the 'preferred' site location option to host the Radiotherapy Satellite Centre as being Nevill Hall Hospital (site 8) based upon the analysis presented.

2.4.20 This FBC is based on this Site Selection Evaluation as set down by the Joint Leadership Team at the IIB Meeting 24 July 2019 and the Projects response to the Welsh Government approval letter to proceed dated 28th November 2019.

Project Partnering Arrangements

2.4.21 Following the selection of ABUHB as the site for the RSC the 2 organizations developed project partnering arrangements where both organsiations will develop and operate the RSC as a partnership with clearly defined roles and responsibilities for each organization within the partnership agreement.

2.4.22 ABUHB will build and provide the landlord services and facilities for the RSC building.

2.4.23 VUNHST will provide the clinical services and own the associated clinical equipment within the RSC.

2.5 Strategic Policy Context

2.5.1 This section of the Full Business Case (FBC) summarises the strategic context for the Radiotherapy Satellite Centre (RSC) Project.

Strategic Context in Wales

2.5.2 The Welsh Government has published a wide range of national strategies which provide the framework for the planning and delivery of public services in Wales. These are supported by a range of policies, frameworks and guidance which relate more specifically to health and social care.

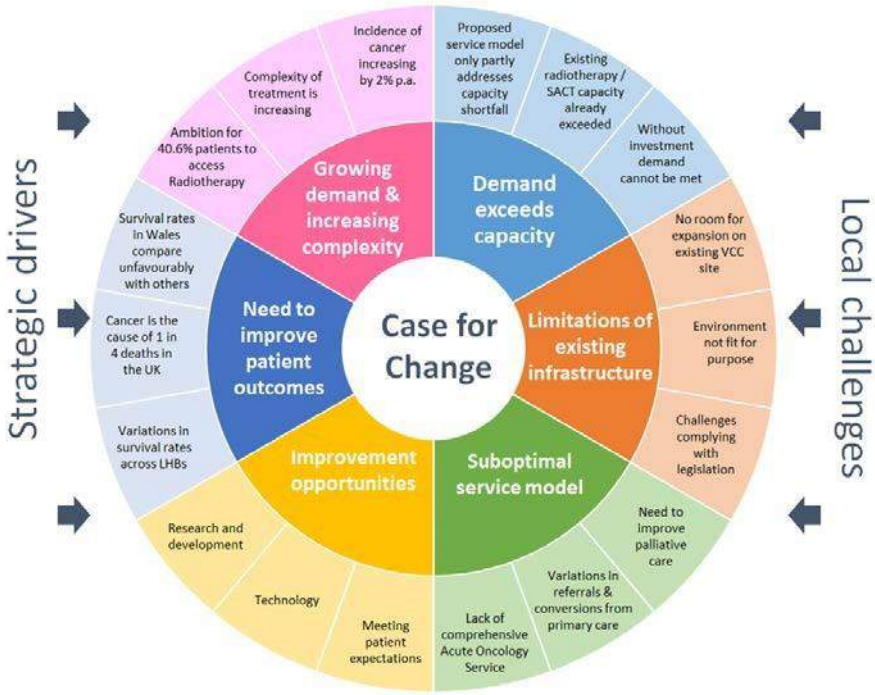
2.5.3 In addition, the TCS Programme and its partner organisation continually scans the environment at a population, national, regional and local level to develop our knowledge and intelligence on key issues which we need to take account of in the strategic planning and delivery of services.

2.5.4 The TCS Programme Business Case (PBC) outlines the strategic context for the Transforming Cancer Services Programme and describes how the Programme is central to VUNHST's ability to deliver key national and local strategic objectives, especially in relation to those outlined in the following strategic documents:

- Well-being of Future Generations (Wales) Act (2015)
- A Healthier Wales: Our Plan for Health and Social Care
- Prudent Healthcare: Securing Health and Well-being for Future Generations
- Together for Health – Cancer Delivery Plan
- The Velindre University NHS Trust Cancer Strategy; and
- Velindre Cancer Centre Strategy for Radiotherapy

Note: It has been agreed with commissioners, through the collaborative scrutiny process, that the PBC is extant and for contextual understanding only. However, the PBC will remain a 'live' document which will be updated at key milestones in the Programme and is currently being updated.

Figure 2-4: Strategic Drivers and Local Challenges



2.5.5 Clinical outcomes for cancer patients in Wales compare unfavourably with other countries.

National context. The Quality Statement for Cancer in Wales

2.5.6 Clinical outcomes for cancer patients in Wales compare unfavourably with other countries.

2.5.7 The Welsh Government's Quality Statement for cancer builds on the work of the 2012 and 2016 Cancer Delivery Plans. Published in March 2021 it describes a five year phase of cancer service development, which must take advantage of the widespread consensus that has emerged on priority areas, bring programmes to fruition, and maintaining the national leadership and local engagement that has been achieved. This will ensure that there is a long-term and consistent approach to improving outcomes as envisaged in the Wellbeing of Future Generations Act and demonstrated by international experience.

2.5.8 This statement discusses how over the past decade, cancers have been one of the most common causes of death in Wales and this is likely to remain so in the decades ahead due to the ageing nature of the population. It is vital that cancer is effectively prevented where possible, that cases of cancer are detected at earlier more treatable stages, and that complex treatment pathways are optimised; while throughout people are properly supported and co-produce their care. Ultimately, the aim is to improve population survival and reduce cancer mortality rates.

2.5.9 Quality attributes of cancer services in Wales are based around the following themes:

Equitable
Equity of access and consistency in standards of care. A workforce planned to meet forecasted demand.

Safe
System level focus on recovery to pre-pandemic waiting list volume. More resilient regional services.

Effective
More cases of cancer are detected at earlier, more treatable stages through more timely access to diagnostic investigations.

Evidence-based surgical techniques, radiotherapies, systemic anti-cancer therapies and genomic therapies are routinely available. All eligible patients are offered access to research trials and Wales provides excellent supporting infrastructure for cancer research.

Efficient
Clinicians working in cancer pathways work at the top of their license or are supported to improve their skill mix and are also enabled to take part in the quality assurance cycle and research activity

Person centred
Person-centred cancer care is culturally embedded and supported by a common approach to assessing and managing people's Needs.

Timely
Cancer services are measured and held accountable using metrics that reflect the quality of patient care and its outcomes. Timeliness of cancer pathways is measured across their entire length, beyond first definitive treatment and including recurrent disease

2.5.10 All the HBs within SE Wales, and within the remit of this business case, along with VUHNST have used these pillars as the basis for their plans for cancer services to meet the needs of their local population .

Local Strategic Context in VUNHST and ABUHB

2.5.11 As mentioned above both VUNHST and ABHB have Cancer Strategies and delivery plans for cancer services which have shared ambitions.

2.5.12 ABUHB Cancer Strategy *Cancer Services: Delivering a Vision 2020-2025* has the following ambition:

Figure 2-6: ABUHB Vision

ABUHB Vision:
Improve prevention, optimise treatments, patient outcomes and reduce health inequalities for our population and those we serve.

2.5.13 Velindre is currently developing a strategy for the Trust which will set out a mission, vision, and strategic goals between now and 2032.

'*Destination 2032: Helping Us to Deliver Our Strategy for the Next Decade*' sets the following vision for cancer services for the next ten years:

Figure 2-7: VUNHST Vision – Healthy People, Excellent care, Inspirational learning is set out in three areas:

VUNHST Vision Statement:

Healthy People:

We will be an organisation that support s people in being as healthy as possible (mind and body), given their situation in life. By people we mean staff, donors, patients, and the communities we serve

Excellent care:

We will be an organisation that delivers clinical services of the highest quality, safety, and experience with outcomes that compare favourably with those of our national and international peers; is highly regarded by the people we work for and with; exceed expectations and attracts the best people to come and work for us.

Inspirational Learning:

We will be an organisation that develops the culture, facilities and Learning partnerships that provides first class research, development and innovation to thrive and drive up the quality of care; learning opportunities for all our staff, patients, families and donors

2.5.14 At the heart of the TCS Programme is the delivery of a patient centred service model that will allow Commissioners to provide sufficient capacity to deal with growing and changing demand for services, whilst improving clinical outcomes for the population of South East Wales.

2.5.15 ABUHB Cancer Strategy: *Cancer Services: Delivering a Vision 2020-2025* affirms the HB's commitment to continue to deliver the best possible care and support for everyone affected by cancer and sets out its ambition to be an exemplar in its delivery of cancer services. The ABUBH's Cancer Strategy and the HBs plans for Nevill Hall Hospital (NHH) include the development of the RSC as a key driver to deliver its ambitions. In the HB's plan the RSC at NHH will operate alongside key other cancer services including local SACT treatments, Acute Oncology Services (AOS) and specialist palliative care.

2.5.16 This FBC will provide the case for the RSC to support the existing, and in due course new, Velindre Cancer Centre in its provision of Radiotherapy services for the population of South East Wales. The nVCC will provide a hub to deliver the many of specialist non-surgical cancer services for South East Wales but with radiotherapy services closer to home for a proportion of the catchment population delivered via a Satellite Centre. As such it is critical to the delivery of the overall TCS Programme and is therefore aligned to the wider healthcare strategic context, at both a local and national level.

2.6 Existing Arrangements Radiotherapy

2.6.1 The purpose of this section of the business case is to describe the current service delivery arrangements for the services covered within the scope of the RSC Project;

Service Delivery Arrangements, including equipment

2.6.2 VUNHST delivers specialist non-surgical cancer services, including Radiotherapy to a catchment population of 1.5million people using a hub and spoke service model. For some specialist Radiotherapy treatments the catchment population is all of Wales.

2.6.3 Services are currently provided across South East Wales from one of two main treatment locations:

- **Velindre Cancer Centre:** The hub of the Trust's specialist cancer services is a specialist treatment, training, research, and development Centre for non-surgical oncology; and
- **Outreach Centres:** outpatient and SACT treatments are delivered on an outreach basis within facilities across South East Wales, including District General Hospitals and from patients' own homes.

2.6.4 Currently all radiotherapy treatments are provided at VCC hub**.**

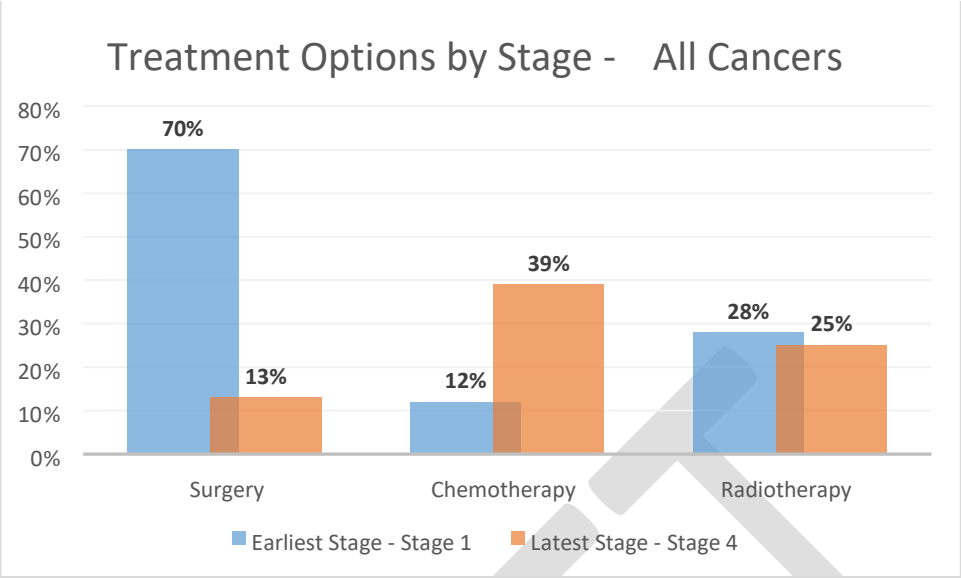
2.6.5 Radiotherapy plays a vital role in the treatment of cancers with:

- 40% of all patients cured of cancer are cured by radiotherapy
- It also can offer patients the choice of organ preservation and avoid the need for major or disfiguring surgery.

2.6.6 With rapid developments in the technology the role of Radiotherapy continues to expand in the treatment of cancers.

2.6.7 Radiotherapy is a flexible treatment modality which is used with a curative or palliative intent, at a consistent rate, regardless of cancer staging as shown by the following graph:

Figure 2.8: Treatment Options by Stage



2.6.8 The current radiotherapy department is based on a single site at the Velindre Cancer Centre (VCC) with a full range of radiotherapy facilities and equipment to deliver the service:

2.6.9 Recent years has seen an increase in the complexity of linear accelerators which impacts on repair, QA and maintenance time to safeguard the reliability and high accuracy of the machines, which is particularly important given the increasing trend of higher doses over less fractions.

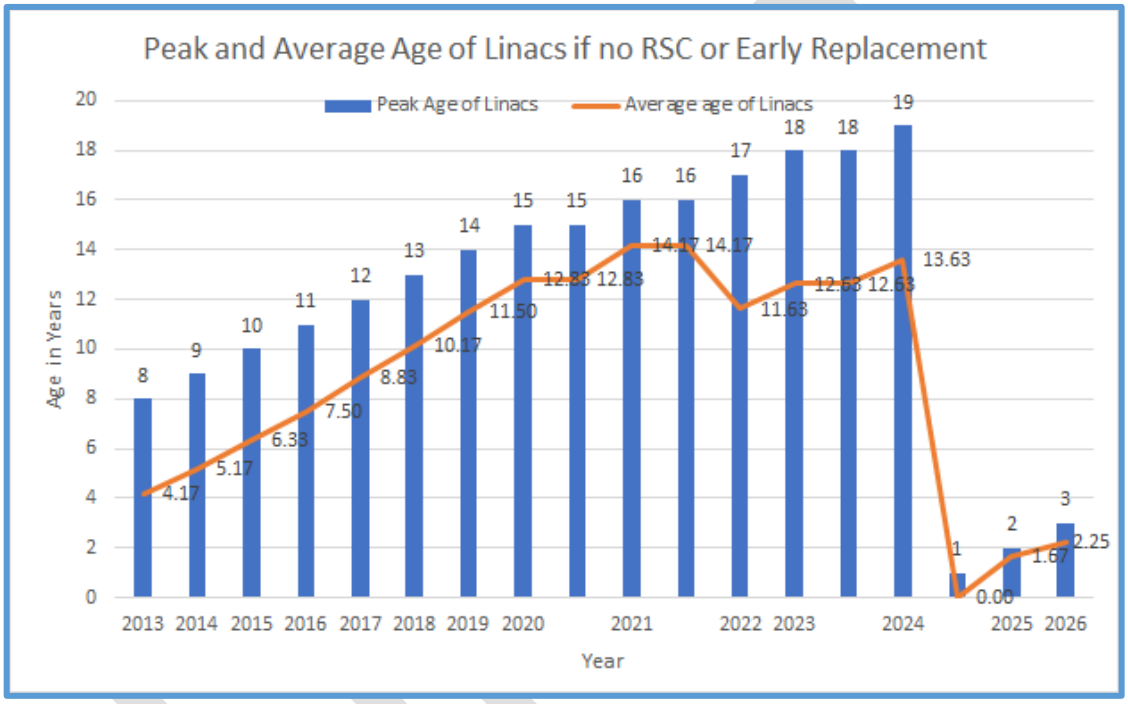
2.6.10 The life expectancy of a Linear Accelerator (LINAC) is 10 years and it is important that the linacs are fit for purpose and not beyond their life expectancy which leads to increased risks about breakdowns and failures, which in turn affects the sustainability of a safe and reliable radiotherapy service.

2.6.11 The LINACs at VCC are ageing with an average age of 11.6 as at 2022; with a peak age of 17 years which is well beyond the expected lifespan. The table below show the aging profile of machines at VCC and four of the Trust's treatment machines being considerably over they recommended life in 2023. Should the RSC not go ahead as planned, and no early procurement of treatment machines approved, the situation at Velindre Cancer would worsen.

Table 2-3: Aging Profile of Machines at VCC

Planning Scenario - No Early Replacement of Linacs - wait for RSC 2023 and nVCC 2024 as previosly planned

		Location	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020		2021		2022	2023		2024		2025	2026
																		Transition YR		Transition YR			Transition YR		Transition YR			
LA10	Std	RSC																						0	1	1	2	3
LA9	Std	RSC																						0	1	1	2	3
LA8	Std	VCC							0	1	2	3	4	5	6	7	8	9	9	10	10	11	12	12	13	0	1	2
LA7	Std	VCC						0	1	2	3	4	5	6	7	8	9	10	10	11	11	12	13	13	14	0	1	2
LA6	Std	VCC	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	15	16	16	17	18			0	1	2
LA5	Std	VCC								0	1	2	3	4	5	6	7	8	8	9	9	10	11	11	12	0	1	2
LA4	Stereo	VCC										0	1	2	3	4	5	6	6	7	7	8	9	9	10	0	1	2
LA3	Std	VCC			0	1	2	3	4	5	6	7	8	9	10	11	12	13	13	14	14	15	16			0	1	2
LA2	Stereo	VCC												0	1	2	3	4	4	5	5	6	7	7	8	0	1	2
LA1	Std	VCC				0	1	2	3	4	5	6	7	8	9	10	11	12	12	13	13	14	15	15	16	0	1	2
Total											6	7	7	8	8	8	8	8	8	8	8	8	8	8	8	10	10	10
Avg Age											4.17	4.43	5.43	5.63	6.63	7.625	8.625	9.625	9.625	10.625	10.625	11.625	12.625	8.375	9.375	0.2	1.2	2.2
Peak Age											8	9	10	11	12	13	14	15	15	16	16	17	18	15	16	1	2	3



2.6.12 The RSC is an important development to ensure VUNHST is able to continue to deliver safe and effective Radiotherapy services.

Benchmarking

2.6.13 VUNHST regularly submits data into the Radiotherapy Data Set (RTDS) alongside other Radiotherapy centres in Wales and England. This allow the centre to undertake benchmarking against other centres in areas of operational efficiency.

2.6.14 In addition as part of the development of TCS programme we have taken the opportunity to benchmark the efficiency of our service.

2.6.15 Benchmarking exercises were undertaken during recent years with a number of leading Cancer Centres from across the UK including:

- The Beatson West of Scotland Cancer Centre;

- The Clatterbridge Cancer Centre NHS Foundation Trust;
- Leeds Teaching Hospital NHS Trust; and
- The Royal Marsden NHS Foundation Trust.

2.6.16 These benchmarking exercises indicated that VUNHST compares favourably with other UK Radiotherapy centres in respect of throughout and efficiency and, therefore, additional capacity cannot be fulfilled by improved efficiency with the current service.

2.7 Business Needs

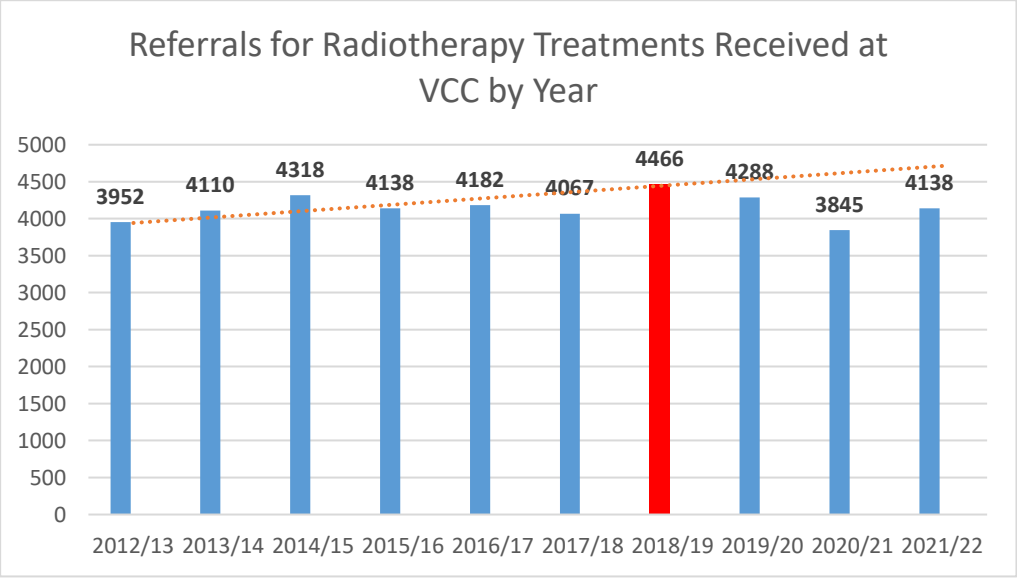
2.7.1 This section will review the clinical growth assumptions and demonstrate that additional capacity is required to meet the forecast increases in demand for Radiotherapy.

2.7.2 Earlier sections outlined the role radiotherapy plays in the treatment of cancers. Regardless of the future delivery of systematically more rapid diagnosis, increased screening capacity and public health initiatives, radiotherapy will remain a valid and effective clinical option for the treatment of a large proportion of all patients with cancer.

2.7.3 There are challenges inherent in attempting to forecast future demand for radiotherapy services given changes in clinical indications, incidence and changing treatment complexity. The TCS Programme has developed clinical growth assumptions which in turn have informed the development of this Full Business Case. TCS assumptions estimate that demand for radiotherapy services in south-east Wales will increase at a rate of 2% per annum to 2030/31.

2.7.4 It is apparent that demand for specialist cancer treatment is increasing. This demand is represented in the most immediate sense by the receipt of increasing numbers of patient referrals. Such an increase has been observed by the radiotherapy service at Velindre Cancer Centre in recent years.

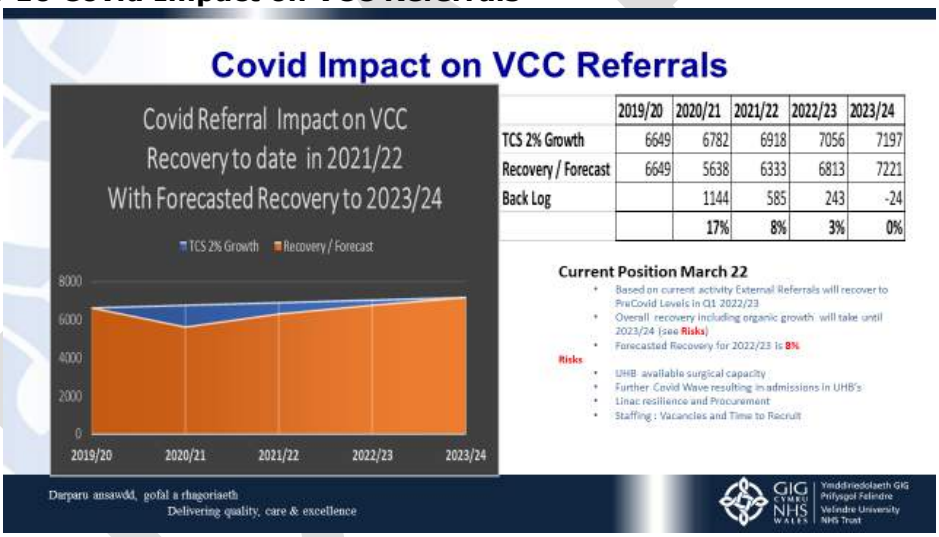
Figure 2-9: Referrals for Radiotherapy Treatments



2.7.5 The graph above details the number of individual patient referrals for treatment with radiotherapy received at Velindre Cancer Centre from 2012/13 to 2021/22, inclusive. The dotted line overlaid on the graph describes an increase in referrals of 2% per annum from a base in 2012/13. Although there are year on year fluctuations, the graph serves to illustrate that the actual historical growth in referrals has been in step with the 2% clinical growth assumption for radiotherapy within TCS plans.

2.7.6 Prior to the pandemic 2018/19 represented the largest number of referrals (4466) received for the radiotherapy treatment at Velindre Cancer Centre in any given year. This follows an earlier peak in 2014/15 (4,318 referrals). Referrals to Velindre Cancer Centre, including Radiotherapy, were impacted by covid in 2020-2022. There was a reduction in referrals in the early days of Covid pandemic but the typical month on month referrals have since increased, subject to periodic Covid related fluctuations, and are currently marginally above pre pandemic levels. This is assumed to be due to the well documented backlog in cancer activity that is currently being experienced. Following the pandemic, it is expected that these growth levels will again be seen in radiotherapy. Such marked increases in demand present stark capacity challenges which will become more acute as the clinical growth assumption underpinning the TCS Programme materialise.

Figure 2-10 Covid Impact on VCC Referrals



2.7.7 However, as shown in Figure 2-10 above the original TCS assumptions of 2% average increase in referrals per annum have been assessed as still relevant in projecting capacity requirements.

2.7.8 Following the pandemic it is expected that these growth levels will again be seen in radiotherapy. Such marked increases in demand present stark capacity challenges which will become more acute as the clinical growth assumption underpinning the TCS Programme materialise.

2.7.9 There are a number of factors that influence the demand for Radiotherapy including:

1) Increasing incidence of cancer

It is recognised that the rate of cancer incidence in the United Kingdom and Welsh populations has been increasing over time. Cancer incidence in the United Kingdom increased by 12% between the early 1990s and the late 2010s and is expected to increase by a further 40% by 2035. This would represent 514,000 new cases of cancer in the United Kingdom compared to the 359,960 reported in 2015. Within Wales it is forecast incidence will increase by 2% pa over the next 10 years.

As mentioned earlier in this case the Wales Cancer Quality Statement has a focus on earlier detection and diagnosis of cancer. These patients will then require treatments including Radiotherapy. It is also likely to shift the balance towards a higher number of radical treatments as cancers get detected earlier.

2) Increasing population

The increased rate of incidence is driven, in part, by the fact that the population is growing and ageing. Welsh Government's most recent *Future Trends Report* forecasts that the population of Wales will increase by 5% between the mid2010s and the mid-2030s. Although population level estimates of future changes in incidence take some account of forecast changes in population level and demographic, the anticipated increase to the population of certain areas in south-east Wales in the coming decades are marked. For example local authority population projections, prepared by *Statistics for Wales* on behalf of Welsh Government in 2016, indicate that the population of Newport will increase by approximately 12,000 by 2039 and that of Cardiff will be 26% larger in 2019 than in 2014, an increase which would represent more than 90,000 extra residents.

It is acknowledged that cancer incidence is higher among the over 65s and the same report predicts that the overall proportion of the Welsh population aged 65 and over will increase from 20% to 25% over the same period.

3) Increasing complexity of treatments

New techniques and developments are impacting on cancer treatments, Including radiotherapy.

New techniques in the planning and delivery of Radiotherapy are improving accuracy of treatments for example to avoid critical organs which helps reduce long term side effects which can be debilitating, but also improves survival. Developments continue to lead to growth in complexity and create an increase demand on resources including pre-treatment and treatment capacity, increased time to plan, treat and an increase in the rate of re-planning.

One new technique is hypo fractionation which involves high volumes but over shorter fractionation regimes. Whilst this enables fewer visits

by patients it requires an increase in accuracy and specification of planning and dosimetric delivery of treatments. This demands more high quality treatment planning but also longer set up time and imaging at the time of treatments. Thus it is predicted that the throughput of treatments per hour will reduce. These, together with the commensurate increase for Quality assurance checking to ensure treatments are delivered in an optimum and safe manner, are having an impact on demand for radiotherapy.

Another example of developments is in chemo radiation with the potential for combination drug therapies that may provide opportunity for enhanced update of radiation by cancer cells or to protect healthy tissues during Radiotherapy.

4) Current uptake levels of RT

Analysis of the update rates of Radiotherapy in Wales show it to be about 37% against best practice of approximately 41% which suggest there are people in Wales who could benefit from Radiotherapy that are not currently receiving it.

It is acknowledged that the proximity of the population to specialist services assist in ensuring greater access and uptake of these services. There is evidence that the uptake of RT treatment by patients diminishes with the distance travelled by patients to reach radiotherapy centres. The provision of a satellite will provide improved access to patients as their travel time will be reduced. The Royal College of Radiologists indicate a journey time of less than 45 minutes is appropriate

Previous work analysing potential sites has shown that a satellite centre will improve the number of patients who live within 45 minute drive of a radiotherapy treatment centre in SE Wales. As the population ages to this should ensure that as many patients as possible can access the relevant treatments. Therefore, it is anticipated that a Radiotherapy satellite centre in South East Wales will also lead to an increase in the update of Radiotherapy treatments.

5) Rapid developments in techniques

Velindre Cancer Centre has always had an excellent reputation for delivering high quality radiotherapy to it patients. It has been instrumental in delivering practice changing clinical research and has always been an early adopter of new technologies such as IMRT and stereotactic radiotherapy. The pace of innovation, clinical and technological change and complexity in cancer services is rapid. It is important that the radiotherapy service at Velindre Cancer Centre be at the forefront of cancer treatment, delivering a range of high quality, people centred services, which can benefit the Welsh population, whilst balancing innovation and research with accurate, timely, effective, efficient use of resources.

2.7.10 Within these demand increases it is projected that the most prevalent tumour types will remain as now. In 2035, approximately a third of all cancers reported in men are anticipated to be cancers of the prostate and a similar proportion of all cancers reported in women will be cancers of the breast.

2.7.11 These drivers and demographic developments strongly indicate that over the coming years the demand for RT will continue to rise and require sufficient and resilient capacity to be made available. The need for this increased capacity for Radiotherapy services in South East Wales is shown in graphs below and it is this which underpins the development of this FBC.

Figure 2-11: Radiotherapy Activity

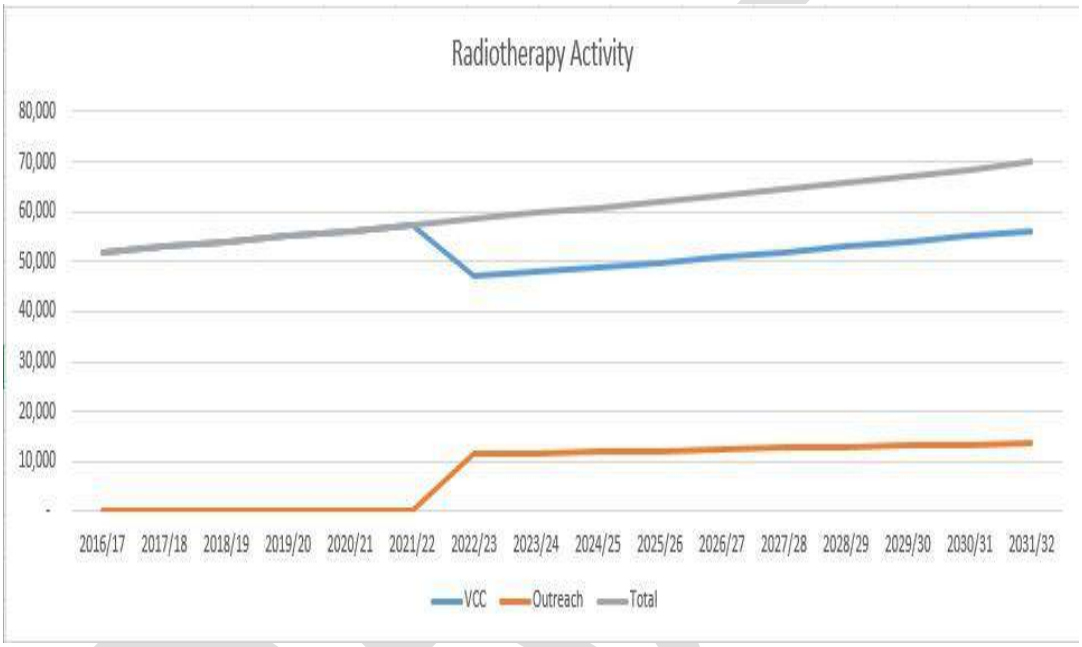
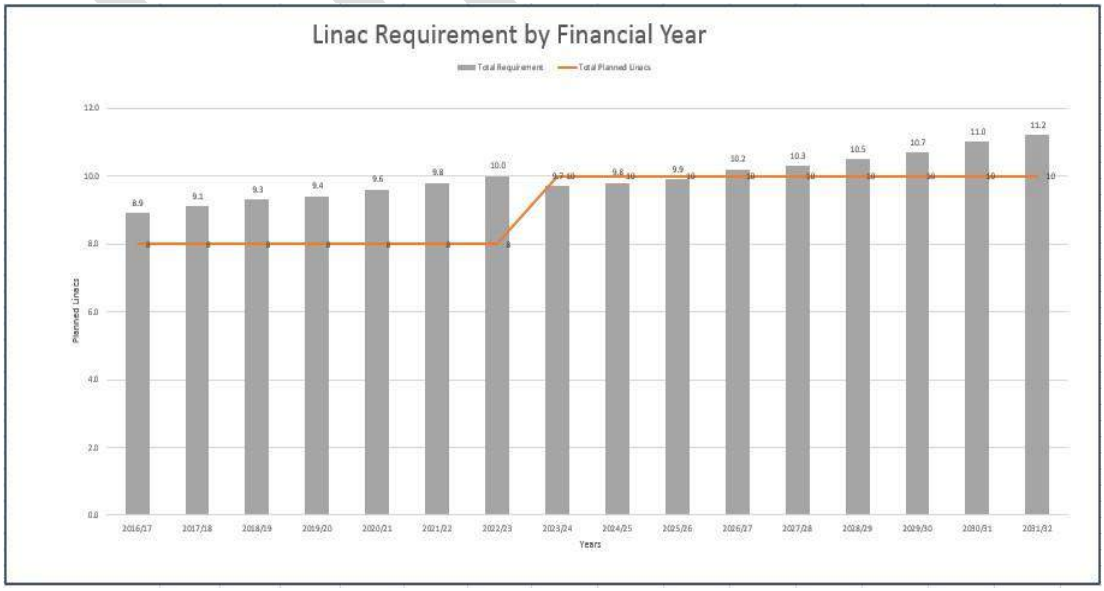


Figure 2-12: Linac Requirement by Financial Year



2.7.12 In summary the key drivers for the drivers for a RSC are:

- Improve access rates for Radiotherapy treatments, as rates are low in Wales compared to best practice and 50% of all cancer patients will benefit from receiving radiotherapy as part of their cancer management and in 40% of cases it contributes to a cure.
- Currently there is a poor patient experience for patients who travel significant distance for radiotherapy, often every weekday for many weeks.
- A RSC will contribute to the National policy: Healthier Wales –as it delivers care at home/locally where possible
- This type of networked model is used by leading cancer centres around the world delivering good outcomes
- Both Organisations are keen to increase access to research and trials and it is planned that local access to radiotherapy will increase availability and update of Radiotherapy trials

2.8 Key Radiotherapy Service and Capacity Requirements

2.8.1 The purpose of this section is to:

- Summarise the methodology which has been applied for forecasting future capacity requirements of South East Wales Cancer Services;
- Provide an overview of the service and capacity requirements and functional requirements; and the Major Medical equipment requirements.

2.8.2 It is important to highlight the relationship between the nVCC FBC, IRS FBC and the RSC FBC in terms of whole system capacity and delivery.

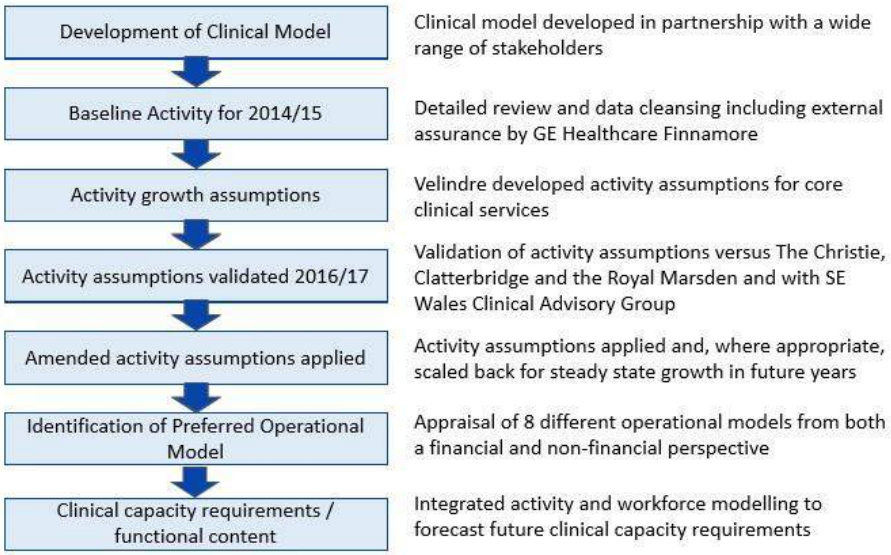
Modelling Future Capacity Requirements

2.8.3 The TCS Programme has developed a comprehensive activity model to forecast future capacity requirements for as set down in the nVCC OBC South East Wales Cancer Services. 2016/17 was been used as the baseline activity year for the model. The 2016/17 data set was been subject to rigorous review, including external validation, to ensure the accuracy of the data.

2.8.4 The functionality of the model has been subjected to quality assurance tests by the Trust's Technical Advisors, by GE Healthcare Finnamore and by the TCS Programme Team.

2.8.5 A summary of the process followed in forecasting future capacity requirements is shown in Figure 2-13.

Figure 2-13: Methodology for Forecasting Future Capacity Requirements



Clinical Growth Assumptions

2.8.6 The TCS Programme has developed a set of clinical growth assumptions for its core services. These clinical growth assumptions have been developed in partnership with clinical colleagues from across South East Wales and are informed by cancer incidence projections provided by the Welsh Cancer Intelligence and Surveillance Unit (WCISU).

2.8.7 The assumptions, following the availability and validation of 2016/17 activity data, have been reviewed by the VCC Senior Management Team and by the VCC service and clinical leads respectively. The main output of this review was a reduction in assumed growth rate for Radiotherapy from 4% to 2% between 2016/17 and 2030/31.

2.8.8 The clinical growth assumptions have been approved by the TCS Programme Management Board and by the TCS Programme Clinical Advisory Board and also reviewed in light of most recent activity.

Table 2-4: Clinical Growth Assumptions for Radiotherapy Services

Service	Annual Clinical Growth Assumption
	2016/17 – 2030/31
Radiotherapy	2%

2.8.9 In addition a validation exercise has been undertaken to compare the Trust's clinical growth assumptions against the following Cancer Centres from across the UK.

- The Beatson West of Scotland Cancer Centre;
- The Clatterbridge Cancer Centre NHS Foundation Trust;
- The Christie Cancer NHS Foundation Trust;

- Leeds Teaching Hospital NHS Trust; and
- The Royal Marsden NHS Foundation Trust.

2.8.10 This validation exercise demonstrated that the clinical growth assumptions were in line with those from other Cancer Centres across the UK, where comparable data is available. It can also be that radiotherapy services at Velindre Cancer Centre has observed growth in recent years in keeping with the assumption.

Forecast Capacity Requirements

2.8.11 Following the activity and capacity modelling process outlined above, the TCS Programme has been able to establish its core capacity requirements. For Radiotherapy these equate to 10 Linear Accelerators.

2.8.12 Given the above activity projections, and based on the agreed operating model referred to above the following planning assumptions were developed for the RSC:

- Radiotherapy Satellite with 2 x operational Linacs. However, there is expansion space to support the installation of two more linacs if required in the future.
- 2 x Operational bunkers on day of opening
- On-treatment review and education
- 1 x CT Simulator
- Good effective and integrated radiotherapy and clinical information systems, for example to enable panning and delivery of treatments.

2.8.13 There will be a phased clinical implementation at the RSC:

- Phase 1 – Less complex / high volume tumour sites
- Phase 2 – Transition to a wider range of tumour sites

Table 2-5: Phased Implementation

Initial Activity	Proposed Activity	Exclusions
Breast Prostate & SABR Planned & unplanned Palliative Emergency	Urology Upper & Lower GI Lung & SABR Gynae Lymphoma Head & Neck Thyroid Neuro Electrons Chemo-radiation Research	Stereotactic Paediatrics Superficial (DXR) Brachytherapy TBI Sarcoma Benign Conditions Whole CNS Research (Early Phase)

Research (subject to risk assessment)

2.8.14 To deliver the required service model the RSC will require access to service provided by ABUHB including pharmacy to enable the delivery of chemoradiation treatments and emergency medical cover. An SLA has been established for the delivery of these.

Workforce

2.8.15 This section of the FBC sets out the Workforce requirements for the Radiotherapy Satellite Centre (RSC) based at Neville Hall Hospital, Abergavenny**.**

2.8.16 Radiotherapy services are provided by 3 main workforce groups: Consultant clinical oncologists, Radiographers, and medical physicists.

2.8.17 Currently all provisions for Radiation Services and the associated workforce are located at Velindre Cancer Centre, Whitchurch Cardiff.

2.8.18 The Workforce requirements for the RSC are based on the following assumptions:

- Radiotherapy planning and treatment based around 2 linear accelerators
- CT simulator with virtual simulation facilities
- Treatment planning
- Mould room
- On- treatment review clinics
- A range of Clinical cases will be treated at the satellite unit, commencing with Breast and Prostate with additional tumour sites being phased in.

Required Workforce Provision

2.8.19 There are two aspects to the workforce required for this business case:

- Ongoing workforce (revenue) requirements for the delivery of the service once the centre opens.

- The workforce requirements to commission the IRS at the RSC, being procured as a contractual option via the IRS business case, and to commission the other associated equipment for installation into the RSC. This expenditure will be capitalised.

Recurring Revenue Workforce

2.8.20 The Workforce for the Satellite Unit will be provided by both Velindre Cancer Centre and Aneurin Bevan Health Board as identified below:

Service	Health Board Provider	Additional Resource
Radiotherapy Service	Velindre Cancer Centre	Yes
Medical Physics Service	Velindre Cancer Centre	Yes
Facilities	Aneurin Bevan	Yes
Therapies – Physiotherapy, Dietetics, Occupational Therapy, Speech & language Therapists, welfare rights	Aneurin Bevan	No – current pathways to provide service
Medical - Emergency	Aneurin Bevan	No - current pathways to provide service
Clinical Psychology	Aneurin Bevan	No - current pathways to provide service
Pharmacy	Aneurin Bevan	Yes
IT	Aneurin Bevan	Yes

Velindre University NHS Trust Workforce

Radiotherapy and Oncology Services

2.8.21 The workforce requirements below takes into account of the Society of Radiographers Principles of Safe Staffing for Radiotherapy and Oncology Services and the legal obligations to comply with HCPC Standards of Conduct, Performance and Ethics. The workforce is consistent with that approved at the OBC Stage.

Job Role	Expected Banding	WTE
Consultant	Threshold 8	1
Medical Sec	Band 4	1
Senior Leader	Band 8B	1
Consultant Radiographer	Band 8B	1
Advanced Practitioner	Band 7	2
Superintendent Radiographer	Band 8A	1
Senior Therapy Radiographer	Band 7	7
Treatment Radiographer	Band 6	8

Treatment Radiographer	Band 5	5
Radiotherapy Helpers/booking clerk	Band 2	2
Review Assistant	Band 4	1
Total		**31**

Medical Physics and Engineering

2.8.22 The numbers below have taken into recommendations for adequate staffing levels set out by the Institute of Physics and Engineering in Medicine and the expectations services to appoint of the Ionising Radiation Medical Exposure Regulations, 2017 and 2018, collectively referred to as IR(ME)R. The workforce is consistent with that approved at the OBC Stage

Job role	Expected banding	WTE
Consultant Clinical Scientist	Band 8c	1
Clinical Scientist/Medical Physics Expert	Band 8a	3
Linac or computer engineer	Band 7	4
Dosimetrist	Band 6	2
Total		**10**

Aneurin Bevan University Health Board Establishment

Job Title	Band	WTE
Domestics	Band 2	2
Porters	Band 2	1
IT Support	Band 5	0.5
Pharmacy technician	Band 5	0.25
Total		**3.75**

Staffing requirements to commission the capital equipment

2.8.23 The commissioning costs for the key equipment for RSC is outlined in the IRS FBC which shows a requirement for the RSC for 9 posts with a financial value of £539k.

2.8.24 ***Appendix 1*** provides full details of the resources identified within the IRS business case for the commissioning process.

2.8.25 Some of the posts identified in the IRS Commissioning Plan for the commissioning of the IRS at both Phases 1 and 2 will cease their commissioning role when the RSC service becomes operational and transfer into posts delivering the clinical service operationally at the RSC. To ensure an accurate interface of revenue and capital costs, the integrated workforce plan has fully identified at a post level the commissioning and operational requirements and the relationship between them. This detailed work has ensured that the commissioning workforce, and their associated costs, have been excluded from the advance recruitment revenue costs that commissioners have agreed to support (with a lead recruitment time of 4.5. months).

Delivering the staffing requirements

2.8.26 Both ABUHB and VUNHST have People Strategies which will provide the framework to deliver the staffing requirements outlined above. Velindre University NHS Trust, which will provide significant majority of the staff for this unit, has a People Strategy that will bring our workforce through to 2032 with the overall mission for people employed by the Trust to be healthy, delivering great care and growing through inspirational learning. The strategy focuses on:

> **Skilled and Developed People:** an employer of choice for staff already employed by us, starting their career in the NHS, or looking for a role that will fulfil their professional ambitions and meet their personal aspirations
>
> **Planned and Sustained People:** having the right people with the right values, behaviours, knowledge, skills, and confidence to deliver evidence-based care and support patient and donor wellbeing.
>
> **Healthy and Engaged People:** Within a culture of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language, and cultural identity

2.8.27 Given that the workforce groups involved in delivering radiotherapy are challenging disciplines to recruit into in the current market, the delivery of the recruitment plan is key to manage this risk. The clinical service has developed an integrated workforce plan, based on the strategy mentioned above, to capture the key drivers increasing demand for the workforce (including the IRS Implementation Plan) that maps out the workforce requirements over the transition and implementation periods, considering the interdependencies of ongoing programmes of work. The integrated workforce plan will not remain static and will be a live document updated on an ongoing basis as activities are delivered and the implementation matures. In addition, in order to manage the recruitment risk to the IRS and RSC Projects, and the critical nature of radiotherapy services in treating cancer, the Trust has recruited a number of key posts at risk.

2.8.28 Workforce growth will be phased in the following way:

- A first wave of recruitment (at Trust Risk) has commenced and is ongoing.
- Radiation Services will develop a further recruitment attraction campaign for prospective candidates to fill expanding establishment.
- A second wave of recruitment is currently being planned.
- Campaigns for a third wave of additional posts will begin in 2023 giving adequate time for advertising, recruitment, and on-boarding processes.
- Lead in time for appointment to posts will be 4.5 months prior to the Satellite Unit opening to allow for training and embedding into the service.

2.9 Spending Objectives

2.9.1 The purpose of this section is to outline the Spending Objectives for the RSC Project. The Project Spending Objectives (PSOs) provide a basis for appraising potential options and for post-project evaluation.

Project Spending Objectives

2.9.2 The following RSC PSOs were developed in partnership at a stakeholder workshop, which was attended by representatives with a broad range of service views. In presenting the RSC PSOs it is important to emphasise that:

- The scope of the FBC is limited to the development of the RSC to support the existing, and in the future, a new VCC; and
- The FBC for the RSC will focus on the additional infrastructure costs directly attributable to the RSC and the variable clinical and facilitate costs that result of a step up in radiotherapy capacity to meet modelled demand.

Table 2-6: Project Spending Objectives

Project Spending Objective	Description
Project Spending Objective 1	To provide access to **quality** and **safe** radiotherapy services that optimises patient **outcomes.**
Project Spending Objective 2	To provide sufficient **capacity** to meet future **demand** for services.
Project Spending Objective 3	To **improve patient, carer** and **staff experience.**
Project Spending Objective 4	To provide **capacity** and **facilities** to support the delivery of high quality **education**, **research**, **technology** and **innovation.**

2.9.3 The PSOs were approved by the RSC Project Board who provided assurance to the Health Board and Trust Board that they were:

- Aligned with the national context for healthcare developments in Wales;
- An alignment with the TCS Programme;
- Aligned with the scope and strategic context of the nVCC Project;
- Specific, measurable, achievable relevant and time-constrained (SMART); and
- Focused on business needs and vital outcomes rather than potential solutions.

Performance Metrics

2.9.4 To support the delivery of these objectives a number of key performance metrics have been developed and mapped against the five drivers for investment outlined within the Welsh Governments Business Case guidance.

Table 2-7: nVCC FBC Project Spending Objectives – Key Performance Metrics

Project Spending Objective	Performance Metrics
PSO1 - To provide access to **quality** and **safe** radiotherapy services that optimise patient **outcomes**	• Percentage compliance with Health Building Notes • Compliance assessment against BREAM • Percentage assessment against WHTM Estate Code (Category A Condition of Buildings) • PROM outcome measures • Access rate to Radiotherapy treatments
PSO2 – To provide sufficient **capacity** to meet future **demand** for services	• Waiting times (reported by HBs) against the Suspected Cancer Pathway targets • Compliance against the COSC quality measures (once formally introduced) • Percentage utilisation of equipment / accommodation: • Linear accelerator utilisation of non-clinical accommodation utilisation
PSO3 – To **improve patient, carer,** and **staff experience**	• Percentage of patients rating their experience as excellent • Percentage staff satisfaction • Percentage recruitment of workforce • Percentage retention of workforce •REM measures •Reduced travel times for patients and carers with resultant better experience and reduction in carbon footprint
PSO4 - To provide **capacity** and **facilities** to support the delivery of high-quality **education**, **research**, **technology,** and **innovation**	• Percentage of patients who have the opportunity to participate in clinical radiotherapy research trials • Percentage of patients for each cancer site entered into radiotherapy clinical trials each year Increased integrated and cross organisation • MDT learning and education

2.10 Scope of the Radiotherapy Satellite Centre Project

2.10.1 As previously described the scope of the Project is limited to the building of an RSC and the following is outside of the scope of the RSC Infrastructure Project:

- All other variable clinical costs of modelled demand growth (excluding radiotherapy which is included within the FBC) which will be considered through the commissioning LTA framework and, therefore, excluded from the RSC FBC;
- All other service development Projects e.g. Rehabilitation which will be subject to separate Business Cases and therefore excluded from the RSC FBC;
- All other outreach capital Projects e.g. SACT services, which will be subject to separate Business Cases and therefore excluded from the RSC FBC; and
- All Digital Projects which the Trust needs to complete irrespective of the RSC Project. These will be the subject of separate Business Cases.

Potential Business Case Options

2.10.2 The scope of the Project is well defined. There are two potential options for delivering the objectives of the Project apart from the Status Quo:

- Do Nothing;
- Option 1: 10 Linear Accelerators at Nvcc
- Option 2: 8 Linear Accelerators at Nvcc and 2 Linear Accelerators within the RSC.

2.10.3 As outlined earlier, the location of the RSC has been previously determined through an independently led options appraisal.

Capacity and Functional Requirements

2.10.4 As outlined earlier the activity and capacity analysis has demonstrated the following Functional Content requirements is 10 linacs i.e. 2 additional linacs from current levels and when compared to the planned Nvcc.

2.11 Project Risks, Constraints, Dependencies and Assumptions

Risks

2.11.1 Identifying, mitigating, and managing the key risks is crucial to successful delivery. Without effective management of the key risks, it is likely that the Project would not deliver its intended outcomes and benefits within the anticipated timescales and spend.

2.11.2 A full risk register for the RSC Project has been developed which includes the following categories:

Business risks: Risks that remain 100% with the Health Board and Trust and include political and reputational risks,
Service risks: Risks associated with the design and build and operational phases of the Project and may be shared with other organisations; and

External Non-System risks: Risks that affect all society and are not connected directly with the proposal. They are inherently unpredictable and random in nature.

2.11.3 The RSC risk register, which is attached at ***Appendix 2,*** is managed by the Project Team. The role of the Project Team in managing risks is described within the Management Case.

Constraints

2.11.4 The main constraints in relation to the RSC Project are outlined below in Table 2-8:

Table 2-8: Main Constraints of the RSC Project

Constraint	Overview
Financial Constraints	The infrastructure solution for the RSC must be deliverable within the (including VAT but excluding equipment) capital funding agreed with the Welsh Government and the revenue resources agreed with Commissioners.
Timescale Constraints	The RSC must be operational in line with the Programme requirements and as agreed with the Welsh Government.
Service Continuity	Delivery of patient services must be maintained during the period of construction.
Compliance with Statutory Requirements	The RSC must be fully compliant with all relevant statutory compliance requirements.

Dependencies

2.11.5 A number of dependencies have been identified in relation to the RSC Project. These are provided in Table 2-9 below:

Table 2-9: Main Dependencies of the RSC Project

Dependency	Overview
Capital Funding Availability	Access to capital funding is critical to deliver the Project, including the procurement of Major Medical equipment and IM&T and essential Enabling Works.
Revenue Funding Availability	Access to revenue funding is essential to support the recurring revenue implications associated with the RSC Project.

Welsh Government Approval	The Full Business Case must be approved by Commissioners and the Welsh Government.
Partnership Working	Co-production in the design and implementation of the Project that involves all stakeholders is essential to the Project's success.
Wider Health Strategy and Governance	It is important that general health strategy and governance in Wales, that underpins the RSC Project remains broadly consistent over the period of change.

Assumptions

2.11.6 The key assumptions underpinning the RSC Project are provided in Table 2-10 below:

Table 2-10: Main Assumptions for the RSC Project

Assumption	Overview
Implementation of the wider TCS programme	It is assumed that the following capital Projects identified within the TCS Programme are funded and the RSC has been 'sized' on the basis of this assumption. • VCC (and nVCC) at Whitchurch; and • Non-surgical cancer Outreach centres across South East Wales delivering SACT and Outpatient services.
Clinical Growth Assumptions	The RSC has been 'sized' on the basis of a number of clinical growth assumptions (in conjunction with the nVCC OBC), summarised below:
Assumption	**Overview**
	• Radiotherapy activity will increase by 2% per annum through to 2031

Flexibility for Expansion on the Site of the Radiotherapy Satellite Centre

2.11.7 It is important to highlight that there is planned expansion space (equivalent to accommodation for 2 additional linear accelerators plus supporting equipment etc.) on the identified site for the RSC. This expansion capacity is important to the TCS Programme Risk Management Strategy in the event that the clinical growth assumptions prove to be understated.

2.12 Conclusion

2.12.1 The Strategic Case has demonstrated the compelling case for investment to support the development of an RSC. The key factors supporting the case for investment are:

- Demand for Radiotherapy is forecast to increase over the forthcoming years and there is currently insufficient capacity to meet this demand;
- There is no expansion space on the existing Velindre Cancer Centre to, for example, install any additional linear accelerators, which limits the Trust's ability to expand its capacity in response to increasing demand for clinical services,
- Patient access to radiotherapy services in Wales is lower than in the rest of the United Kingdom and location of radiotherapy centres have been identified as a contributing factor; and
- The new Velindre Cancer Centre, has been sized on the basis that an RSC would be delivered in advance of its opening in accordance with the TCS Clinical Model.
- The RSC provides additional radiotherapy service capacity to the patients of South East Wales to meet demand significantly in advance of any other potential service development.

3.0 ECONOMIC CASE

3.1 Introduction

3.1.1 The purpose of the Economic Case in the Full Business Case (FBC) is to revisit the options that were identified as part of the Outline Business Case (OBC) and confirm that the preferred option continues to offer optimum value for public money following the conclusion of the procurement process.

3.1.2 The FBC will confirm that the Preferred Option continues to offer best value for public money by:

- Revisiting the OBC Options to confirm they remain valid and outline any changes.
- Detailing the procurement process and evaluation of Best and Final Offers (BAFOs).
- Confirming the ranking of the options remains unchanged by updating the Economic Appraisal with latest cost and benefit assumptions, including the results of the procurement process.
- Demonstrating the Preferred Option offers best value for money.

3.1.3 The conclusion confirms that the preferred option offers best value for money.

3.2 Revisiting the Options

3.2.1 In line with HM Treasury Green Book and NHS Wales Infrastructure Investment guidance, the Options Framework was used in the OBC to identify and evaluate the long list of options and agree a shortlist of options to evaluate value for money.

Critical Success Factors

3.2.2 This involved agreeing Critical Success Factors (CSFs), which are the attributes essential for successful delivery of the Project. These are outlined in the table below.

Table 3-1 Critical Success Factors

CSF	Description
Strategic fit	• Meets agreed Project Spending Objectives, related business needs and service requirements; and • Provides holistic fit and synergy with other strategies, programmes and projects.
Potential value for money	• Optimises public value (social, economic, environmental) in terms of potential costs, benefits, and risks.
Supplier capacity and capability	• Matches the ability and capacity of potential suppliers to deliver the required services; and • Is likely to be attractive to potential suppliers.
Potential affordability	• Can be funded from available sources of finance; and • Aligns with sourcing constraints.
Potential achievability	• Is likely to be delivered given the Health Board and Trust's and partner organisations' ability to respond to the changes required; • Matches level of available skills required for successful delivery; • Facilitates the continued delivery of services throughout the duration of the project; and • Delivers an operational RSC in line with the Programme agreed with the Welsh Government.

3.2.3 These CSFs were used alongside the Project Spending Objectives (PSOs) to evaluate possible options for the delivery of the Project.

The OBC Longlist Assessment

3.2.4 The Options Framework provides a systematic approach to identifying and filtering a broad range of options for a Project. It was used in the OBC to identify the options for the solution to deliver the Radiotherapy Satellite Centre Project and to conduct the following assessment:

- Assess how well each option meets the PSOs and CSFs
- Identify the main advantages and disadvantages of the option.
- Determine whether the option will be carried forward as either the preferred way forward or a possible solution, or discounted.

3.2.5 The scope of the Project was a fixed point that had already been determined as part of the overall Transforming Cancer Services in South-East Wales (TCS) Programme. Specifically, this involves increasing Radiotherapy capacity in South-East Wales with the implementation of two Radiotherapy treatment machines, in addition to the eight treatment machines currently located at the existing Velindre Cancer Centre (VCC) which are expected to be replaced and relocated to the new Velindre Cancer Centre (nVCC) as part of the Integrated Radiotherapy Solution (IRS) Project.

3.2.6 The options appraisal in the OBC therefore focused on identifying and assessing options for the solution to deliver this. The TCS Programme Delivery Board determined the possible options to be appraised and these are presented in the table below.

Table 3-2 the OBC Options

Ref	Option	Description
1.1	**Do Nothing**	Continue with existing arrangements and retain the current Radiotherapy capacity (8 Radiotherapy treatment machines).
1.2	**Do minimum**	Implement 2 additional Radiotherapy treatment machines at nVCC, with no satellite provision.
1.3	**Intermediate**	Develop a new Radiotherapy Satellite Centre (RSC) at Nevill Hall including 2 Radiotherapy treatment machines.

3.2.7 The advantages and disadvantages of each of these options were identified as part of the OBC. These have been reviewed for the FBC and confirmed they remain valid as outlined in the table below:

Table 3-3 Advantages and disadvantages of options

Advantages	Disadvantages
1.1 Do Nothing	
• Does not require any capital investment.	• Service will be unable to accommodate forecast demand in the future. • Does not increase access closer to home so reduces Programme benefits associated with reduced patient travel and improved uptake of services. • Does not align with the TCS strategy concerning improving the overall cancer pathway and so will impact on delivery of other Programme benefits.
1.2 Do Minimum: 2 additional treatment machines at nVCC	

Advantages	Disadvantages
• Potentially reduces capital costs by negating the need to develop an additional facility.	• Does not increase access closer to home so reduces Programme benefits associated with reduced patient travel and improved uptake of services. • Physical challenges of accommodating 2 additional Radiotherapy treatment machines on nVCC site. • Reduces expansion capacity on nVCC site. • Does not provide additional capacity during development of nVCC so creates a significant risk that demand will exceed capacity during this time. • Does not mitigate risks associated with recruiting and retaining staff in one geographical location. • Requires an increase in revenue service payment cost.
1.3 Intermediate: New Radiotherapy Satellite Centre at Nevill Hall	
• Improves access to care closer to home, leading to increased uptake of treatment which will result in improved patient outcomes. • Ability to provide additional capacity during the nVCC transitional period. • Flexibility of workforce working, larger recruitment pool and flexibility between sites.	• Increased capital due to the introduction of an additional building.

3.2.8 Each option was also assessed against the PSOs and CSFs. The results of this, including the overall assessment of each option, are presented in the table below:

Table 3.3-4 Assessment of options

		1.1 Do Nothing	1.2 Additional Capacity at nVCC	1.3 New RSC at Nevill Hall
PSO1	To provide access to quality and safe radiotherapy services that optimises patient outcome	X	?	✓
PSO2	To provide sufficient capacity to meet future demand for services	X	?	✓
PSO3	To improve patient, carer and staff experience	X	✓	✓
PSO4	To provide capacity and facilities to support the delivery of high quality education, research, technology and innovation	?	✓	✓
CSF1	Strategic fit	X	?	✓
CSF2	Potential value for money	X	?	✓
CSF3	Supply side capacity / capability	✓	✓	✓
CSF4	Potential affordability	✓	✓	✓
CSF5	Potential achievability	X	?	✓
Assessment		Baseline	Possible - Carry forward	Preferred way forward

3.2.8 Following this assessment it as concluded that:

- Development of the RSC at Nevill Hall (Option 1.3) was identified as the preferred way forward because it best meets the spending objectives and the critical success factors, by providing increased capacity, greater workforce resilience and access to care closer to home which will lead to improved patient outcomes. This option offers a significant advantage in terms of providing additional capacity in advance of the nVCC opening.

- Do nothing (Option 1.1) was carried forward as a baseline only to allow comparison of the options. It is not a feasible option as it does not provide enough capacity to meet growing demand and since it will not achieve spending objectives, is not likely to represent value for money.

- Providing additional Radiotherapy capacity at nVCC (Option 1.2) only partly meets the spending objectives in terms of providing additional capacity but creates some risks in terms of timescales and does not deliver access to care closer to home. It was carried forward as a possible option for evaluation as part of the economic appraisal.

The OBC Shortlist

3.2.9 The RSC Project Board reviewed the shortlist of options by testing the following:

- Was the option likely to deliver the spending objectives and CSFs?
- Was the option likely to deliver sufficient benefits?
- Was the option practical and feasible?
- Was the option deliverable within the constraints of the project?
- Was the option deliverable without incurring an unacceptable degree of risk?

3.2.10 Following this review, the shortlist of options was approved by the RSC Project Board and notified to Welsh Government in a letter to Rob Hay dated 28th November 2019. The final shortlist of **three** options includes:

- **The Do Nothing Option:** This option provides a benchmark for assessing the value for money of all options. It attempts to optimise existing arrangements as far as possible in order to improve the organisation's capability to meet current and some future demand for core services. It requires investment in outsourcing services to meet demand beyond that available from internal capacity.

- **The Do Minimum Option:** This option offers a realistic way forward to meet future demand for core services through the expansion of a purpose built nVCC. This option requires single stage implementation which will be funded through a Public Private Partnership (Building) and NHS Capital Funding (Equipment).

- **The Intermediate Option (Preferred Way Forward):** This option requires the development of a purpose-built RSC operating in partnership with Aneurin Bevan University Health Board. This option offers a phased implementation which will be funded from NHS Capital Funding (Building and Equipment).

The OBC Economic Appraisal

3.2.11 The next stage of the OBC involved evaluating the three shortlisted options within the economic appraisal. The results are outlined in the table below.

Table 3-5 OBC Economic Appraisal results (£'000)

	Do Nothing	Do Minimum (nVCC Extension)	Preferred (RSC)
Initial capital costs	0	2,299	27,086
Lifecycle capital costs	0	0	3,349
Total capital costs	**0**	**2,299**	**30,435**
Transitional costs	0	712	712
Outsourcing during transitional period	0	14,488	0
Recurring revenue costs	616,664	199,563	144,520
Total revenue costs	**616,664**	**214,763**	**145,232**
Quantified risks - capital costs	0	0	1,707
Optimism bias	0	0	1,358
Revenue expected risk value	0	5,569	3,147
Total risk costs	**0**	**5,569**	**6,212**
Total costs	**616,664**	**222,632**	**181,880**
Benefits	0	0	(582,733)
Total benefits	**0**	**0**	**(582,733)**
Net Present Social Value (undiscounted)	**616,664**	**222,632**	**(400,854)**
Net Present Cost (discounted)	242,925	96,158	83,589
Total benefits (discounted)	0	0	(374,190)
Net Present Social Value (discounted)	**242,925**	**96,158**	**(290,601)**
Rank	**3**	**2**	**1**
Benefit Cost Ratio (discounted)	**0.00**	**0.00**	**4.48**
Rank	**2**	**2**	**1**

3.2.12 This demonstrated that the development of a new Radiotherapy Satellite Centre (RSC) at Nevill Hall, including two Radiotherapy treatment machines, offered best value for money and should therefore be carried forward as the Preferred Option.

3.3 Results of the Procurement Process

3.3.1 The purpose of this section is to provide a summary of the procurement process and how the Best and Final Offers (BAFOs) were evaluated, and the preferred bidder selected.

Procurement Process

3.3.2 The procurement process was undertaken as per the procurement strategy, route and evaluation that was outlined in the Commercial Case of the OBC.

Procurement Results

3.3.3 The FBC Commercial Case outlines in detail the most economically advantageous tender and sets out the commercial and contractual arrangements that have been negotiated.

3.3.4 It outlines the procurement results for the construction (professional) services and each of the work packages that were outlined in the Strategic Case.

3.3.5 The resulting cost assumptions are incorporated within a revised Economic Appraisal as outlined in the subsequent sections of this Economic Case.

3.4 Updated Cost Assumptions

3.4.1 The purpose of this section is to present revised cost assumptions including firm costs that have emerged as a result of the procurement process and any further refinements required.

Capital Costs

3.4.2 The capital requirements differ for each of the three shortlisted options and include:

Do Nothing:
- Requires some outsourcing of services to address demand requirements.
- Assumes the nVCC will be built / be commissioned in 2025.

Do Minimum (nVCC Extension):
- Construction of an extended nVCC to meet the additional capacity required across the South-East Wales Region.
- nVCC designed and sized in line with additional service scope and in line with relevant Health Building Notes.
- Expansion zones identified through the design of the nVCC to facilitate the potential future introduction of new services.

Preferred (RSC):
- Construction of the RSC to supplement the existing (and new) Velindre Cancer Centre;
- Designed and sized in line with existing service scope and in line with relevant Health Building Notes.
- Expansion zones in the nVCC identified through the design of the RSC and nVCC to facilitate the potential future introduction of new services.

3.4.3 The capital cost calculations and assumptions developed at OBC have been refreshed by the Health Board and Trust and their Technical and professional Advisors and have been shared and agreed with NHS Wales Shared Services.

3.4.4 Since the OBC, the capital costs for the Preferred Option have been finalised to include the following adjustments:

- Construction and general equipment costs for the Radiotherapy Satellite Centre have been updated based on the results of the procurement process and at £31.9m (excluding VAT) are within the approved sum uplifted for inflation, decarbonisation, and scope changes such as digital.
- The cost of the major equipment (i.e. two Radiotherapy treatment machines) being procured as part of the IRS Project are now included.

3.4.5 The capital costs for the Do Minimum option have been uplifted to the same price base as the Preferred Option (i.e. uplifted from the OBC BCIS PUBSEC Index 250 to the FBC Index 277).

3.4.6 For further details refer to the Capital Cost Forms in the Estates Annex.

3.4.7 The revised assumptions used to calculate the costs are provided below.

Table 3-6 Main Capital Cost Assumptions

	• Construction costs have been calculated by the Project's Technical Advisors and the nVCC Project Team based on BCIS PUBSEC Index 277. • Capital cost forms (FB forms) are completed based on the results of procurement process. • The phasing of the capital costs is based on the Project plan. • Appropriate on-costs have been applied to cover capital expenditure associated with utilities, communications, external building works, and auxiliary buildings. • Appropriate fees have been determined by the Project's technical advisors, based on industry norms. • Equipment estimates cover IM&T, medical and non-medical equipment as provided by the technical advisors. Other equipment (Group 3 and 4 items) has been determined, by the technical advisors based on industry norms. • Contingencies reflect the capital risks within each of the shortlisted options and are based on an assessment by the Project and its Technical and Professional Advisors. The calculation is provided in the Estates Annex. • It is assumed that the Do Minimum option (nVCC extension) will be delivered via the MIM funding model and so only equipment related costs are included within capital (all building-related costs included within revenue costs).

3.4.8 The revised capital costs are outlined in the table below. For the purposes of the FBC, costs exclude VAT.

Table 3-7 Capital Costs (£'000)

	Do Nothing	Do Minimum (nVCC Extension)	Preferred (RSC)
Construction costs	0	0	22,042
Fees	0	0	3,091
Non works costs	0	0	2,324
Equipment costs	0	2,548	2,871
Quantified risk	0	0	1,620
RSC capital costs	**0**	**2,548**	**31,948**
IRS equipment	0	6,080	6,080
IRS commissioning	0	585	585
IRS capital costs	**0**	**6,665**	**6,665**
Total capital costs excluding VAT	**0**	**9,213**	**38,613**

3.4.9 An analysis of the phasing of total capital costs for the Project is outlined in the following table:

Table 1-8 Capital Costs by Financial Year (£'000)

Financial year	Do Nothing	Do Minimum (nVCC Extension)	Preferred (RSC)
Year 0 - Prior Years	0	0	2,818
Year 1 - 2022/23	0	37	7,277
Year 2 - 2023/24	0	285	18,469
Year 3 - 2024/25	0	8,892	9,651
Year 4 - 2025/26	0	0	399
Total capital costs excluding VAT	**0**	**9,213**	**38,613**

3.4.10 Following the upfront capital investment, the Trust will continue to require an annual capital allocation to finance new and replacement items of equipment. These costs are not included within the costs summarised in the above tables.

3.4.11 In addition to the upfront capital investment, the Health Board and Trust and their appointed Technical Advisors estimated the lifecycle cost associated with each of the shortlisted options. The assumptions used to calculate the costs are provided below and it is assumed that the calculation of these costs remain largely unchanged since the OBC, other than:

- Uplift price base to 2021/22.
- Reflect latest Project timescales.

Table 3-9 Lifecycle Cost Assumptions

	• Lifecycle costs are calculated over the full 60-year appraisal period in line based on average cost per m2 in line with similar projects. It is assumed to commence in 2024/25 following completion of the Project. • All lifecycle costs for the Do Minimum option (nVCC extension) are assumed to be included within the annual MIM charge.

3.4.12 An analysis of the annual lifecycle costs of the project is provided in the following table:

Table 3-10 Total Lifecycle Costs (£'000)

Cost category	Do Nothing	Do Minimum (nVCC Extension)	Preferred (RSC)
GIFA m2	N/A	N/A	2,533
Annual lifecycle costs	N/A	N/A	60

Non-Recurrent Costs

3.4.13 The Trust requires non-recurring revenue funding to ensure the delivery of the Project and to cover the commissioning phase.

3.4.14 The assumptions used to calculate the costs are provided below and it is assumed that the calculation of these costs remain largely unchanged since the OBC, other than:

- Uplift price base to 2021/22.
- Reflect latest Project timescales.

Table 3-11 Main Transitional Cost Assumptions

	• Non-recurring costs are to be incurred to facilitate Pre-Commissioning in 2024/25

3.4.15 The resulting Project running costs and commissioning costs are outlined in the table below:

Table 3-12 Transitional Costs (£'000)

Cost category	Do Nothing	Do Minimum (nVCC Extension)	Preferred (RSC)
Pre-commissioning costs	0	726	726
Total Costs	**0**	**726**	**726**

Recurring Revenue Costs

3.4.16 The recurring revenue costs reflect the ongoing running costs required for each of the options.

3.4.17 Costs will differ for the three shortlisted options in relation to the operational requirements of each, the main elements of which are described below:

- **Do Nothing:** Includes the costs to source additional demand outside of the capacity of the facility.
- **Do Minimum (nVCC Extension):** Includes the costs associated with operating additional capacity within an extended nVCC.
- **Preferred (RSC):** Includes the costs associated with operating the service remotely from the VCC.

3.4.18 Since the OBC, the recurring costs for the Preferred Option have been finalised to include the following adjustments:

- All costs inflated to 2021/22 prices.
- Final SLA agreed for IT costs.
- Utilities, Hard FM, and Soft FM costs updated to reflect latest floor plans for the RSC.
- Rates estimate agreement with Advisors.
- Revised model of expenditure for the following:
  - Consumables costs linked to proposed clinical mix and volumes.
  - Patient transport costs linked to EASC and private transport volumes, adjusted for local delivery.
  - Travel costs based on assumed rotation of nVCC and RSC staffing.
  - Equipment and IM&T maintenance costs based on indicative operational costs.
- The ongoing revenue costs associated with the major equipment (i.e. two Radiotherapy treatment machines) being procured as part of the IRS Project are now included.

3.4.19 The revenue costs for the Do Minimum option (nVCC Extension) have been updated in accordance with the changes made to the RSC option to ensure a like-for-like comparison. In addition, the increased annual charges associated with the MIM delivery vehicle have been estimated based on the latest Annual Service Payment (ASP) for the nVCC as at 1st April 2022.

3.4.20 The revenue costs for the Do Nothing option (Outsourcing) have been updated to reflect current service costs with outsourced providers. This estimate is predicated on sufficient capacity being available at current price levels.

Table 3-13 Recurring Revenue Cost Assumptions

- Costs are at 2021/22 prices.
- Costs are based on forecast workforce and operating requirements to provide Radiotherapy services for the level of demand that is expected to exceed current/future nVCC capacity, depending on the option:

Do Nothing

- Since this option does not address the capacity constraints, costs to outsource unmet demand to an external provider have been estimated.

Do Minimum (nVCC Extension)

- Costs have been estimated for the additional workforce and operating costs required to provide increased capacity on the nVCC site.
- In addition, an estimate has been made of the increased annual charge associated with the MIM delivery vehicle. This has been calculated based on the estimated capital costs of nVCC extension, on a proportional basis (i.e. the estimated annual charge for the main nVCC scheme in relation to estimated capital costs) and is on a like-for-like basis (including quantified risk but excluding Groups 2, 3, and 4 equipment).
- At the end of the MIM term, this will be replaced by lifecycle costs.

Preferred (RSC)

- Costs have been estimated based on the workforce and operating costs required to deliver services from the Radiotherapy Satellite Centre at Nevill Hall.

3.4.21 Annual recurring revenue costs have been estimated for each of the options from 2024/25 onwards following the commissioning of the new facilities under the RSC option. It is anticipated that costs will continue at these levels from that point forward.

3.4.22 The summary of the full year annual recurring revenue costs from 2025/26 are outlined in the following table:

Table 3-14 Future Recurring Revenue Costs 2025/26 (£'000)

Cost category	Do Nothing	Do Minimum (nVCC Extension)	Preferred (RSC)
Pay costs	0	1,944	2,113

Non-pay costs	0	833	870
Cost of outsourcing	5,406	0	0
Additional MIM charge for nVCC extension	0	1,371	0
RSC operating costs	**5,406**	**4,148**	**2,983**
IRS operating costs		395	395
Total recurring revenue costs	**5,406**	**4,542**	**3,378**

3.4.23 In addition, the Do Minimum option includes the cost of outsourcing unmet demand has been included for 16 months reflect the capacity constraints during the additional construction period required to deliver this option.

Assessing the Cost of Risk

3.4.24 A range of risks have been identified for the Project, some of which can be quantified and a financial value determined. Other risks are either qualitative or cannot be attributed to specific aspects of the Project, such as revenue risks, the impact of which is excluded from this economic appraisal.

3.4.25 For the purposes of assessing the costs of risk for the Project the following capital risks have been calculated including:

- Quantified capital risks: which are included in the capital cost contingencies; and
- Expected risk value as outlined below.

3.4.26 It is assumed that optimism bias is no longer required at FBC stage as this is now fully incorporated into the Quantified Risk value, given the degree of certainty around design and pricing at this point.

Expected risk value

3.4.27 In addition, an expected risk value has been calculated to reflect the risk of delays to the programme for each of the option.

3.4.28 The impact of any delay is increased outsourcing costs which are estimated to cost £5,406k p.a.

Table 3-14 Expected risk value assumptions

	Do Nothing	Do Minimum (nVCC Extension)	Preferred (RSC)
High impact	N/A	12-month delay (25% probability)	9-month delay (25% probability)
Medium impact	N/A	6-month delay (40% probability)	4.5-month delay (25% probability)
Low impact	N/A	3-month delay (25% probability)	1-month delay (10% probability)
No impact	N/A	No delay (10% probability)	No delay (45% probability)
Expected risk value (£'000)	-	2,771	1,556

Estimating the Value of Benefits

3.4.29 As outlined in the Strategic Case, the Project delivers benefits in a variety of areas some of which can be quantified and valued financially.

3.4.30 For the purposes of the economic appraisal, we have focused on quantifying benefits which differentiate between the options, are measurable and evidence-based, and can be monetised using recognised methodology. This includes the following:

- Additional capacity available to meet forecast demand
- Reduced travel time for patient and carers
- Improved access to treatment and clinical trials leading to better clinical outcomes

3.4.31 The approach used to calculate a monetary value for each of these benefits was developed as part of the OBC and refined following the receipt of scrutiny queries from the Infrastructure Investment Board (IIB). An overview of the revised approach is outlined below:

Additional capacity - The additional capacity provided in both the Do Minimum (nVCC extension) and the RSC options, avoid the need to outsource activity to external providers in the long term, resulting in lower revenue costs when compared to the Do Nothing option. The RSC option also avoids the need to outsource activity to external providers in the short term as this can be delivered 16 months earlier than the Do Minimum option. Since these costs and savings are accounted for within recurring revenue costs they are not stated as separate benefits in the table below.

Reduced travel time - It is estimated that around 6,343 attendances p.a. will benefit from closer proximity to the RSC at Nevill Hall, saving patients and carers around 2,957 hours of travel time each year.

Applying a value of time travelled based on Department for Transport's (DfT) Transport Appraisal Guidance (TAG) Data Book – specifically, other travel not related to business or commuting – results in an equivalent annual societal benefit £30k p.a.

In addition, the reduced travel time will result in a reduction in carbon dioxide emissions. Assuming an average speed of 30-miles per hour and based on the DfT TAG Data Book forecast emissions associated with average fuel consumption and vehicle type applying the economic value of carbon emissions, this creates a societal benefit equivalent to £42k p.a. The detailed calculations for these assumptions are available in Appendix FBC/E3.

Improved access - It is estimated that current uptake of Radiotherapy services in Wales is 37% (Based on MALTHUS modelling). Given that best practice guidance is uptake of 41% and there is evidence to suggest that distances of over 45 minutes to access services is a barrier to treatment, it is reasonable to assume that the introduction of a satellite radiotherapy centre at Nevill Hall will increase uptake to at least 39%, equating to an estimated 231 referrals each year (based on average referrals for the last 3 years and ignoring any impact of growing demand related to demographic growth or increased incidence rates).

The increased uptake of treatment is expected to have a direct impact on clinical outcomes, including cancer survival rates. Applying current survival rates of 49.9% (Based on assumptions within the TCS Programme Benefits Paper) would result in 115 additional cancer survivors each year. It should be noted that this is likely to increase in line with improvements to survival rates, for instance if the target survival rate of 71% was achieved (as outline in the TCS Programme Benefits Paper), this would equate to 164 additional cancer survivors. However, for the basis of the RSC business case, current survival rates have been applied.

The social value of the life years gained by cancer survivors as a result of the improved access can be quantified by using the concept of Quality Adjusted Life Years (QALYs). QALYs are widely used in health, transport and welfare policy domains. Although there is a limited evidence-base to draw on reasonable assumptions can be made as follows:

- Average QALY for cancer survivors is difficult to establish but the TCS Programme Benefits Paper identified a paper which suggested that a reasonable assumption is 0.3 per year of survival.
- Based on TCS Programme Benefits paper it is estimated that average 5 life years gained for each survivor.
- Value of QALY is based on standard NHS assumption of £60k per QALY.

This results in a societal benefit equivalent to £10,375k p.a., detailed workings are available in ***Appendix 3.***

3.4.32 In addition, there are a number of benefits which are relevant to the case but are difficult to reasonably quantify in monetary values and/or do not differentiate between the options and so have not been incorporated within the economic appraisal. These are outlined in the Benefits Register in ***Appendix 9***, and include:

- Patients have access to seamless pathway of care in a single place
- Improved patient and carer experience
- More resilient and flexible workforce
- Improved staff satisfaction (although may be dis-benefit for some staff members - additional travel)
- Improved safety and compliance with standards
- Better sustainability, resilience and future proofing
- Opportunities to attract further investment

3.5 Economic appraisal

3.5.1 Based on the updated assumptions outlined in section 3.4 a discounted cash flow for each of the options has been prepared in line with the requirements of HM Treasury Green Book guidance. The key assumptions used in this analysis are summarised below:

Table 3-15 Key Assumptions Used in the Economic Appraisal

- Costs and benefits are calculated over a 60-year appraisal period.
- Baseline (Year 0) will be 2021/22
- Costs and benefits use real base year prices – all costs are expressed at 2021/22 prices in line with the baseline costs.
- The following costs are excluded from the economic appraisal:
  - Exchequer 'transfer' payments, such as VAT;
  - General inflation;
  - Sunk costs; and
  - Non-cash items such as depreciation and impairments.
- A discount rate of 3.5% is applied to the economic appraisal for years 1-30 and 3.0% for years 31 onwards, with the exception of QALY benefits which are discounted at 1.5% in line with HMT Green Book guidance.
- No financial benefits are incorporated.
- Quantified risks including Quantified Capital Risk and Optimism Bias are included based on the approach outlined above.

3.5.2 The results of the discounted cash flow are outlined in the following table:

Table 3-16 FBC Economic Appraisal Results

Expenditure Heading	Do Nothing	Do Minimum (nVCC Extension)	RSC
Initial capital costs	0	9,213	36,973
Lifecycle capital costs	0	1,866	3,471
Total capital costs	**0**	**11,079**	**40,444**
Transitional costs	0	726	726
Outsourcing during transitional period	0	7,208	0
Recurring revenue costs	306,810	220,605	194,739

Total revenue costs	**306,810**	**228,540**	**195,465**
Quantified risks - capital costs	0	0	1,620
Optimism bias	0	0	0
Revenue expected risk value	0	2,771	1,566
Total risk costs	**0**	**2,771**	**3,186**
Total costs	**306,810**	**242,389**	**239,095**
Benefits	0	0	-585,010
Total benefits	**0**	**0**	**-585,010**
Net Present Social Value (undiscounted)	**306,810**	**242,389**	**-345,916**
Net Present Cost (discounted)	120,863	101,292	108,719
Total benefits (discounted)	0	0	-374,968
Net Present Social Value (discounted)	**120,863**	**101,292**	**-266,249**
Rank	**3**	**2**	**1**
Benefit Cost Ratio (discounted)	**0.00**	**0.00**	**3.45**
Rank	**2**	**2**	**1**

3.5.3 The Economic Appraisal demonstrates that the Preferred Option continues to offer the best Net Present Social Value of the three options, suggesting that it offers best value for money in terms of whole life costs and benefits.

3.5.4 It also offers the best benefit cost ratio at 3.45 suggesting that it offers best value for money in terms of the relationship between benefits and costs.

3.5.5 The detailed analysis of the Comprehensive Investment Appraisal (CIA) model is provided in ***Appendix 4.***

3.6 Sensitivity Analysis of the Preferred Option

Decision Analysis

3.6.1 The Economic Appraisal demonstrates that the Preferred Option has the best overall Net Present Social Value, indicating this option delivers the best value for money of the shortlisted options.

Sensitivity analysis and switching

3.6.2 The results of the Economic Appraisal above have been subject to a sensitivity analysis to examine the impact of movements in capital and revenue costs.

3.6.3 Switching value analysis has been applied to areas of material cash flows to identify the extent that costs must change in order for the Net Present Social Value to equal that of the preferred option. The results of the analysis are presented below:

Table 3-17 Switching Values

Costs	Do Minimum
Revenue costs	-257.4%
Net Present Cost	-242.7%

3.6.4 The results above demonstrate that for the Do Minimum Option to rank as the Preferred Option its Net Present Social Value would need to improve by 242.7%.

3.6.5 The Do Nothing option has been excluded since it delivers no benefits and is not a feasible option.

3.6.6 In addition to the switching analysis, alternative scenarios have been used to consider how options may be impacted by future uncertainty and provide an assessment of risk in the ranking of options including:

1. Revenue costs of RSC increase by 25%
2. Benefits reduce by 25%
3. Exclude expected risk value

3.6.7 The results of the sensitivity analysis are shown in the table below:

Table 3-18 Results of sensitivity scenario analysis

Scenario	Revised NPC		
	Do Nothing	Do Minimum (nVCC Extension)	RSC
NPSV	120,863	101,292	-266,249

RSC revenue costs +25%	**120,863**	**101,292**	**-248,965**
RSC benefits -25%	**120,863**	**101,292**	**-172,507**
Exclude expected risk value	**120,863**	**98,793**	**-267,661**

3.6.8 This analysis demonstrates that while each of these scenarios change the Net Present Social Value, none of them have any impact on the ranking of options and therefore this analysis supports the identification of the Preferred Option.

3.7 Conclusion

3.7.1 The options appraisal undertaken at OBC has been updated with the results of the procurement process and refined cost and benefit assumptions. The results of this confirm that the Preferred Option – to develop the Radiotherapy Satellite Centre at Nevill Hall Hospital, Abergavenny – continues to offer best value for money.

3.7.2 The Preferred Option offers best Net Present Social Value and delivers a wide range of benefits which are complementary with local and national priorities as well as the delivery of a range of short and long term objectives to support the improvement of specialist non-surgical cancer service delivery across South East Wales.

4.0 COMMERCIAL CASE

4.1 Introduction

4.1.1 As required by the Five Case Model template this section of the Full Business Case (FBC) explains the proposed Deal in respect of the preferred option outlined in the Economic Case.

4.2 Required Services

4.2.1 This FBC states a requirement for the delivery of a Satellite Radiotherapy Unit at Nevill Hall Hospital under the NEC3 Engineering & Construction (ECC) Form of Contract and Designed for Life: Building for Wales Framework.

4.2.2 The Estates Annex provides information on the detailed design of the project the content of which having been thoroughly reviewed throughout the design process by the VUNHST and ABUHB client teams and NHS Shared Services.

Equipment & ICT Infrastructure

4.2.3 The procurement of all Groups 2, 3 and 4 equipment, and major medical equipment for the Project will be funded through Welsh Government capital funding and procured via the assistance of Shared Services Procurement Services.

4.2.4 Equipment and ICT costs have been calculated based on equipment lists provided by VUNHST and ABUHB, these are included in the Estates Annex. The vast majority of equipment will be purchased and owned by VUNHST with only a very small amount of equipment being required by ABUHB.

4.2.5 The capital costs now include the major equipment being procured as part of the IRS, these were excluded from the OBC costs. The procurement of this equipment is currently being progressed as part of a much larger procurement for both the existing Velindre site and the proposed new Velindre Cancer Centre by VUNHST. The FBC for the larger procurement is planned to be submitted to Welsh Government in May 2022.

4.2.6 VUNHST will be responsible for the specification, procurement, installation, commissioning, maintenance, replacement and disposal of all major medical equipment for the unit. The tale below provides a summary of the major medical equipment required:

Department	Equipment	Number Required
Radiotherapy	Linear Accelerator	2
Radiotherapy	CT Simulator	1

4.2.7 The table below identifies the equipment costs, including VAT, applicable to each organisation including IRS:

	Groups 2 ,3,4 equipment & ITC	IRS	Total
VHNHST	£3,414,240	£7,998,275	£11,412,515
ABUHB	£30,660	0	£30,660

4.3 Proposed Charging Mechanisms

4.3.1 There will be no ongoing service provision and therefore no recurring charges by the SCP following completion of the proposed new unit.

4.4 Risk Transfer

4.4.1 The general principle is that risks should be passed to "the party best able to manage them", subject to value for money (VFM). The UHB has carefully considered those risks best placed with the Supply Chain Partner (SCP) and those it will bear itself. This has been achieved at FBC stage through series of structured risk workshops and regular risk register review meetings, involving the UHB, SCP, Project Manager and Cost Advisor. Further information on the proposed Risk Management Strategy for the project, together with the quantified risk registers for the preferred option, is included in the Estates Annex.

4.4.2 Under the Designed for Life: Building for Wales Framework, which is described at length in the following section of the Procurement Strategy, the NEC3 Engineering & Construction (ECC) Form of Contract is used. The Engineering & Construction Contract is a "collaborative" contract that requires each project to include a Risk Register with risk allocated to the party best able to deal with it. The early involvement of the Supply Chain Partners means that they are fully briefed about risks in the project and accept ownership of risks than would normally be the case under a more traditional form of contract.

4.4.3 The table below shows how the project risks have been apportioned under a predominately Public Capital Funded procurement. The total assessed "Risk" cost at FBC stage is currently £1.620 million plus VAT for the preferred option. This is split ABUHB £1.081 million and SCP £539k.

Risk	ABHB	SCP	Shared
Design			Y
Site availability	Y		
Planning	Y		
Approval and Funding	Y		
Construction		Y	
Technical Commissioning		Y	
Operational Commissioning	Y		
Operating risk	Y		
Revenue risk	Y		
Technological and Obsolescence	Y		
Legislative Change	Y		

4.5 Contract Length

4.5.1 A stage 4, 5 & 6 Programme has been prepared by the SCP in full consultation with the Project Manager and UHB. The Programme fully complies with the requirements of the NEC3 ECC contract and the Designed for Life Framework. The Accepted Programme as required by the contract contains a detailed and comprehensive Programme of activities and the Completion Date is clearly identified.

4.5.2 Throughout Stages 5 & 6 the Accepted Programme will continue to be issued by the SCP to the Project Manager on a monthly basis for acceptance, including a mark-up of actual progressed achieved in the month and a strategy for recovering any lost time, in order to effectively monitor progress as work proceeds and robustly manage the project programme to ensure timely delivery of the project.

4.6 Proposed Key Contractual Clauses

4.6.1 The contract will be in accordance with the All Wales Designed for Life 4 Building for Wales Framework. The contract will be the NEC 3 Form of Contract. The conditions of contract are the core clauses and the clauses for main option C: Target Contract and Secondary Options – X1, X2, X4, X5, X7, X15, X16, X18, Y(UK) and Z of the NEC Engineering and Construction Contract (June 2005), with amendments dated September 201. The additional Z clauses comprise the standard Deigned for life: Building for Wales Framework amendments.

- This contract is based on the following key principals:
- Clarity – The Contract is written in plain language
- The Risk Register is a key project and contract management tool
- Foresight and Early Warning Notifications
- A Target Cost and Cost not to be exceeded.
- Timely two-way communication
- Compensation Events
- Monthly Accepted Programme is sued as a key project and contract management tool

4.6.2 Key external professional roles appointed on behalf of the Employer include, direct client appointments for the Project Manager and Supervisor. A Cost Advisor has also been appointed to support the Project Manager and Health Board.

4.7 Personnel Implications (including TUPE)

4.7.1 TUPE (*Transfer of Undertaking Protection of Employment*) does not apply to this investment as there is no change to the employing organisation. However, there will be implications for a small number of VUNHST staff in terms of a change in location of employment. This will be managed using the VUNHST's Management of Change Policy.

4.8 Procurement Strategy

4.8.1 The project falls within the terms of the All Wales Designed for Life 4 Building for Wales Framework.

4.8.2 The Health Board had appointed External Project managers and External Cost Advisers.

4.8.3 A "Cost not to be exceeded" has been agreed with the SCP and this is included in this FBC submission. Whilst approval of the FBC is awaited the Target Cost will be agreed and all necessary contractual documentation will be drawn up in readiness for a speedy exchange of contracts and start on site.

4.8.4 A Value for Money Report has been prepared by the Cost Advisor which is attached at ***Appendix 5.*** This describes the work packages procurement and evaluation process that has been undertaken to arrive at the "Cost not to be Exceeded".

4.8.5 The Health Board is also in the process of procuring the appointment of a Supervisor, in order to perform the required duties in the NEC3/ECC Contract.

4.9 Pain /Gain Share

4.9.1 The All Wales Designed for Life 4 Building for Wales Framework defines the Pain / Gain Share arrangements.

4.9.2 From Stage 4 onwards (Construction and Project Closure), the Gain Share will be limited to the first 5% of any savings between the total of the Prices and the Price for Work Done to Date arising during Stages 4, 5 and 6 and will be equally apportioned 50:50% between the Health Board and the SCP. Savings over this amount (i.e. less than 95% of the) will accrue 100% to the Health Board. To summarise the *Contractor's* share percentages and the *share ranges* are:

Share Range	***Contractor's* Share Percentage**
Less than 95%	Nil
From 95% to 100%	50%
Greater than 100%	100%

5.0 THE FINANCIAL CASE

5.1 Introduction

5.1.1 The purpose of this section is to set out the indicative financial implications of the preferred option (as set out in the Economic Case) and proposed deal (as described in the Commercial Case).

5.2 Capital Costs

5.2.1 The preferred option is Option 3 the construction of a new Satellite Radiotherapy Unit at Nevill Hall Hospital. The estimated outturn costs for the preferred option is £46,180 million, the detail of which is set out below:

	FBC Option 3 - £'000m
Works Cost	22,042
Fees	3,091
Non-Works	2,324
Equipment (VT £2.845, AB £0.026)	2,871
Contingency	1,620
Sub-Total	**31,948**
VAT	6,390
VAT Recovery on fees	(156)
Total VAT	**6,234**
Total Capital Cost (for comparison with uplifted OBC)	**38,182**
Satellite Integrated Radiotherapy Solution (IRS)	6,665
VAT on IRS	1,333
Total IRS	**7,998**
Total Project Capital Cost For Approval	**46,180**
Below the line Exceptional Market Volatility Risk including VAT	***1,356***

5.2.2 The submitted and approved OBC was indexed at Pubsec 250 providing a forecast Outturn Capital Cost totalling £25.379M exclusive or VAT (£30.285M inclusive of VAT). During the development Stage 3 (OBC to FBC) several Post OBC submission Client amendments were requested to be included following support from NWSSP-SES and WG. These amendments included modifications to the Treatment Rooms radiation protection (e.g., eliminating projects both internally and externally in the design and

increased FFL from floor slab to soffit), enhancements to Access & Security, Digital Wayfinding, ANPR Controls to dedicated patient parking, and the inclusion of Piped Medical Gases. These client additions provide an enhanced equivalent OBC Outturn Cost of £27.702m exclusive of VAT / £33.064M inclusive of VAT prior to any escalation adjustments (i.e. at Pubsec 250 = base).

5.2.3 Taking into account committed capital expenditure during the development of Stages 2 and 3, £3.330M exclusive of VAT, provides an adjusted forecast of Outturn Capital Costs as £24,372M excluding VAT at Pubsec 250. The inflationary adjustment is calculated by taking this adjusted forecast measured at Pubsec 250 and adjusting this to the published forecasted Pubsec Index (294) representing the mid-point of construction, this being 3Q23. This provides an adjustment of £4.289M exclusive of VAT, or £5.147M inclusive of VAT. This is the inflationary adjustment used in the comparator from OBC to FBC.

5.2.4 With the inflationary adjustment taken into consideration the forecasted comparable OBC Outturn Capital Cost becomes £33.064M plus, Inflationary adjustments £5.147M, i.e. Forecast Outturn Capital Cost £38.211M.

5.2.5 A more detailed breakdown of the capital cost calculations is contained within the FB Forms in the Estates Annex and a Value for Money report recommending acceptance of the "Cost not to be Exceeded" is attached at ***Appendix 5.*** The "Cost not to be Exceeded" is £29,587,769.

5.2.6 The total FBC capital cost, (excluding IRS), is £38,182 million, which is within the above uplifted approved OBC sum, i.e. uplifted for inflation, Decarbonisation and SMART of £38,211 million A more detailed reconciliation comparing the FBC costs with the uplifted OBC, is attached at ***Appendix 6.***

5.2.7 The capital costs now include the major equipment being procured as part of the IRS, these were excluded from the OBC costs. The procurement of this equipment is currently being progressed as part of a much larger procurement for both the existing Velindre site and the proposed new Velindre Cancer Centre by VUNHST. The FBC for the larger procurement is planned to be submitted to Welsh Government in May 2022.

5.2.8 The detailed cash flow for the preferred option is contained with the FB forms in the estates annex and is summarised below:

	Prior years	**2022/23**	**2023/24**	**2024/25**	**2025/26**
Total*	£3,321,639	£8,834,723	£22,224,302	12,693,784	462,035

*** includes anticipated market volatility costs**

5.2.9 The FBC assumes all capital costs and inflation will be funded by Welsh Government in each of the years as per the above, in accordance with current Welsh Government policy.

5.2.10 The following key assumptions have been made in the capital case:

- Capital costs are reported at BCIS Pub Sec Index Level 277.
- Costs included for Fees are based on typical rates assuming the scheme is procured through the Designed for Life: Building for Wales procurement programme

- Non-Works Costs are based on estimated capital costs that will be incurred in developing the scheme through to Operational Completion and include Planning Fees, Artworks and Commissioning costs
- A Contingency allowance of £1.620 million plus VAT has been included based on a quantified Risk Register. The Risk Register is included in the Estate Annex
- VAT has been applied at the rate of 20% to all cost components. It is assumed that VAT recovery will be applicable to all professional fees. Further detailed advice on the VAT reclaim will be sought imminently following agreement of the Target Cost.

5.2.11 Equipment and ITC costs are based on detailed schedules provided by VUNHST and ABUHB, these are included in the Estates Annex. The table below identifies the spilt of the equipment and ITC capital costs between Velindre and ABUHB, all costs include VAT:

	Groups 2 ,3,4 equipment & ITC	**IRS**	**Total**
VHNHST	£3,414,240	£7,998,275	£11,412,515
ABUHB	£30,660	0	£30,660

5.2.12 Capital costs reflect the capital requirements of the Project that will be funded from a Capital Resource Allocation. In this instance the capital resource will flow to both organisations, VUNHST and ABUHB. The former will own and be responsible for the ongoing maintenance and replacement of almost all of the proposed equipment. ABUHB will own and be responsible for the proposed new building, associated site infrastructure works and a relatively small amount of equipment.

5.3 Revenue Costs

5.3.1 The preferred option (Option 3) is the construction of a new Satellite Radiotherapy Unit at Nevill Hall Hospital

5.3.2 The costs have been updated from the OBC with the total revenue cost of the NHH RSC option to commissioners amounting calculated as £2.983m (an increase of £0.436m from the Option 3 revenue cost included in the OBC of £2.547m). The revised revenue cost is broken down as follows

	Option 3 - NHH RSC £
Workforce	
Radiotherapy Delivery	1,453,481
Medical Physics Delivery	555,748
Facilities	74,074
IT	19,679
Pharmacy	9,840

Pay	**2,112,822**
Non Pay	
Utilities	110,382
Hard FM	80,179
Rates	96,300
Soft FM	9,192
Consumables	33,500
Patient Transport	29,329
Equipment Maintenance	395,000
IM&T Maintenance	44,194
Pharmacy	708
Travel	71,500
Non Pay	**870,284**
TOTAL COST	**2,983,106**

5.3.3 The revenue projections are based on the delivery of the following levels of activity which are unchanged from the OBC:

Treatment Type	**No of Fractions**
Prostate Fractions	7,434
Breast non-DIBH	3,234
Breast DIBH	3,234
Palliative Treatment	1,699
Total	**15,600**

5.3.4 A full cost analysis of Option 3 and the other options, including a comparison with the OBC costings, is set out in ***Appendix 7***. Costs have been updated as follows:

- Costs inflated to 2021-22 Prices including the 21-22 workforce wage awards and non-pay inflation. At this stage it is not possible to update the prices to 2022-23 levels due to the uncertainties around the 2022-23 pay award.
- There have been no changes to the workforce assumptions
- Non pay assumptions updated to reflect latest building squared dimensions
- Consumables costs updated to reflect proposed clinical case mix and volumes
- Patient transport assumptions based on latest EASC/Private Transport volumes
- Equipment Maintenance and IM&T Maintenance updated to reflect current operational costs
- Travel costs updated to reflect proposed staffing rotation.

NB There have been no changes to the workforce assumptions.

Transitional Costs

5.3.5 Non-recurring revenue costs reflect expenditure that the Health Board and Trust will incur in order to deliver the Project but will not recur over time. They are largely one off, up-front costs. Non-recurring costs are to be incurred in the following areas:

- Pre Commissioning Costs; and
- Commissioning

5.3.6 Velindre has discussed the profile of pre-commissioning costs, specifically on the 3-6 month maximum lead in time for recruitment of posts. The proposed costs remain on a staggered basis based on market availability of staff, associated programmes and procurements that enable the Satellite Centre and lead in training times. This position will continue to be challenged and scrutinised as part of the commissioner review and internal Velindre Project management.

5.3.7 The table below sets out the pre-commissioning costs which have been uplifted to 2021-22 prices:

	£
Phasing	523,000

Distribution of Recurring Revenue Costs

5.3.8 The Collective Commissioning Group (CCG) have considered and agreed the approach to the distribution of revenue costs to inform the OBC and FBC processes.

5.3.9 The methodology was developed through the following stages

- Identification of recurring revenue costs in the establishment of the RSC
- ABUHB costs to be recharged to Velindre under a Service Level Agreement.
- Velindre to charge HBs under LTA arrangements
- Identification of the proposed activity case-mix at the RSC
- Calculation of the income to Velindre of the proposed activity case-mix using the new Velindre Contractual LTA Framework.

5.3.10 The key assumption used is activity undertaken at the RSC will be chargeable as any other Velindre activity.

5.3.11 When the full cost tariff is compared to the RSC cost proposal, it shows that the cost proposal is 86% of the full cost tariff.

	Recurring Revenue Costs £000
RSC Cost proposal	2,983,106
Tariff Income at Full Cost Rates using activity case mix	3,459,202
Comparator as % of Full Cost Tariff	86%

5.3.12 Actual costs are to be charged under the LTA Framework mechanism on activity residency with the costings underpinning the Velindre Contractual Framework being updated to reflect the 86% stepped cost.

5.3.13 On a notional basis, the RSC cost proposal split by commissioners using the percentages shares in current LTA arrangements would result in the following:

Commissioners	**Split %**	**Recurring Revenue Costs £**
Swansea Bay UHB	0.64%	19,092
Aneurin Bevan UHB	39.24%	1,170,571
Cardiff & Vale UHB	28.69%	855,853
Cwm Taf Morgannwg UHB	27.78%	828,707
Hywel Dda UHB	1.51%	45,045
Powys THB	2.14%	63,838
WHSSC	0.00%	0
Total Recurring Revenue Costs	**100%**	**2,983,106**

5.3.14 To ensure full cost recovery by VUNHST under the LTA contractual framework, the full and marginal rates in the LTA mechanism would need to be re-costed to include the RSC development.

Transitional Revenue Costs

5.3.15 The commissioner shares have been utilised to distribute the transitional (non-recurrent) revenue costs of the Project over Commissioners.

	Split %	**Costs £**
Swansea Bay UHB	0.64%	3,347
Aneurin Bevan UHB	39.24%	205,225

Cardiff & Vale UHB	28.69%	150,049
Cwm Taf Morgannwg UHB	27.78%	145,289
Hywel Dda UHB	1.51%	7,897
Powys THB	2.14%	11,192
WHSSC	0.00%	0
Total Transitional Revenue Costs	**100.00%**	**523,000**

Cost Inflation and Risk Sharing

5.3.16 The CCG has agreed an approach to risk sharing where the cost base will be reviewed prior to commissioning the RSC.

5.3.17 The CCG has agreed to an appropriate inflation mechanism, whereby the agreed commissioner quantum will be uplifted using CPI.

5.3.18 It was agreed that further scrutiny of the costs base will be required prior to commissioning of the new Centre. At this time, any costs that have increased outside of ABUHB and VUNHST's control would require separate discussion.

5.3.19 As identified above, it is recommended that the costs be reviewed prior to commissioning. It is acknowledged that FBC approval will result in the risks being borne by VUNHST and/or ABUHB as appropriate (unless a case is made otherwise as identified below).

5.3.20 In that regard, Commissioner funding for professionally supported cost increases, outside of Velindre's control, should not be unreasonably withheld. Further, cost drivers such as pay awards, mandated standards and unavoidable external policies would also be accepted as reasonable factors for post approval support.

5.3.21 It has been agreed that the cost distribution will apply to these, and any future variant of the FBC cost, unless Commissioners collectively agree to the application of another method at some point in the future.

5.3.22 The preferred option results in an NHS saving of £1.2m costs for MIMs financing payments. Commissioner Health Boards will appreciate Welsh Government consideration of a proportion of this avoided cost be made available to mitigate the recurrent revenue costs of the preferred option.

Collaborative Commissioning Leadership

5.3.23 The Financial Framework identified that the RSC FBC has focused on the additional costs of this new building and service at a projected level of activity. The actual level of activity and case-mix required will be addressed through the commissioning and planning cycle irrespective of the provision of a new building.

5.3.24 It is necessary to highlight that, although not a decision dependent factor, the additional variable clinical costs of demand, and the associated approach to provide further additional resources through a new Commissioning LTA Framework, are

important business factors that require determination and collaborative commissioning agreement.

3.3.27 The FBC is predicated on the implementation of the new VCC contractual framework which is currently being implemented with commissioners.

5.4 Depreciation and Impairment

5.4.1 As the capital consequences of this project are shared between both ABUHB and VUNHST there are two profiled summary of the depreciation and impairment costs associated with the preferred option are set out in the tables below:

Preferred Option Depreciation and Impairment
ABUHB Consequences

DEL / AME FUNDING REQUIREMENTS	2022/23	2023/24	2024/25	Recurring
Option 3	£000	£000	£000	£000
ABUHB DEL Depreciation Building	0	0	143	286
ABUHB DEL Depreciation Equipment	0	0	3	6
ABUHB Accelerated Depreciation	395	0	0	0
ABUHB AME Impairment	0	0	23,154	0
ABUHB Total Requirement	**395**	**0**	**23,300**	**292**

Velindre Consequences

DEL / AME FUNDING REQUIREMENTS	2022/23	2023/24	2024/25	2025/26 recurring
Option 3	£000	£000	£000	£000
Depreciation - DEL Buildings	0	0	0	0
Depreciation - DEL Equipment & IT	0	0	609	812
Accelerated Depreciation	0	0	0	0
Impairment - AME	0	0	0	0
Velindre Total Requirement	**0**	**0**	**609**	**812**

5.4.2 Impairment on the Radiotherapy Unit itself has been calculated based on advice from the District Valuer. The asset value post impairment has been depreciated over the estimates of useful economic life provided by the District Valuer.

5.4.3 The FBC assumes all impairment and depreciation will be funded by WG in each of the years as per the above, in accordance with current WG policy. ***Appendix 8*** provides the Depreciation and Impairment calculations.

5.5 Impact on the Organisation's Operating Cost Statement and Balance Sheet

5.5.1 This section examines the impact of the proposed investment on the Health Board and Trust accounts. It should be noted that the following summarised extracts from the Statement of Comprehensive Net Expenditure (SOCNE) and Statement of Financial

Position (SOFP) only model the impact of the capital and revenue changes of the proposed investment outlined in the tables below. It does not reflect the overall forecast position of the Health Board. As with the Depreciation calculations two sets of tables are provided:

ABUHB - Impact on the Organisations Statement of Comprehensive Net Expenditure (SOCNE)

	2022/23	2023/24	2024/25	2025/26 recurring
Option 3	£000	£000	£000	£000
Revenue Cost Impact	0	0	791	1,171
Depreciation - DEL Buildings	0	0	143	286
Depreciation - DEL Equipment & IT	0	0	3	6
Accelerated Depreciation	395	0	0	0
Impairment - AME	0	0	23,154	0
Total Costs	**395**	**0**	**24,091**	**1,463**

ABUHB - Impact on the Organisations Statement of Financial Position (SoFP)

	2022/23	**2023/24**	**2024/25**	**2025/26**
Option 3	£000	£000	£000	£000
Non-Current Assets b/f:	3,728	12,168	33,074	12,825
Non-Current Assets Additions:				
Equipment & IT	0	31	0	0
Assets Under Construction / Buildings	8,846	20,876	3,050	0
Total Additions	8,846	20,907	3,050	0
Non-Current Assets Impairment:				
Assets Under Construction / Buildings			-23,154	
Total Impairments	0	0	-23,154	0
Non-Current Assets Depreciation:				
Buildings	-11		-143	-286
Equipment & IT			-3	-6
Accelerated Depreciation	-395	0	0	0
Total Depreciation	-406	0	-146	-292
Closing NBV Impact on SoFP	**12,168**	**33,074**	**12,825**	**12,241**

VUNHST - Impact on the Organisations Statement of Comprehensive Net Expenditure (SOCNE)

	2022/23	2023/24	2024/25	2025/26 recurring
Option 3	£000	£000	£000	£000
Revenue Cost Impact	0	174	2407	2744
Depreciation - DEL Buildings	0	0	0	0
Depreciation - DEL Equipment & IT	0	0	609	812
Accelerated Depreciation	0	0	0	0
Impairment - AME	0	0	0	0
Total Costs	**0**	**174**	**3016**	**3556**

Velindre - Impact on the Organisations Statement of Financial Position (SoFP)

	2022/23	2023/24	2024/25	2025/26
Option 3	£000	£000	£000	£000
Non-Current Assets b/f:				
Buildings	0	0	0	0
Equipment & IT	0	0	0	0
Assets Under Construction	0	0	0	0
Non-Current Assets Additions:				
Equipment & IT	0	0	7296	0
Assets Under Construction / Buildings	0	0	0	0
Total Additions	0	0	7296	0
Non-Current Assets Impairment:				
Assets Under Construction / Buildings				
Total Impairments	0	0	0	0
Non-Current Assets Depreciation:				
Buildings				
Equipment & IT			-609	-812
Accelerated Depreciation	0	0	0	0
Total Depreciation	0	0	-609	-812
Closing NBV Impact on SoFP	**0**	**0**	**6687**	**-812**

5.5.2 As shown in the extracts above, all assets will be shown on the Health Board's and Trust balance sheets. Whilst the unit is being built it will be shown as a non-depreciating asset under construction. The asset will be valued on completion and recorded on the balance sheet at that value in accordance with the Health Board's accounting policies.

5.6 Conclusion

5.6.1 In developing the Financial Case, ABUHB and VUNHST has worked closely with its specialist advisors, Commissioners and the Welsh Government to agree the Financial Framework to be adopted and present a robust assessment of the overall capital and revenue consequences of the proposed Project.

5.6.2 In assessing affordability, the Health Board and Trust has carefully considered the timing of expenditure and how this will impact on commissioners and other stakeholders, including the presentation of the professionally agreed approach to the distribution of the agreed revenue costs.

6.0 Management Case

6.1 Introduction

6.1.1 The FBC Management Case sets out the management arrangements which will successfully deliver the RSC Project to time, cost and quality.

6.2 Project Management Arrangements

6.2.1 The Health Board and Trust have will continue to manage the delivery of the project via a Project Board and Project Team. Individual responsibilities will however change during the course of the construction, should the FBC be approved, to reflect the need for VUNHST to take the lead in the operational and service commissioning. At that point there will need to be two SROs, ABUHB taking the lead for the provision of the facility and VUNHST taking responsibility for service commissioning and operational readiness.

6.2.2 The key individual roles and responsibilities required to support the delivery of the RSC Project are set out below:

Table 6-1: RSC Project Leadership Team

Role	Name/Status	Responsibility
Senior Responsible Owner (SRO)	Nicola Prygodzicz ABUHB / Carl James VUNHST	The Senior Responsible Owner (SRO) is responsible for ensuring that the Project's objectives are delivered on time and within the desired cost and quality constraints. The SRO oversees the effectiveness of the Project Management Team ensuring that the Project Management structure is appropriate to ensure the project objectives are delivered and that the benefits are realised. At the appropriate time in the programme the SRO responsibility will be shared between ABUHB and VUNHST to reflect the increasing importance of service commissioning and operational readiness.
Project Director	Andrew Walker ABUHB	The Project Director reports to the SRO and is operationally accountable for project delivery of the RSC including the operational delivery of the RSC Procurement through the appropriate processes which he will lead. The Project Director will provide leadership and positive team working to create an environment that facilitates effective project delivery.

Director of Commercial and Strategic Partnerships **VUNHST**	Huw Llewellyn	The Director of Commercial and Strategic Partnerships is the Project Director for the TCS Digital and Equipment Project and along with the RSC Project Director will ensure that the interface between the RSC Project and the TCS Digital and Equipment Project is effective. The Director of Commercial and Strategic Partnerships will advise on the commercial, partnership, management, financial and economic aspects of the Project process and provide strategic advice to the RSC Project and on its interface with the nVCC and IRS Projects.
TCS Service Director **VUNHST**	Andrea Hague	The Trust Director of Service Transformation is responsible for leading a group of operational managers in order to ensure that a service and operational focus is maintained in all aspects of the RSC project. The post holder is responsible for identifying, developing, agreeing and delivery of all operational and clinical aspects of the Velindre Service at the RSC. This will include workforce, operational procedures and processes, facility requirements for interface management and commissioning.

6.2.3 Senior Clinical Leadership is provided to the Project through two key posts; one from each of the partner organisations.

Table 6-2: RSC Project - Clinical Leads

ABUHB Clinical Lead	Ian Williamson	The Health Board's clinical lead is responsible for leading a group of clinicians to ensure that a 'local' clinical focus is maintained in all aspects of the RSC project and that patient experience and quality is always a primary consideration.
VCC Clinical Lead	Tom Crosby	The Trust's clinical lead is responsible for leading a group of clinicians to ensure that a 'specialist' clinical focus is maintained in all aspects of the RSC project and that patient experience and quality is always a primary consideration.

6.2.4 These officers comprise of the RSC Project Board along with other colleagues from the Health Board and Trust as set down below:

Table 6-3: RSC Project Board

Name	Role
Nicola Prygodzicz	Executive Director of Planning, Digital and IT, ABUHB (Chair)
Carl James	Executive Director of Planning, Digital and IT, VUNHST
Andrea Hague	Director of Service Transformation , VUNHST (Deputy Chair)
Andrew Walker	Strategic Capital and Estates Programme Director, ABUHB
Huw Llewellyn	Director of Commercial and Strategic Partnerships, VUNHST
Ian Williamson	Lead Clinician, ABUHB
Prof. Tom Crosby	Lead Clinician, VUNHST
Suzanne Jones	Assistant Director of Finance, ABUHB
Lorraine Morgan	Programme Manager – Strategic Capital and Estates, ABUHB
Kathy Iken	Lead for Operational Implementation, VUNHST

6.2.5 The Officers above will be supported by a Project Team including a range of "Technical" ABUHB and Velindre Clinical and Technical Leads, as set out below, as well as a team of External Advisors (see Section 5.9).

Table 6-4: RSC Project Team

Name	Role
Andrew Walker	Strategic Capital and Estates Programme Director ABUHB (Chair)
Andrea Hague	Director of Service Transformation , VUNHST (Deputy Chair)
Lorraine Morgan	Programme Manager – Strategic Capital and Estates, ABUHB
David Osborne	Finance Lead, VUNHST
Phil Meredith	Finance Lead, ABUHB
Suzanne Jones	Assistant Director of Finance, ABUHB
Jacqui Couch	Clinical Transformation Manager, VUNHST
Bernadette McCarthy	Radiotherapy Services Manager, VUNHST
Kelly Jones	Capital Accountant, ABUHB

Jason Hoskins	Assistant Project Director nVCC (Technical), VUHNST
Gareth Daniels	ITC Lead VUNHST
Tony Millin	Head of RT Physics, VUNHST
Mark David	Operations Manager, VUNHST
Amanda Jenkins	Workforce Lead, VUNHST

6.2.6 The delivery of the Project is being managed in accordance with the PRinCE2 ('Projects in a Controlled Environment') methodology suitably adapted for local circumstances in order to meet the needs of this Project. The Project management arrangements will therefore be driven by outputs, or in the PRINCE2 terminology, "Products". All products will be formally signed off by the RSC Project Board before being approved (if appropriate) by the TCS Programme Delivery Board or the Health and Trust Boards as appropriate.

6.2.7 The Infrastructure Project Execution Plan (PEP) will be updated pre commencement of construction and will include all the management controls required to ensure the RSC Project, and its contracted firms, meet their fiduciary obligations with respect to the implementation of the Project.

6.2.8. The preparation of the FBC has been supported by an External Project Manager and External Cost Advisor both of which have been appointed from the All Wales Designed for Life: Building for Wales Framework:

- The **Project Manager** (Gleeds Management Services) has and will continue to perform the role in accordance with the Outline Schedule of Duties for Project Managers, as defined at Framework level, unless otherwise amended and agreed with the Health Board. This role encompasses a project management role of the technical aspects of the business case process and subsequent design, procurement, construction and project closure stages under the NEC3 Form of Contract.

- The **Cost Advisor** (Lee Wakemans) has and will continue to oversee the financial management of the capital expenditure, in conjunction with the Health Board Finance Directorate. They will monitor project costs, implement rigorous verification and checking of all costs presented by the SCP, and deliver a project from a Health Board perspective which is affordable and provides value for money.

6.2.9 In addition to the above a Health Care Planner (Archus) has been appointed to lead the preparation of the FBC Economic Case.

Project Plan

6.2.10 The Estates Annex includes the detailed construction programme. The table below highlights the key project milestones:

Milestone	Date
Submission of FBC to WG	May 2022
WG Approval	July 2022
Start on Site	August 2022
Construction Completion	February 2024
Linac Commissioning Period & Anticipated Beam on Date	February to July 2024

6.3 Change Management

6.3.1 The table below sets out the core plan and the main tasks identified to date:

Table 6-5: Change Management Plan

Area	Planned tasks
Planning phase	✓ Appoint key Project roles and Change Managers, confirming responsibilities and leadership ✓ Confirm stakeholders and interested parties both within and outside ABUHB and VCC ✓ Develop core plan in more detail, identifying high level milestones for the Change Management Plan, mapped to the overall Project Plan ✓ Confirm involvement of HR, managers and other individuals/groups in the process
Communications and stakeholder engagement	✓ Confirm communications lead and protocols (route and timing of approval of communications) ✓ Develop communications routes, including face to face briefings bulletins, intranet pages ✓ Formulate and agree key communications messages against high level milestones ✓ Set up stakeholder map and engagement plan ✓ Launch change Programme ✓ Ongoing communications work
Training and development	✓ Complete detailed workforce planning to identify 'shadow' structures, roles and competencies for those roles ✓ Work with staff through workshops and other training to clarify the workings of the new Service Models and how these will impact in practice ✓ Identify training and development required to fulfil roles and competencies ✓ Develop training plan, aligned to pilot work and overall milestones in implementation plan ✓ Link training and development into communications plan

Piloting	✓ Identify and confirm areas where piloting of new models and practice will be implemented ✓ Confirm schedule of pilot work, mapped against high level project and change management milestones ✓ Agree feedback arrangements from pilots and how this links into training/development, communications and overall change management plan ✓ Execute pilots, feedback and report progress
Full Implementation	✓ Identify scheduling/phasing of full implementation at VCC ✓ Using results of piloting and training work, develop detailed implementation and transition plan, mapped to project phasing ✓ Discussion and agreement with key staff ✓ Execute implementation and transition plans

6.4 Benefits Realisation

Benefits Realisation Strategy

6.4.1 The TCS Programme team has been working closely with the Welsh Government and other partners to ensure that the management of the RSC Project benefits are robust. This work has included the identification and quantification of Project Benefits where possible. This has then allowed for the quantified benefits to influence the Economic Case where the choice of the preferred option is made. The quantification of benefits relating to the RSC reflect the wider societal benefits within the wider TCS Programme. These are included only where they can be directly attributable to the provisioning of the RSC.

6.4.2 This Project is about the provisioning of the RSC to improve clinical outcomes. It delivers a key aspect of the clinical model and increases integration with local services and support for further research and education. The use of a quantified benefits assessment methodology brings significant rigour to how the benefits have been assessed and informed the preferred option.

6.4.3 This brings into sharp focus the need to ensure that the Project maximises the delivery of the benefits associated with the RSC Project.

Benefits Mapping and Assurance

6.4.4 One of the most important features in benefits realisation is to ensure that the perceived benefits identified as part of the preferred option will deliver the Project Spends Objectives (PSOs).

6.4.5 As previously described in the Outline Business Case, the benefits associated with the Project have been captured and presented.

6.4.6 All Benefit Groups have been matched to a beneficiary, whether this be a patient, carer, ABUHB and Velindre University NHS Trust, other Local Health Boards, or at a Governmental level or societal level.

Benefits Realisation Plan

6.4.7 A formal Benefits Realisation Plan was prepared for the Outline Business Case and this has been updated for the Full Business Case, this is attached at ***Appendix 9*****.** The plan is designed to enable benefits, and dis- benefits, that are expected to be derived from the RSC Project, to be planned for, managed, tracked and realised.

6.4.8 The Benefits Realisation plan will help demonstrate whether the scheme's investment objectives are able to generate the desired 'measures for success. This can be assessed by tracking the desired outcomes and subsequent benefits of the RSC Project.

6.5 Risk Management

6.5.1 The overall arrangements for the management of risk is undertaken at Project Board level. Issues with the highest risk scores are routinely discussed at the Project Board. This covers risks related to the *construction itself* and *service* risk. There are Risk Registers for each.

6.5.2 Responsibility for the former, i.e. the management of the construction risk register, rests with the external Project Manager. The Risk Register is reviewed on a quarterly basis via the Construction Progress meetings that are attended by the Supply Chain Partner, the external Project Manager, the external Cost Advisor, Health Board and Trust staff.

6.5.3 The current costed project risk register that has informed the Project contingency sum is included within the FBC Estates Annex.

6.5.4 The Service / Operational Risk Register is managed by the TCS Services Director. This Risk Register is reviewed regularly via the Project Team and the Project Board. The latest version as attached as an ***Appendix 2*** to this FBC.

6.5.5 The Project Team will consider and mitigate risk and maintain those which can be actively managed by this Group. However, when a risk is deemed so potentially severe post mitigation that it could impact on the overall delivery of the RSC (to time, cost or Quality) the risk will be escalated to the RSC Project Board for more senior oversight. The RSC Project Board will manage risk that directly affects their prescribed deliverables. The members of the RSC Project Board will review the Risk Register at each meeting adding, reassessing or closing risks as necessary and where consideration will also be given to the escalation of risks to the TCS Programme Delivery Board and/or the Health Board and/or the Trust Board as appropriate.

6.6 Contract Management

6.6.1 This FBC states a requirement for the delivery of a Radiotherapy Satellite Centre on the Nevill Hall Hospital site, under the NEC3 Engineering & Construction (ECC) Form of Contract and Designed for Life: Building for Wales Framework.

6.6.2 The Commercial Case sets out in detail the overall approach and arrangements for the management of the construction contract.

6.7 Post Project Evaluation

5.7.1 A Post Project Evaluation (PPE) incorporates the Project Evaluation Review (PER) and the Post Implementation Review (PIR). The Post Project Evaluation plan for both these elements will be developed and will be undertaken after the operational commissioning of the new facility.

Post Evaluation Review (PER)

6.7.2 The purpose of the PER is to improve project appraisal at all stages of the project from preparation of the business case through to the design, management and implementation of the scheme and will be timed for 6 months following the commissioning of the new facility.

6.8 OGC Gateway Review Arrangements

6.8.1 A Gateway Review was undertaken in March 2022 and the project was rated as "Amber". The Gateway Report is attached at ***Appendix 10*****.** The recommendations of that review have or are being addressed in the context of the preparation of the final FBC and ongoing Project Governance arrangements. These are set out below:

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion
1.	**The early work by the Project team with AB CHC, patients and patient groups should continue through to implementation and the high standard of communications to patients and public should be maintained.**	R - Recommended	Ongoing as part of the implementation of the project
2.	**A more detailed workforce plan with supporting evidence should be completed.**	C- Critical	A Workforce Plan has been produced and is attached as an Appendix to this FBC
3.	**SRO and joint partners to commit to the procurement process, in**	C- Critical	The IRS procurement process is progressing with a view to selection of a preferred supplier and

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion
	order not to delay any further.		submission of a FBC to WG in May 2022.
4.	**Continue the dialogue with Natural Resources Wales to ensure speedy resolution of environmental issues, emphasising delay will deny the population of the area access to life saving Radiotherapy treatment.**	C- Critical	Natural Resources Wales will be formally consulted as part of the Planning Application process. The Planning Application was submitted on 1st April 2022.
5.	**Welsh Government should be asked to fund the enabling works to avoid the use of scarce discretionary capital.**	E- Essential	WG have advised that they will not approve any further enabling works prior to FBC approval.
6.	**A lessons learned document should be compiled and made available to others likely to undertake major projects, for example the related project for the nVCC.**	R - Recommended	A lessons learned document produced post construction of the Grange University Hospital has been shared with the Project Board and Project Team. Relevant issues will be addressed going forward in the review of service and capital risk registers
7.	**The Project should develop and agree a more detailed Integrated Assurance and Approvals Plan (IAAP) which should clarify how and when key decisions are to be**	E- Essential	This will be undertaken post FBC approval

Ref. No.	Recommendation	Urgency (C/E/R)	Target date for completion
	made within the governance structure.		
8.	**An external review of the governance should be undertaken to clarify the arrangements necessary to move beyond the FBC and into implementation and benefits delivery.**	E- Essential	This will be undertaken post FBC approval.

6.8.2 A further review, Gateway Review 4 – Readiness for Service, will be undertaken once contracts are in place and when planning for transition and implementation is well developed.

Aneurin Bevan University Health Board
Learning and Reflections from Business Continuity (Black Escalation Status)

Purpose of Report

- To explain the context and set out the basis on which the decision was made to declare Business Continuity (Black escalation status).
- To provide an explanation of the triggers which led to calling the highest level of escalation, the steps taken to de-escalate and stabilise the system.
- To report on the learning identified from the incident.

The Board is asked to: *(please tick as appropriate)*	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	
Executive Sponsor: Interim Chief Executive	
Report Author: Executive Director of Nursing	
Report Received consideration and supported by: Executive Team considered related SBAR report on 12th May 2022.	
Date of the Report: 15th May 2022	

Background and Context

At 17:00 on Tuesday 29 March 2022, Aneurin Bevan University Health Board (ABUHB) invoked a state of business continuity and declared level black based on indicators signalling significant risk to patient safety.

This paper explains the context in which this decision was made, the triggers which led to calling the highest level of escalation, the steps taken to de-escalate and stabilise the system and the learning from the incident.

NHS Wales has an Emergency Pressures Escalation Plan that has recently been updated to ensure a more integrated approach, which incorporates social care. This revised plan was agreed by Chief Executives at the end of March 2022. Its purpose is to ensure effective patient flow and the maintenance of patient safety in the management and coordination of urgent pressures. Each Health Board and Trust has a corresponding framework which details the escalation status and actions required at each level. The aim is to provide a clear operational approach for the effective management of capacity.

Each Acute site identifies their escalation levels at set times through the day and the morning declaration is published daily on the National Dashboard and feeds into a national system pressures meeting held every day at 11 am, chaired by Welsh Ambulance Services NHS Trust (WAST).

NHS Wales frequently declares High Amber and Red status for urgent and emergency care and Aneurin Bevan University Health Board has been routinely at red status, particularly at the Grange University Hospital. Red status is no longer a level that is only seen during the Winter period, as was the case in past years.

The entire health and social care system is seeing patients whose physical and mental health conditions have worsened due to the impact of the pandemic, plus patients with new health care needs that appear to have developed as a result of isolation. There are higher than pre-pandemic rates of patients presenting across many services, including primary care, where practices are reporting an increase in demand of circa 20%.

This increase in demand is particularly prevalent across the urgent and emergency care system. For context, prior to the pandemic as part of the Clinical Futures design programme, the Health Board expected to see between 100 and 170 patients self-presenting to its Emergency Department per day. In the most recent six months this range has increased to between 140 and 280 patients with the average attendance currently numbering 260 per day. In parallel, the number of patients who are presenting to the Minor Injury Units has also increased significantly, a position that was not anticipated, or indeed planned for.

There is an inability to move patients through the hospital system in a timely manner, the reason for which is multi-faceted. This is having significant consequences for the performance of the Emergency Department and associated ambulance handover times. On any one day, there are also around 250 to 300 patients who are assessed as 'medically optimised' but are unable to be discharged to their place of residence for a variety of reasons, resulting in delayed transfer to a more appropriate care setting.

The limited availability of community and domiciliary care is causing significant pressure which restricts the opportunities to discharge patients to their home or a community setting with packages of care. The impact of the pandemic on social care is having a detrimental effect on NHS ability to discharge patients in a timely manner and consequently is negatively impacting on effective and timely patient flow through the system. System capacity is constrained and compressed between the high demand through Emergency Department and Assessment Units coupled with an inability to discharge patients in a timely manner from wards.

Infection control guidance, appropriate distancing requirements and testing protocols have meant that processes are taking longer and the physical capacity within departments and services are more constrained.

The workforce across the health and social care system is fragile with Covid-19 continuing to have an impact. The requirements for staff is at an all-time high due to high levels of demand across our system along with higher levels of absence and vacancies. This is combined with complex workforce challenges in social care and WAST who are also experiencing high levels of absence and vacancies. The increasing pressure comes at a

time when there are unmet health and care needs in the population, existing workforce gaps and a fatigued workforce.

Assessment and Conclusion

In December 2019, the Executive Team agreed an Emergency Pressures Escalation Policy (the Policy) for the organisation. The aim was to enable the identification of the degree of organisational pressure (based on a set of triggers), at time of high demand and risk, and outline the key actions required at each level of escalation to maintain patient safety, minimise risk and return the Health Board to business as usual.

The Policy sets out five categories of escalation, based on the NHS Wales Emergency Pressures Escalation and De-Escalation Plan, as set out in the image below:

The Black escalation category is where the system is not able to de-escalate from Red and patient safety is severely compromised. Black status should be a rare event and will only ever be called in extremis and means the organisation has entered a state of business continuity (this is when an organisation maintains essential services during and after a disaster).
The Emergency Pressures Escalation Framework requires the monitoring of system pressure which can be attributed to a number of triggers:

- Number of patients in the Emergency Department and Assessment Units, above footprint;
- Number of patients in resuscitation department, majors and 'red release';
- Triage Time and Waits To Be Seen (WTBS) time;
- Number of ambulances held on the forecourt outside the Emergency Department;
- Number of patients delayed on an ambulance for more than 60 minutes;
- Availability of beds to accommodate admissions, including ITU, CCU and NICU;
- Use of pre-empting and boarding*;
- Number of patients identified as delayed discharges;
- Number of patients confirmed as Covid-positive;
- Deficit in workforce and skill mix availability

*Pre-empting is when a patient is moved to a ward even though a bed space is not available to accommodate them but a space will become available as other patients are transferred or discharged. Boarding is the practise of accommodating additional patients on a ward beyond the ward bed capacity. The term boarding is utilised when a patient is moved to a ward where no potential or definite discharges have been identified. Boarding

should be time limited. This practise is instigated at times when the Emergency Department is at full capacity and overcrowding has occurred as a result.

The Health Board has remained under significant pressure throughout the pandemic, however the week beginning Sunday 27 March 2022 saw levels of demand that were even greater than usual with an inability for the system to de-escalate. This situation was a culmination of increasing numbers of patients with a high acuity presenting for emergency care, poor discharge profiles and exceptional levels of staff absence.

Towards the end of Monday 28 March 2022, the Emergency Department was extremely busy and experienced a record number of attendances. In some cases, waits to see a doctor, where a patients' condition was not life threatening, were greater than 14 hours.

The total attendance at the Emergency Department that day was 317; with 253 patients being discharged and 63 patients admitted. Most of the demand for emergency care was generated by walk-in attendances, which peaked at 271. There were 215 presentations for the Majors Department alone, a significant increase to the usual 100 presentations per day that the department would usually experience. The number categorised as Majors is the highest seen in a day since the Grange University Hospital opened. At the same time, the discharge of emergency admissions from the Grange University Hospital was on the lower end for a Monday; typically, this would be around 50 to 90 patients discharged following admission; 58 were discharged that day.

As pressure grew in the Emergency Department and Assessment Units the number of delayed transfers of car, from acute hospitals doubled from 61 patients on Monday 28 March 2022 to 122 patients on Tuesday 29 March 2022. This is high for acute hospitals compared with the months running up to that week.

During the afternoon of Tuesday 29 March 2022, the Executive Team met to consider additional actions required in light of the sustained pressure being experienced particularly at the Grange University Hospital, triggered by escalation from the Operations Team.

The situation report at the time indicated the following:

- Number of patients in the Emergency Department peaked to 180 on the Monday night and the number remained at 140 by Tuesday afternoon;
- Patients had remained in the Emergency Department for more than 24 hours; the longest patient in the department was for 4 days;
- 18 ambulance crews were outside hospitals, with the longest wait being 20 hours;
- Triage Time was around 2 hours (target 15minutes);
- Waits To Be Seen (WTBS) by a Doctor in the Emergency Department were up to 14 hours (target 3 hours);
- Very low discharge profile across the Grange University Hospital and enhanced Local General Hospitals. At the time that Executive Directors met, only 9 patients had a definite plan for discharge, together with 6 potential discharges;
- High attendances (via Ambulance and people walking in)
- High number of patients with a Delayed Transfers of Care;
- High numbers of patients awaiting an Inter-Hospital Transfer from the Grange University Hospital;
- Depleted availability of GP appointments;
- Increasing number of Covid positive patients in hospital beds;
- All additional capacity was used, and patients had been boarded in the day;

- WAST were experiencing high levels of escalation.

All sites were experiencing high levels of staff absence and an informal exercise was conducted to assess the staffing availability in each area using a scale of 0 to 10; with 10 being catastrophic and unable to function. The deficit of staff was significant with areas such as the Emergency Department, Flow Centre and wards at the Grange University Hospital citing a score of 9.

Operational teams had already enacted the actions outlined in the Health Board's Emergency Pressures Escalation Framework which had triggered additional patient reviews across all specialties to identify any capacity or opportunities for increased patient flow. Mutual aid support had been agreed with Cwm Taf Morgannwg University Health Board (CTMUHB) and conversations were ongoing with Cardiff and Vale University Health Board. All areas that could pre-empt and board were doing so, ambulance diverts were in place, together with redirection with significant reconfiguration across Nevill Hall Hospital and Royal Gwent Hospital enacted to create additional capacity.

It was clear the escalation level equated to exceptional pressure across the system with departments congested and very few discharges able to take place; all of which was compounded by incredibly challenging staffing deficits. This culmination of pressure created a crescendo and the system was unable to de-escalate with a significant risk to patient safety. Based on the data, presenting situation and predicted demand a recommendation was made to the Chief Executive that the organisation was no longer experiencing conditions indicative of Red escalation but was more aligned to Black and, as such, a status of business continuity should be invoked.

Aneurin Bevan University Health Board has never needed to declare Black status previously and the decision to declare Black was carefully considered by the Executive Team, taking all facts into consideration. Doing so, however, enabled enhanced collaboration with neighbouring Health Boards for mutual aid, with Local Authority partners to trigger additional support and with WAST to deploy additional agency vehicles through NEPTS to enable increased patient transfers between sites. All staff on non-clinical days were called in to assess patients that were deemed medically fit with a view to enacting expedited discharges home where it was clinically safe to do so. In addition, patients who were waiting for a social care assessment were expedited. A public communication was used to inform the public that ABUHB hospitals were under significant pressure with advice to only attend the Emergency Department with life threatening conditions or serious injury. The Community Health Council was notified, and an Early Warning Notification was submitted to the Delivery Unit.

As a result of the above actions, the organisation started the following day in a slightly improved position although services remained under significant pressure and enhanced strategic oversight in a state of business continuity remained. Throughout the day, on Wednesday 30 March 2022, the focus continued on creating bed space for patients with the most clinical need. Support from Care Homes and Local Authorities continued via the Step Closer to Home Pathways and clinical teams were asked to expedite discharge with a revised risk tolerance.

By Thursday 31 March 2022, due to an improved position as a result of the additional actions taken over the previous 48 hours and signs of the system stabilising, the Executive Team agreed to de-escalate from Black to Red status. Whilst this was a positive sign of

improvement, it must be recognised that Red status still carries an escalation assessment indicating extreme pressure. As such, and in preparation for the weekend to follow, all efforts were required to continue to create capacity. A number of additional actions were agreed, to include:

- Additional Physician Associate support over the weekend;
- Additional transport to maintain higher numbers of inter-site transfers;
- Enhanced pharmacy support;
- Additional medical cover to support weekend discharges and increased numbers of ward rounds;
- Enhanced use of the Urgent Primary Care Centre;
- Ensuring all GP emergency admissions have had face to face consultations;
- Local Authority support for Social Worker reviews and increased packages of care;
- Continued multi-disciplinary team reviews of patients with long lengths of stay or delayed transfers of care;
- Therapy support and 'Home First' presence in Emergency Department.

Conclusion and Learning

The triggers and indicators signalled the Health Board was under extreme pressure, which built from Monday 28th March, culminating in a precarious position by Tuesday 29th March with:

☐ An over-crowded Emergency Department
☐ Substantial ambulance delays on the forecourt at the Emergency Department
☐ Exit block from the Wards across the GUH and the ELGH's
☐ WAST Escalation with an inability to provide a timely response to people in the Community.

This collectively presented an extremely high-risk situation in terms of quality, safety and patient experience. Following detailed analysis and a data-driven debate by the Executive Team, a recommendation was made to the Chief Executive, at 17.00 hours, that a declaration of Black status and Business Continuity was advisable, with the aim of stabilising the system and reducing the risks to patients.

Black status was declared that evening, yielding positive action from WAST in terms of additional vehicles to enable inter-hospital transfers and mutual aid from CTMUHB. On-Call Consultants were asked to attend the Grange University Hospital to further review patients with a view to transfer or discharge. These actions enabled an easing of pressure at the GUH, but the Emergency Department remained over-crowded with long delays for assessment, treatment and admission.

The Executive Team held regular briefing sessions over the following 48-hour period, to assess the metrics and impact of Business Continuity, with a degree of stabilisation noted and formal de-escalation by Thursday 31st March 2022.

Declaring Black status enabled enaction of the highest level of the ABUHB Escalation Policy and, as such, a testing of the policy framework for effectiveness. Whilst the Policy served its purpose in terms of Black actions, adequately guiding the Health Board response, it was recognised that a strengthening of the Policy was required, most notably with respect to the cascade of the declaration and triggering of 'above and beyond' actions for all teams.

Having reflected on the situation and incident, it is evident the data from the Monday 27th was showing the system was struggling and, with hindsight, would escalate without greater targeted intervention.

The Health Board Escalation Policy directs that when Black is declared the Major Incident Policy must be enacted. The Major Incident Policy, however, does not appear to be the correct policy framework to address the urgent care challenges faced by the Health Board. The Major Incident Policy of the Health Board provides the Framework by which the organisation, as a Category 1 Responder under the Civil Contingencies Act (CCA) 2004, will respond to a Major Incident or an Emergency (as defined within the CCA). The CCA defines an emergency as "an event or situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK".

The Civil Contingencies Act (CCA) 2004 and accompanying non-legislative measures, delivers a statutory framework of roles and responsibilities for organisations involved in civil protection at the local level.

As a Category 1 responder under the CCA, Aneurin Bevan University Health Board is subject to the full set of civil protection duties. These are to:

- assess the risk of emergencies occurring and use this to inform contingency planning;
- put in place emergency plans;
- put in place business continuity management arrangements;
- put in place arrangements to make information available to the public and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- share information and co-operate with other local responders to enhance coordination and efficiency.

In the context of the Health Board's duty to put in place business continuity management arrangements, the CCA requires Category 1 responders to 'maintain plans to ensure that they can continue to exercise their functions in the event of an emergency, so far as is reasonably practicable'. Business continuity plans should incorporate the principles of Integrated Emergency Management (assessment, prevention, preparation, response, and recovery).

Whilst business continuity management and emergency planning may be described as separate processes within an organisation, a business continuity incident may occur at the same time as a major incident or emergency or be triggered by it and so there needs to be complimentary and integrated plans in place

On reflection it is deemed the Emergency Pressures Escalation Framework potentially triggering the Health Board's Major Incident Policy requires further consideration to ensure adequate internal response is in place prior to a multi-agency response being initiated.

It has therefore been deemed necessary for the Health Board to establish a Corporate Business Continuity Plan which is complementary to the Major Incident Policy. The purpose of both being:

- Corporate Business Continuity Plan:

To ensure that the Health Board is ready and able to anticipate, prepare for, prevent, respond to and recover from disruptions, whatever their source and whatever part of the business they affect, so that priority patient services can be maintained.

- Major Incident Policy:

To provide the framework for the strategic and tactical management, multi-agency response, co-ordination and controlling of resources in a major incident or emergency.

Both policies will need to be underpinned by site and/or service specific business continuity plans.

Based on the Health Boards' ability to de-escalate within 48 hours, the Executive Team believe the declaration of Black was the correct decision to improve quality, safety and patient experience. It was a data-driven and policy compliant decision.

Recommendation

The Executive Team have identified a number of actions to further strengthen the Health Board response to urgent care escalation to include:

- Proactive analysis of daily data to predict escalation, with earlier in the day decision making regarding escalation actions;
- Review the local Escalation Policy, in light of the approval of a revised national framework;
- Develop a decision-making tool for de-escalation;
- Develop a Corporate Business Continuity Plan.

The Board is asked to note this report for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	This report provides details on actions taken to operationally manage the system, linked to declaring Business Continuity. The learning and reflections are being reported to the Board for assurance. As such, there are no key risks directly associated with this report.
Financial Assessment, including Value for Money	There is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	Whilst this report provides details on actions taken operationally manage the system, including patient safety and experience, an assessment has not been undertaken for this report as it is for assurance purposes.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has not been undertaken for this report as it is for assurance purposes only.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	This assurance report provides details of the operational response provide in the delivery of safe urgent and emergency care.

The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not directly applicable to this specific report.
Glossary of New Terms	CCU – Coronary Care Unit ICU – Intensive Care Unit NICU – Neonatal Intensive Care Unit
Public Interest	This report is written for the public domain.

Aneurin Bevan University Health Board

Board Governance: Annual Review of Effectiveness 2021/22

Purpose of the Report

Following the Board's Development Session on 8th March 2022, this report provides the outcome of the Board's annual self-assessment of effectiveness, including actions identified for improvement to be delivered in 2022/23.

The Board is asked to:	
Approve the Report	
Discuss and Provide Views	✓
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor: Ann Lloyd, Chair

Report Author: Rani Mallison, Director of Corporate Governance

Report Received consideration and supported by:

Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**Board Development Session, 8th March 2022**

Date of the Report: 15th May 2022

Background and Context

As set out in the Board's Standing Orders (Section 10.2), the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups.

The purpose of regular self-review is to promote self-knowledge, reflection and vigilance, and the development and improvement of leadership and governance. It helps boards identify strengths and development areas to deliver continuous improvement. High performing boards are likely to carry out some form of self-review of their leadership and governance regularly and frequently.

The three key roles through which effective Boards demonstrate leadership within their organisations are known as:

a) Formulating strategy;
b) Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; and
c) Shaping a positive culture for the Board and the organisation.

The behaviour and culture of the Board are key determinants of the Board's performance. Effective Boards and their members:

a) Prioritise service quality and safety
b) Behave consistently in line with Nolan's seven principles of public life;
c) Model an open approach to learning;
d) Invest time to develop constructive relationships around the Board table;
e) Reflect a drive to challenge discrimination, promote equality, diversity, equity of access and quality of services. They respect and protect human rights in the treatment of staff, service users, their families and carers, and the wider community;
f) Ensure that their approach to strategy, accountability and engagement are consistent with the values they seek to promote for the organisation

The most effective Boards invest time and energy in the development of mature relationships and ways of working.

Assessment

For 2021/22, the Board used the NHS England and NHS Improvement (NHSE and NHSI) Well-led Framework for Leadership and Governance Developmental Reviews, as the basis for reviewing its effectiveness during the year. The Well-led Framework supports boards to maintain and develop the effectiveness of their leadership and governance arrangements.

The Framework has a strong focus on integrated governance and leadership across quality, finance and operations as well as an emphasis on organisational culture, improvement and system working.

The Framework is structured around eight key lines of enquiry and includes a scoring matrix to support boards in assessing their position (**Appendix A**):

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

The Board held a Development Session on 8th March 2022 and used the eight key lines of enquiry (KLOE) to undertake an assessment of its performance during 2021/22. The

purpose being to enable the Board to identify areas for improvement moving forward into 2022/23. This Session also took into consideration independent and objective feedback from auditors and inspectors, such as Audit Wales' Structured Assessment which comments on the existence of proper arrangements for the efficient, effective, and economical use of resources within the Health Board.

The Care Quality Commission, in partnership with NHSE and NHSI, have developed several prompts as part of their assessments of organisations in NHS England which relate to the eight KLOEs provided in the well-led framework (Key lines of enquiry for healthcare services | CQC Public Website) These prompts were provided with each main question (KLOE) to support the Board in undertaking an assessment of its position.

In undertaking a self-assessment against the eight key lines of enquiry, the Board determined that it was at an "amber-green" rating for all aspects:

Well-Led Key Line of Enquiry	Green	Amber-Green	Amber-Red	Red
	Meets or exceeds expectations	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Does not meet expectations
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?		✓		
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?		✓		
3. Is there a culture of high quality, sustainable care?		✓		
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?		✓		
5. Are there clear and effective processes for managing risks, issues and performance?		✓		
6. Is appropriate and accurate information being effectively processed, challenged and acted on?		✓		
7. Are there people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?		✓		
8. Are there robust systems and processes for learning, continuous improvement and innovation?		✓		

Recognising that a green rated position could not yet be achieved for 2021/22, the Board identified several improvement actions for 2022/23. These are set out below, along with the delivery mechanism by which the Board will oversee delivery:

Well-Led Key Line of Enquiry	Improvement Action for 2022/23	Delivery Mechanism 2022/23
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?	a) Deliver a programme of board development, including mentoring and support to Board Members	Included as a Governance Priority within the IMTP 2022-25
	b) Establish a comprehensive Induction Programme for Board Members (Independent and Executive)	Included as a Governance Priority within the IMTP 2022-25
	c) Progress plans to support succession planning and talent management	Included as a priority within the People Plan 2022-25

	d) Ensure all Board member positions are appointed to	Included as a Governance Priority within the IMTP 2022-25
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	a) Ensure sufficient time for the Board to focus on strategic developments and horizon scanning	Board Strategic Planning Sessions established for 2022/23
	b) Refresh and Restate the Board's Values and Behaviours Framework	Included as a Governance Priority within the IMTP 2022-25
	c) Undertake an evaluation of the Clinical Futures Model of Care	Identified as a priority for the Board's Partnerships, Population Health & Planning Committee to receive in 2022/23
	d) Refresh the Clinical Future Strategy and produce a "plan on a page"	Identified as a priority with the IMTP 2022-25
3. Is there a culture of high quality, sustainable care?	a) Implement a systematic approach to capturing user feedback to inform learning	Identified as a priority with the IMTP 2022-25
	b) Continue to implement the People First Engagement Plan to learn from staff experiences and feedback	Included as a Governance Priority within the IMTP 2022-25
	c) Develop and Implement an Outcomes Framework to understand delivery and impact	Identified as a priority with the IMTP 2022-25
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	a) Establish a Deployment and Accountability Framework to enable appropriate decision making at all levels of the organisation, along with strengthened internal control and accountability	Included as a Governance Priority within the IMTP 2022-25
	b) Develop a Partnership Governance Framework to support achievement of the Board's objectives, including those responsibilities delivered through strategic partnerships	Included as a Governance Priority within the IMTP 2022-25
5. Are there clear and effective processes for managing risks, issues and performance?	a) Continue to embed effective risk management arrangements throughout all aspects of business	Included as a Governance Priority within the IMTP 2022-25
	b) Develop and Implement an Outcomes Framework to understand delivery and impact	Identified as a priority with the IMTP 2022-25

	c) Continue to implement the Board's Efficiencies Framework, ensuring application is consistent across the organisation	Identified as a priority with the IMTP 2022-25
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	a) Develop and Implement an Outcomes Framework to understand delivery and impact	Identified as a priority with the IMTP 2022-25
	b) Continue to embed our approach to value based and prudent health care within the organisation	Identified as a priority with the IMTP 2022-25
7. Are there people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	a) Implement a systematic approach to capturing user feedback to inform learning	Identified as a priority with the IMTP 2022-25
	b) Refresh the Board's Engagement Strategy for 2022-2025	Identified as a priority for the Board's Partnerships, Population Health & Planning Committee to receive in 2022/23
8. Are there robust systems and processes for learning, continuous improvement and innovation?	a) Continue to invest in and support the development of Research, Improvement, Innovation and Value Based Healthcare t	Identified as a priority with the IMTP 2022-25

Conclusion and Recommendation

This paper summarises the Board's self-assessment of effectiveness for 2021/22, identifying those actions identified to strengthen the Board's ways of working in 2022/23. The actions identified will be monitored through established mechanisms and considered as part of the Board's self-assessment later in 2022/23.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework and this proposal should enhance the risk management process.
Financial Assessment, including Value for Money	There is no direct impact associated with this report.
Quality, Safety and Patient Experience Assessment	There is no direct impact associated with this report.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no specific equality issues associated with this report.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.

Link to Integrated Medium Term Plan/Corporate Objectives	The risks against delivery of key priorities in the IMTP, will be better monitored and assessed.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	WBFGA considerations are embedded in board working pract
Glossary of New Terms	None
Public Interest	Report to be published

Appendix A

Well-led Framework for Leadership and Governance Developmental Reviews

Scoring Matrix

Rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, no major omissions and robust action plans to address perceived gaps with proven track record of delivery
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, some minor omissions. Actions plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in quality governance identified. Significant volume of actions plans required and concerns about management's capacity to deliver

Aneurin Bevan University Health Board

PEOPLE PLAN 2022 – 2025

PUTTING PEOPLE FIRST

Executive Summary

Our People Plan 2022-2025; Putting People First, outlines the 3-year forward view of our people priorities as a Health Board. The plan describes how the Health Board will develop and enhance the capacity and capability of our workforce with a clear focus on wellbeing, inclusion and engagement.

This report, which was presented to the Executive Team on 05 May 2022, sets out how the People Plan has been developed with staff and partners including what has been considered in terms of the external and internal context. The plan describes the 3-year journey and the ambitions of the Health Board around three core objectives:

- **Staff Health & Wellbeing,** creating an environment for staff to feel proud to work for the Health Board and are included, engaged, and have a sense of belonging. This is underpinned by our pillars of wellbeing (sense of control, purpose, fairness, belonging, cared for, and valued).
- **Employer of Choice,** building on the reputation of the Health Board as a great place to train, work and grow.
- Creating opportunities for **Workforce Sustainability and Transformation** ensuring that we have the right workforce models that embed innovative thinking.

These objectives are aligned to our established Values and Behaviours Framework and our belief that staff experience shapes patient experience. Staff stories and images of our staff in their working environment are included in the document to provide an authentic Health Board identity.

The People Plan is supported by a Delivery Framework which describes how delivery against the key success measures, milestones and actions will be monitored and reported and includes steps to be followed in the case of any necessary escalation.

The plan aligns with the themes of the Health and Social Care Workforce Strategy (Health and Social Care Workforce Strategy - HEIW (nhs.wales), the National Planning Framework and with the Health Board's IMTP. It also builds on our workforce data and intelligence together with the experience of our staff and partners. Collectively these inputs have shaped our priorities for 2022 to 2025 enabling workforce models and approaches that support the best outcomes for our patients and staff.

The Board is asked to approve the People Plan 2022 – 2025 and the associated Delivery Framework.

In addition, the Board is asked to endorse the refreshed illustrations for the Health Board values which are more inclusive and embraces the diversity of our staff and population. These images were refreshed as a result of staff feedback during a rapid review of the Values and Behaviours Framework as part of the Covid-19 recruitment process. A full review of the framework is planned for 2022.

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

Executive Sponsor: Sarah Simmonds, Director of Workforce & OD

Report Author: Debra Wood-Lawson, Deputy Director of Workforce & OD

Report Received consideration and supported by:

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

Date of the Report: 03 May 2022

Supplementary Papers Attached:
Appendix 1 People Plan 2022 – 2025
Appendix 2 Delivery Framework
Appendix 3 Summarised description for staff communication

Purpose of the Report

The purpose of the report is to seek Board approval to the People Plan 2022 – 2025, **Appendix 1** and the Delivery Framework, **Appendix 2**. In addition, the Board is asked to endorse the refreshed illustrations for the Health Board values which are more inclusive and embraces the diversity of our staff and population.

Background and Context

Our new People Plan 2022 -2025, Putting People First, reflects our current challenges, opportunities, and the changing context in which we now operate due to the impact of the Covid-19 pandemic and of leaving the European Union.

As well as integration with the Health Board's IMTP and the Health and Social Care Workforce Strategy, the plan is aligned to several key national strategic documents. The plan is connected to the goals of and takes into consideration our legislative and regulatory requirement, such as those set out in:

- Programme for Government and Ministerial Priorities
- Wellbeing and Future Generations (Wales) Act
- Fair Work Wales
- The Equality Act
- Socio-economic Duty
- The Welsh Language Standards
- Foundational Economy in Health and Social Care Strategy
- NHS Wales Decarbonisation Strategic Delivery Plan

It builds on our workforce data and intelligence together with the experience of our staff and partners. Collectively these inputs have shaped our ambition and priorities.

Assessment and Conclusion

The People Plan provides the Workforce and Organisational Development (OD) strategy for the Health Board.

The development of the plan has been achieved through detailed discussions with Executive Team, a Board Development session, formal and informal discussions with staff side and the Local Negotiating Committee, together with general managers and colleagues within the Workforce and Organisation Development function. Feedback from Workforce Business Partners, staff surveys and the People First staff engagement programme has played a central part in shaping the final document.

The plan outlines a roadmap in a set of actions that will help us improve the experience of our people now and in the future. The actions will be underpinned by a Delivery Framework which sets out the governance and assurance mechanisms for reporting, including the oversight and management of any associated risks via the Workforce and OD and Corporate Risk Registers.

Subject to Board approval, the People Plan will be formally launched within the organisation and will be supplemented by a summarised description inviting staff to read the fuller document, **Appendix 3**. We have taken the opportunity to style the document in a way that makes it easier to navigate and update on the intranet, improving access for staff. Progress against the plan will be communicated widely across the organisation on a quarterly basis, through updating the intranet and also supported by leaflets, videos and the circulation of a new Workforce and OD dashboard. Ensuring the voice of staff continues to be central to the implementation of the plan will be supported by opportunities for two-way conversations and ongoing commitment to partnership working with staff side colleagues.

Appropriate updates on the delivery of the plan will be shared via the People and Culture Committee, Executive Team, Trade Union Partnership Forum and the Local Negotiating Committee as well as periodically with divisional teams and staff. Given the theme running through the plan will be about resilience across Health and Social Care, there will also be updates as appropriate to the Regional Partnership Board and the Gwent Public Services Board.

Recommendation

The Board is asked to note the details and priorities within the People Plan and the collaborative approach taken to develop the 3 core objectives and how the delivery of the plan will be monitored, reported and communicated.

The Board is asked to:

- Approve the People Plan 2022 – 2025 and the associated Delivery Framework.
- The Board is asked to endorse the refreshed illustrations for the Health Board's values which are more inclusive and embraces the diversity of our workforce and our population.

<table>
<tr><th colspan="2">Supporting Assessment and Additional Information</th></tr>
<tr><td>Risk Assessment (including links to Risk Register)</td><td>There are no additional risks presented by the People Plan 2022 – 2025, and any emerging or changing risks during its implementation will be captured through the local and corporate risk registers.</td></tr>
<tr><td>Financial Assessment, including Value for Money</td><td>Effective and efficient use of resources is a key aspect of the People Plan approach.</td></tr>
<tr><td>Quality, Safety and Patient Experience Assessment</td><td>Patient experience is intrinsically linked to Health Board staff and their experience and wellbeing.</td></tr>
<tr><td>Equality and Diversity Impact Assessment (including child impact assessment)</td><td>The People Plan has undergone an EQIA, using the revised integrated template. This includes the Socio-Economic Impact, Wellbeing of Future Generations and Welsh Measures. As part of this assessment, it has looked at Equality based ESR data, to identify areas for additional support, which is reflected in the People Plan. Especially in areas of wellbeing and support for staff.</td></tr>
<tr><td>Health and Care Standards</td><td>
<table>
<tr><th>Theme</th><th>Standards</th></tr>
<tr><td>Staying Healthy</td><td>• Health Promotion, Protection and Improvement</td></tr>
<tr><td>Safe Care</td><td>• Managing Risk and Promoting Health and Safety
• Safeguarding Children and Safeguarding Adults at Risk</td></tr>
<tr><td>Effective Care</td><td>• Safe and Clinically Effective Care
• Communicating Effectively
• Quality Improvement, Research and Innovation
• Information Governance and Communications Technology
• Record Keeping</td></tr>
<tr><td>Dignified Care</td><td>• Dignified Care
• Patient Information</td></tr>
<tr><td>Individual Care</td><td>• Planning Care to Promote Independence
• Peoples Rights
• Listening and Learning from Feedback</td></tr>
</table>
</td></tr>
<tr><td>Link to Integrated Medium Term Plan/Corporate Objectives</td><td>The People Plan 2022 – 2025 is integrated into the Health Boards IMTP.</td></tr>
<tr><td rowspan="2">The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working</td><td>Long Term – The People Plan 2022 – 2025 demonstrates a long-term approach to prioritising actions and working in partnership for the Health Board, health and social care systems and our communities.</td></tr>
<tr><td>Integration – This plan is aligned to the IMTP.</td></tr>
</table>

	Involvement – The plan has undergone extensive discussion with a range of stakeholder. This will be the continued approach and ensure that decisions are based on evidence, data etc and the involvement of other people with an interest in the service change/development and this reflects the diversity of our population.
	Collaboration – The delivery of the People Plan 2022 – 2025 is a collective effort for the organisation.
	Prevention – The plan will focus on the early detection and proactive approach to finding solutions to the challenges facing the Health Board and partners within the health and social care system.
Glossary of New Terms	N/A
Public Interest	This report is of public interest.

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

WWW.ABUHB-SWYDDI.CO.UK
WWW.ABUHB-JOBS.CO.UK

happy to talk flexible working

#TRAINWORKLIVE
TRAINWORKLIVE.WALES

Dyfodol Clinigol
Clinical Futures

STEP INTO HEALTH

Workforce & Organisational Development

PEOPLE PLAN 2022/25

Putting People First

CONTENTS

WELCOME TO OUR PEOPLE PLAN 2022/25

Putting People First

This year we have adopted a digital first approach reflecting how we operate as a service. As a result, while the People Plan continues to be a core part of our reporting framework, we have simplified the format and included links to interactive online content, such as videos. This online material brings to life what we do, how we do it, and provides you with a better overall understanding of our service.

ABUHB Website (external)

Workforce & OD Intranet (Internal)

REFERENCES:

The **People Plan** has been designed to aid navigation. We have cross-referenced relevant material and navigation buttons are 'clickable' when using the digital version of the People Plan.

Online content can be accessed by clicking links on the digital version of this People Plan, copying the website address into an internet browser, or scanning the QR code on a mobile device.

Read more page reference

Click to seep related content online

VIDEOS: DO YOU HAVE ANY OTHER STRATEGIC DOCUMENTS OR VIDEOS YOU WOULD LIKE TO INCLUDE????

An introduction to W&OD???

An introduction to the People Plan???

FOREWORD FROM THE CHIEF EXECUTIVE

"WE BELIEVE IN PUTTING 'PEOPLE FIRST', SUPPORTING INDIVIDUALS TO LEAD AND MANAGE THEIR OWN CARE."

I am pleased to introduce the Aneurin Bevan University Health Board People Plan 2022 – 2025. This plan promotes the strategic workforce direction to support our Integrated Medium Term Plan (IMTP). Our IMTP has been developed in collaboration with our partners and outlines what we do and how we are going to shape the future of the services for our population, patients, and staff.

This People Plan sets out our long-term ambition and will be delivered in partnership both internally and externally. As a Health Board we strive for excellence in all that we do and actively encourage a culture of support, respect, integrity, and teamwork.

We believe in putting 'People First', supporting individuals to lead and manage their own care. We believe that modernising the way we organise the delivery of care is essential to improving outcomes, patient experience and ensuring we make the right choices with our resources.

I hope that you enjoy reading this Plan and will work with us to make the delivery a reality.

GLYN JONES

Chief Executive Officer

Aneurin Bevan University Health Board

FOREWORD FROM THE EXECUTIVE DIRECTOR FOR WORKFORCE AND OD

"DELIVER THE HIGHEST LEVELS OF PROFESSIONALISM, DEDICATION, AND COMPASSIONATE PATIENT CARE TO ALL THOSE IN OUR COMMUNITIES"

Over the past 2 years we have seen first-hand how the care we provide at Aneurin Bevan University Health Board touches all our lives. The Health Board is, above all, brought to life by our people and the values we hold to deliver the highest levels of professionalism, dedication, and compassionate patient care to all those in our communities.

The staff of Aneurin Bevan University Health Board have proved that they can rise to ambitious challenges. The workforce has shown resilience in maintaining services at a time of increasing demand, this is particularly so during the Covid-19 pandemic.

Our People Plan 2022 -2025, Putting People First outlines the 3 Year forward view, of the Workforce & Organisational Development Division priorities. It sets out how we will drive, lead, and support the organisation to build on our successes in relation to our values, workforce improvement, capability, and expertise with a clear focus on wellbeing, inclusion, and engagement of our people. Key actions and milestones set out how we will achieve this through a shared commitment of working together.

I have every confidence that colleagues will rise to the challenge and use their enthusiasm, energy, and innovation to deliver the ambitions set out in the People Plan.

Croseo i'n Cynllun Pobl
Welcome to our People Plan

SARAH SIMMONDS

Executive Director of Workforce & OD

Aneurin Bevan University Health Board

INTRODUCTION

A health system is its people and we are proud of all our staff, their dedicated work and compassionate care for our patients and population.

Our new People Plan 2022 -2025, Putting People First, will reflect our current challenges, opportunities, and the changing context in which we operate due to the impacts of the Covid-19 pandemic and from leaving the European Union. The People Plan aligns with the themes of the Health and Social Care Workforce Strategy (Health and Social Care Workforce Strategy - HEIW (nhs.wales), National Planning Framework and with the IMTP, it builds on our workforce data and intelligence together with the experience of our staff and partners. Collectively these inputs will shape our ambition and our priorities for 2022 to 2025.

The People Plan outlines a roadmap that will help us improve the experience of our people now and in the future. The plan is aligned with our organisational values and most importantly our belief that staff experience shapes patient experience. The plan addresses the short term actions needed to stabilise our workforce following the impact of the pandemic and the actions needed to establish and embed new ways of working in the medium to longer term. Much of what is set out in our plan is already underway, however, some developments are new and designed to creatively support long term sustainability.

At its heart it will seek to develop seamless workforce models, ensuring people with the right skills, competencies and experience are in the right place at the right time across our system. A detailed action plan sets out what we will do to create sustainable and innovative solutions by connecting with our employees and our communities of future workforce, to enable at new ways of working, developing new skills and capabilities with flexible and agile models, to widen access to training and employment and ensure our workforce is reflective of our diverse communities.

The Plan will align to the Health Board's IMTP (insert link) and to deliver against our vision:

'To support and enable the workforce to develop a dynamic organisation that cares, learns and improves through a culture of high trust and collaboration'.

To do this we will listen to staff voices, use our data, experience, expertise, and relationships with partners.

In developing the plan, we have listened to our staff, Trade Union colleagues and our stakeholders and have heard their views on the most likely challenges facing the organisation over the next three years, and how the workforce might need to adapt to meet these challenges.

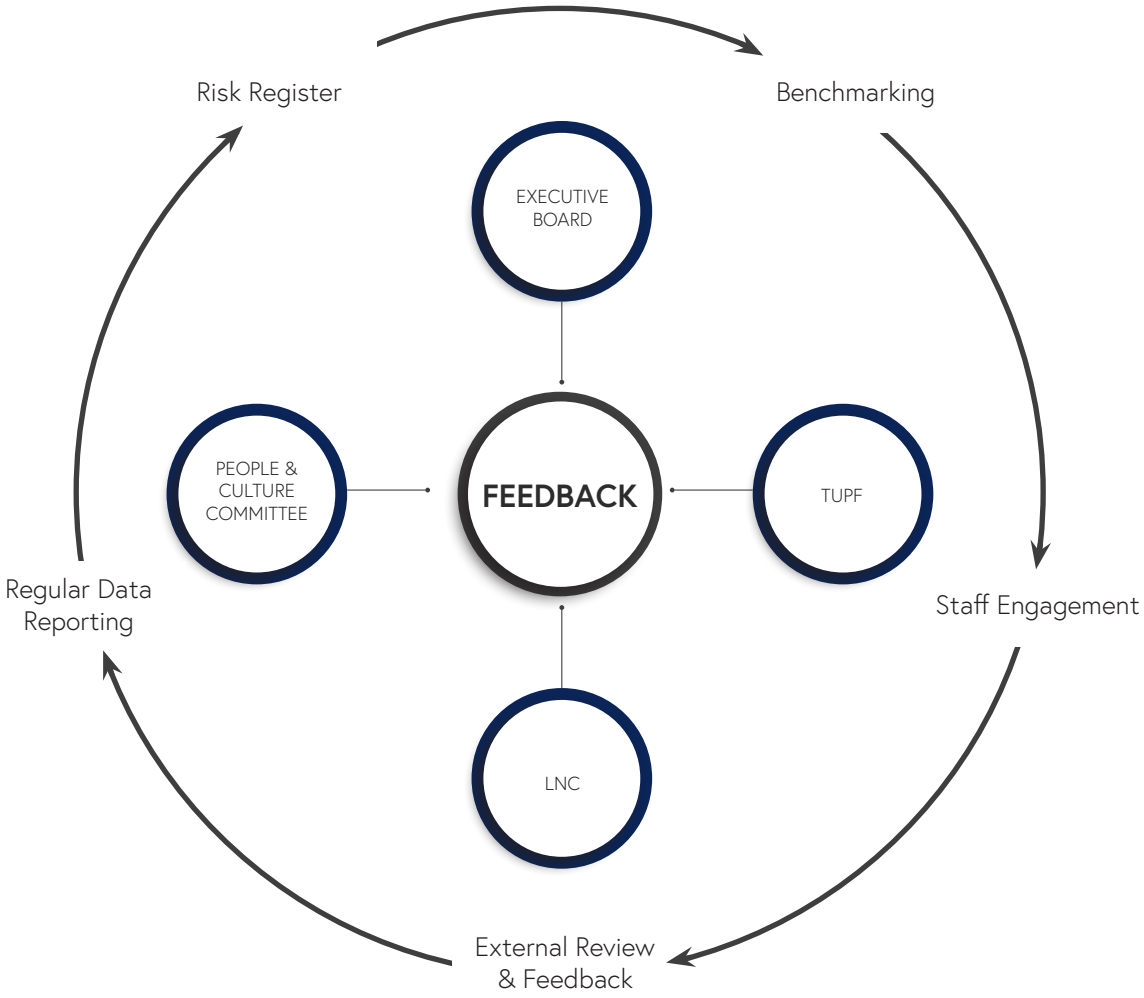
The Health Board's People Plan 2022 – 2025 is our workforce and organisation development strategy and sets out our ambitions, recognising that there is a direct correlation between staff wellbeing and patient outcomes. The plan will focus on the following 3 core objectives:

- An exemplar for Staff Health & Wellbeing, creating an environment for staff to feel proud to work for the Health Board and are included, engaged, and have a sense of belonging. This is underpinned by our pillars of wellbeing (sense of control, purpose, fairness, belonging, cared for, and valued).

- Employer of Choice, building on the reputation of the Health Board is a great place to train, work and grow.

- Creating opportunities for Workforce Sustainability and Transformation ensuring that we have the right workforce models that embed innovative thinking.

The Health Board will deliver the People Plan with an ongoing commitment to working in partnership with staff side colleagues. We have a strong track record on partnership working and recognise the intrinsic value of, and collaborative intent between, the Health Board and the Trade Unions. Our approach engenders ongoing partnership and engagement processes which are open, collaborative, and timely. The Health Board is committed to hearing the voices of staff and working in partnerships with Trade Unions as well as actively engaging with our diverse workforce. The strategies to implement the People Plan will create opportunities to connect with our current staff and new recruits in our communities informally and formally through our established Trades Union Partnership Forum and Local Negotiating Committee.



CONTEXT

As well as integration with the Health Board's IMTP, the plan is aligned to several key national strategic documents. A Healthier Wales: Our Workforce Strategy for Health and Social Care and takes into consideration our legislative and regulatory requirement, such as those set out in:

- Programme for Government and Ministerial Priorities
- Wellbeing and Future Generations (Wales) Act
- Fair Work Wales
- The Equality Act
- Socio-economic Duty
- The Welsh Language Standards
- Foundational Economy in Health and Social Care Strategy
- NHS Wales Decarbonisation Strategic Delivery Plan

Set out below in Figure 1 is the planning framework within Welsh Government which helps describe the interlinking plans and priorities and how these are translated into the Health Board's Integrated Medium-Term Plan (IMTP).

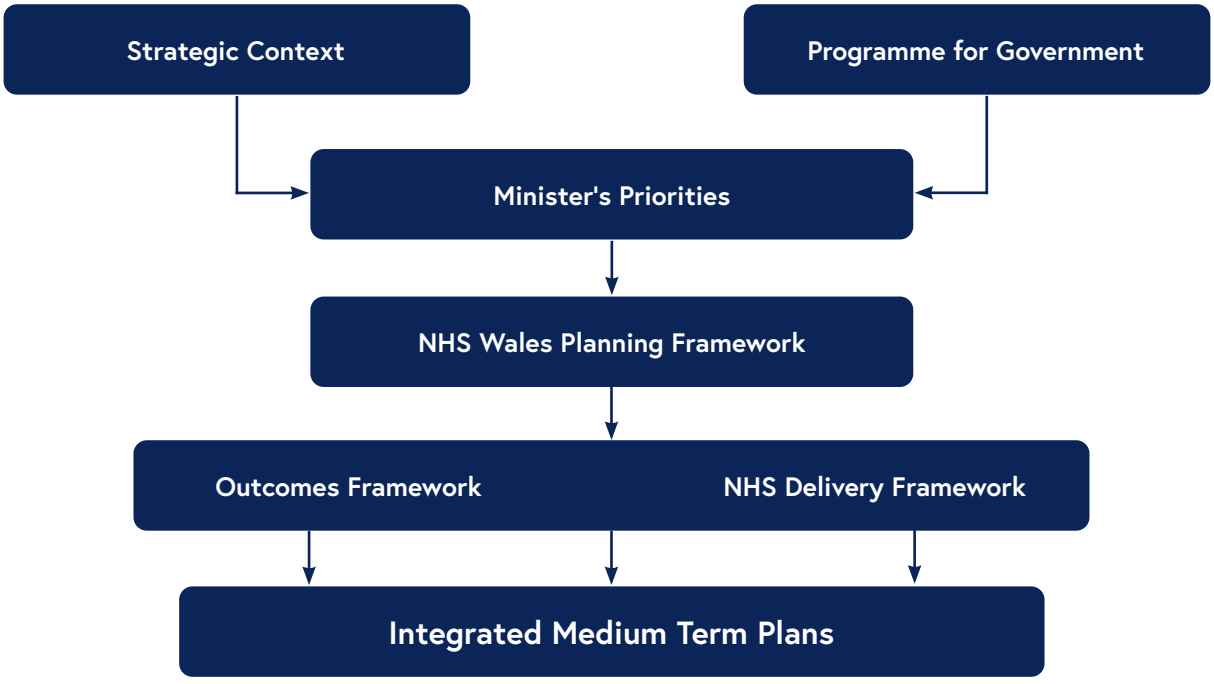


Figure 1. National and local planning framework

We are proud of the way in which our staff have responded showing resilience, bravery, dynamism, resourcefulness, and great skills to the overwhelming challenges presented by COVID-19. The world was changing before the pandemic with more prominence around self-care and the importance of wellbeing, taking advantage of what digital and new technologies can offer and resetting the dialogue between communities, service delivery agencies, as well as employers and employees. As a consequence of the pandemic health inequalities have come to the fore, alongside the need to build sustainable communities with easy access to services to address health and social care needs.

The workforce across the health and social care system is fragile and the pandemic has seen individuals making different career choices. For some this will have meant leaving the NHS and social care or choosing not to take up the opportunities that are presented within the sector.

All this comes at a point when we know we have unmet health and care needs in the population, existing workforce gaps and a fatigued workforce who have heroically risen to the challenges and over a sustained period. It is now imperative to transform, innovate, integrate, and create new models of working.

Working in collaboration with partners such as the Gwent Public Service Board (GPSB), the Regional Partnership Board (RPB), the People Plan seeks to develop workforce models to support integrated services in the long-term working seamlessly across health and social care, focusing on its population, health priorities, integration, and prudent models of service delivery across our geographical footprint and beyond our organisational boundaries.

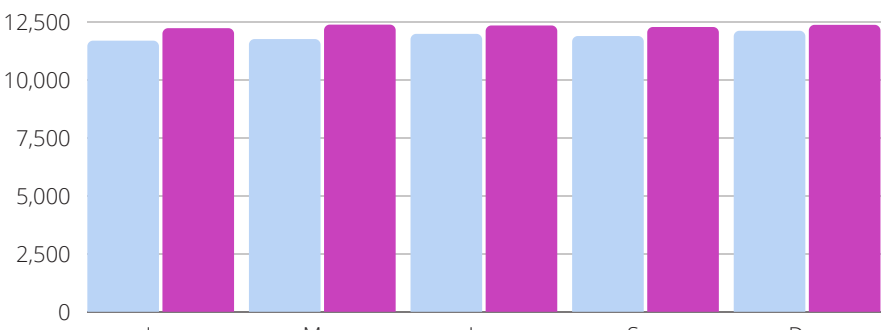
THE HEALTH BOARD

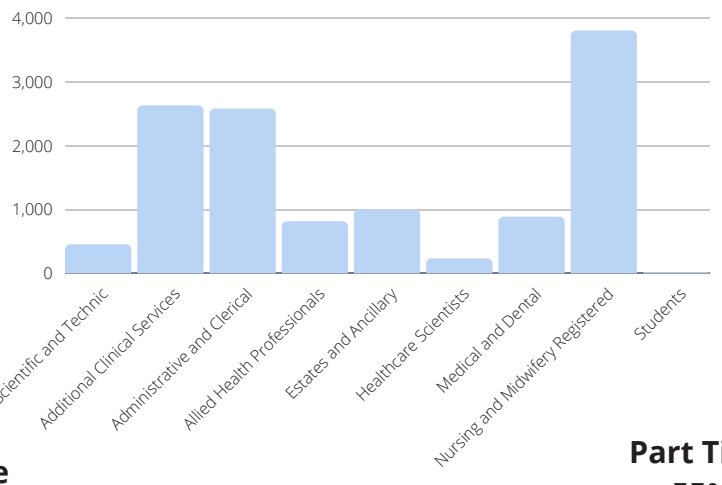
The Health Board employs 12,327 whole time equivalents (WTE) which translates to 15,751 staff and is the largest employer in Gwent. Figure 2 shows the demographic breakdown of our workforce.

OUR WORKFORCE

Our Workforce data includes staff in post comparison, gender, full/part time, ethnicity, sickness and age analysis

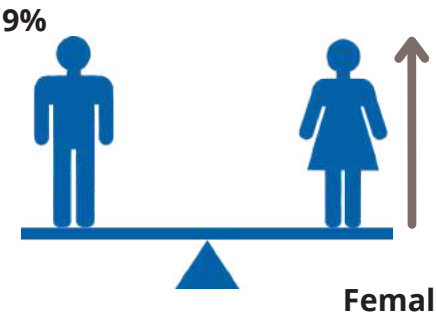
Staff in Post has increased by 255 an increase of 2.11%





The top 3 staff group increases are within Additional Clinical Services (59 wte 9.27%), Admin & Clerical (167 wte 7%), Nursing & Midwifery Registered (138 wte 4%)

Male 19%



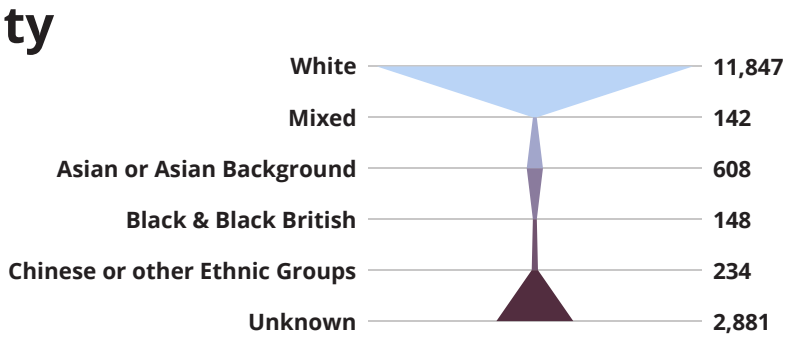
Female 81%

Increase by 2%

Part Time 55%

Full Time 45%

Ethnicity



75% White Ethnicity

18% Unknown/Not stated

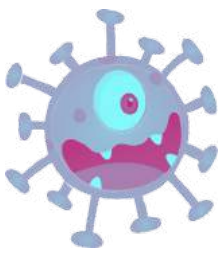
81.22% of the workforce is female, the Health Board employ 9077 more females than males.

Gender Pay Gap

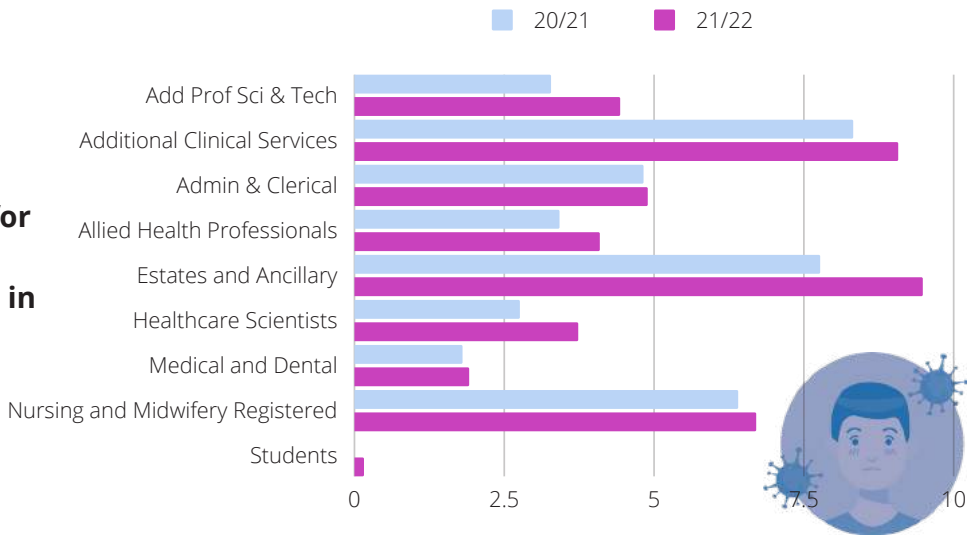
Females mean hourly rate is 21.24% lower than males

Mean Hourly Rates
Male - £21.19
Female - £16.69

Females are paid on average 79p for every £1 that males get paid



Sickness Absence for 21/22 is 6.40% compared to 5.80% in 20/21



36% of staff over 50 years old an increase of 1%

22% of staff over 55 years old an increase of 1%

THE HEALTH BOARD

Our workforce is ageing as is the demographic profile of our population. The demand for workforce supply is currently growing at twice the rate of the population so we need to think differently about engaging/employing a multi-generational workforce who will have different needs and motivations.

Our response will increase our focus on appropriate workforce models, utilising technologies, harnessing opportunities to transform the profile of our workforce, and working with partners to increase resilience through career pathways between health and social care.

The health inequalities of our population will also be found within our workforce. 80% of our staff live within our communities. Therefore, it is essential that staff health and wellbeing is a key priority and a feature of our preventative plans. Through our staff and with our partners we build prosperous and resilient communities by offering accessible training, employment, and career development pathways from entering to leaving work.

The Health Board continues to optimise the opportunity to develop and implement sustainable workforce models across all aspects of our system. Our plans will continue to focus on development of new and advanced practice job roles, multidisciplinary workforce models and maximising the contribution of all our staff and specifically the unregistered workforce. The Health Board continues to work with local authority partners on available options to collaborate and strengthen the health and social care workforce.

Part of that IMTP is ensuring resources are allocated across communities and care pathways with adequate focus across the Clinical Futures Strategy ensuring we enhance the focus on self-care, care closer to home and then through appropriate care settings for all patients according to their need. This is illustrated below in Figure 3:

WHERE DO WE NEED TO BE IN 3 YEARS' TIME

We have set an ambitious plan for improving the way we deliver services; work with our partners and manage our resources within a context of increasing demand and limits on the staff and resources available.

We will need to be focussed on prioritising where we put our efforts and we know that we will not achieve this unless we think and behave differently.

Our ambitions are to deliver:

The development, in partnership, of a workforce to deliver all our strategic priorities providing delivery of care where and when it is needed now and in the future by:

- A workplace that facilitates a sense of belonging and promotes an inclusive culture where people will want to stay
- A flexible and listening organisation that supports it's workforce to be engaged, motivated and healthy staff
- The development in partnership, of a workforce to deliver our strategic priorities providing care where and when it is needed
- Systematic programme of talented and succession planning- future proofing through our progression and leadership offer
- A digital ready and agile workforce embracing new ways of working in teams, across organisations and sectors, and supported by technology
- Accessible and clearly understood entry pathway to training, employment and opportunities to develop skills and careers across the health and social care system which widens access for our divers local communities

The implementation of the People Plan will be underpinned by the Health Board's established Values and Behaviours Framework (link to framework). The framework details the behaviours required from all employees in support of our values, equality, diversity and inclusion and a positive culture.

In the autumn of 2021, a review of the framework was undertaken with input from focus groups across the Health Board. Feedback confirmed that the values remained strong and connected with the organisation and was used to develop the inclusive and fresh images you see below.

KEY DELIVERABLES FOR 2022 – 2025

Our Core Objectives:

Staff Health & Wellbeing

Creating an environment for staff to feel proud to work for the Health Board and are included, engaged, and have a sense of belonging.

Read more on page 12

Employer of Choice

Building on the reputation of the Health Board is a great place to train, work and grow.

Read more on page 16

Workforce Sustainability

Ensuring we have the right workforce models that embed innovative thinking.

Read more on page 21

Each of our 3 objectives will be supported by a detailed Action Plan which identifies the actions to deliver our ambition and how we will measure our progress.



KEY DELIVERABLES FOR 2022 – 2025

OBJECTIVE 1: STAFF HEALTH AND WELLBEING

Objective 1: Staff Health and Wellbeing – creating an environment for staff to feel healthy, engaged, andproud to work for the Health Board. Feeling that they are included, engaged, and have a sense of belonging.

Having healthy, motivated, and engaged staff will result in improved retention, increased innovation, and lower levels of sickness absence, as well as better patient experiences. Supporting our people to feel valued, engaged with a positive sense of wellbeing at work is at the forefront of our People Plan.

We are proud to have achieved the Platinum Corporate Health Standard in 2021 demonstrating our commitment to the health and wellbeing of our people. From our experiences and regular staff wellbeing surveys we understand that the impact that responding to the COVID 19 pandemic has had on the wellbeing of our staff and workers. Research has indicated that he true impact of the pandemic may not be understood for a further 5-7 years, therefore it is imperative that we continue to develop and deliver a wellbeing offer that cares for the physical and psychological health of our staff. Taking care of carers is at the heart of our plan.

Staff Health and Wellbeing

- Establish a Wellbeing Centre of Excellence, which is underpinned by research and evidence.
- New integrated psychological wellbeing roles and permanent peer support networks will be implemented.
- Tangible wellbeing options will be intensified and available.
- Improve staff engagement because of the Cynnal Cynefin / People First – Reconnecting the Workforce programme.
- Introduce the 'Healthy Working Day' maximising the health and wellbeing of all.
- Prioritising the roll-out of compassionate leadership competency frameworks, approaches embedding in our policies and people practices.
- Benchmark occupational health provision.
- Enabling best in class people practices: reducing staff absence PADR, staff satisfaction and core skill competencies.
- Building on our financial wellbeing offer.

Action 1: We will fulfil our ambitious plans and establish the first Welsh **Wellbeing Centre of Excellence.** This will incorporate support to staff, research, development and new approaches all of which will have benefits for all staff across NHS Wales. This will make a unique contribution to 'A Healthier Wales' by becoming the first Welsh NHS Employee Well-being Service to proactively address the complex psychosocial determents of poor wellbeing at work. The Centre will work proactively and reach out to partners in the Public Sector to develop a partnership and population approach to our wellbeing offer.

Action 2: We continue to implement **new integrated psychological wellbeing** roles and peer support networks within services. We were able to pilot the benefits of this action with effective redeployment of staff during the pandemic and are now developing with Divisions, opportunities to make these arrangements available on a permanent basis. The full impact of the pandemic on the wellbeing of our workforce is still unknown an integrated and peer led wellbeing offer will increase accessibility to professional advice, enabling our workforce to be healthy, engaged and support retention.

Action 3: Tangible measures to enhance wellbeing of our staff will be a top priority. The Health Board will continue to develop an evidenced base medium to long term strategy that adopts a two-pronged approach. Firstly, we will identify tangible measures and respond to the mental health needs of our staff by a strengthened well-being service and secondly, develop a systematic way of supporting teams to identify and address symptomatic causes of poor wellbeing. This approach will be underpinned by the needs of staff expressed through our regular wellbeing surveys and a move to new integrated psychological wellbeing roles and peer support networks, such as Menopause Cafes.

Action 4: We will embed the innovative programme "Cynnal Cynefin / People First – Reconnecting the Workforce" and work through the 5-stage approach of addressing the key workforce biopsychosocial issues which were highlighted through a series of organisational surveys including the medical engagement scale, junior doctor report and wellbeing surveys. The programme will, by re-connecting with our people, support our commitment to being a listening organisation and our commitment to ensuring people's voices are heard, and their ideas acted upon.

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

Action 5: We will identify and support the key areas of working life to support a Healthy Working Day for all our staff. This will be supported by organisational development interventions to facilitate the space, expertise and time for individuals, teams, the organisation, and our communities to grow, experience and deliver exceptional care.

We will facilitate the development and growth of multidisciplinary teams through the Health Board culture that is true to our values. This Healthy Working Day offer will be set out in a newly developed Prospectus for Training and Development.

Action 6: Within the Prospectus for Training and Development there will be a specific focus developing our leaders and managers, including a bespoke programme for clinical leaders, to develop the Health Board's compassionate leaders of the future. We will strengthen and extend our graduate management schemes both within the Health Board and with our partners.

Action 7: We will continue to work with colleagues across NHS Wales to benchmark occupational health services. We will continue to work with occupational health external organisations and review multidisciplinary roles to increase our capacity. We will develop and adopt more streamlined methods to make the service more efficient, such as using streamlined processes to provide clearance for recruitment.

Action 8: We will support managers to ensure our people practices and policies are implemented to support healthy working relationships. We will refresh the approach taken to reduce investigation timelines, provide managers and supervisors with the skills to compassionately implement HR policies. This approach will be supported by a leading-edge research project that will identify the potential harm that can be a consequence of poorly applied policies. Our overall approach will support the ethos of the All Wales Respect and Resolution Policy and Healthy Working Relationships agenda that aims to embed the principles of a just and learning culture. This approach will be delivered through expanding our commitment to a coaching culture increasing our training provision and an internal pool of trained mediators.

Action 9: We will enhance our financial wellbeing offer in light of recent cost of living increases ad price rises. Research shows that financial stress can have a direct impact on productivity, decision making, absence and turnover. Whilst, as an NHS Wales employer, we provide the living wage to our people, we will seek to become and accredited living wage employer.

Staff Health and Wellbeing Success Measures

- Improved indicators through Health Board wellbeing surveys and NHS staff surveys
- Medical Engagement surveys
- Reduction in sickness absence
- Reduction in turnover
- Improved Occupational Health and Employee Wellbeing waiting times
- Embedded Respect and Resolution Framework
- Increased pool of mediators
- Established coaching network
- Research outcomes
- Improved patient outcomes and experiences

KEY DELIVERABLES FOR 2022 – 2025

OBJECTIVE 2: EMPLOYER OF CHOICE

Objective 2: Employer of Choice – The ability to deliver high quality patient care is dependent on our ability to attract, recruit, retain and develop the right people with the right skills, competencies, experience, and values. Our actions build on our commitment to support the prosperity of our local communities, create accessible training, employment, and development opportunities so people join us, stay with us, and enable us to grow a workforce that's diversity is reflective of our population.

Investing in leadership capability and capacity is a critical feature of this theme. There is a correlation between leadership behaviours, culture, employee engagement and performance. Therefore, this theme also focuses on how we support current leaders and develop the next generation.

Employer of Choice

- Recruitment and Retention Strategies implemented that is adaptable to multi-generational and diverse staff.
- Strengthened focus on retention- growing our talent, succession planning in a systematic way, proactive retirement planning.
- Enhancing current and creating new inclusive entry routes and career pathways. Enhancing entry level offers and development pathways (working closely with education, third sector and social care).
- Build on our connections with schools, education, and training providers to promote the range of careers that the NHS can offer.
- Pilot and evaluate innovative selection methods for appropriate roles supporting accessibility to employment.
- Additional and broadened apprenticeship schemes are implemented.
- Create career pathways that support a life course approach to employment i.e., from training to retirement and beyond.
- Develop and deliver new middle management development offers- equipping middle managers with the skills to manage, develop and support a multi-generational, agile, and flexible workforce.
- Delivering refreshed leadership development schemes and increase those who have completed core skills competencies
- Work plans embed intersectionality which elevates and embeds Equality, Diversity and Inclusion.
- Delivery of a new Equality Impact Assessment (EQIA) process. · Implement a Welsh Language Strategy and scale up our Active Offer.
- Prospectus for Training and Development opportunities to support talent, succession, and career.
- Defined inclusive and diverse volunteering opportunities.

Action 10: We are operating in an increasingly competitive recruitment market and want to be an organisation that people choose to work in and one they choose to stay. This will be supported by our existing strong **Health Board identity and branding**.

We will continue to work with recruitment partners including BAPIO, NHS Professionals and national and overseas campaigns to support safe staffing levels. We will continue to promote the Step into Health to demonstrate our commitment to ex-military personnel.

We will implement detailed plans to recruit junior doctors, Physician Assistants (PAs) and Advanced Nurse Practitioners (ANPs) working with recruitment partners such as British Association of Physicians of Indian Origin (BAPIO) and NHS Professionals to support safe staffing for our medical specialties following an assessment of Medicine workforce against Royal College of Physicians (RCP) guidance.

We will do more to build on our flexible working offer and innovative role profiles, which incorporate responsibilities such as research and education, to ensure we stand out in the market and Aneurin Bevan University Health Board is seen as the Employer of Choice for those making career decisions.

Action 11: A **Talent Management and Succession Plan** will be in developed to ensure we deliberately attract, select, develop, and deploy the best people for key/business critical roles within the Health Board. These services will be set out in Prospectus of training and development and will also be supported by the development of excellent induction and training interventions from entry level to senior management. We will deliver refreshed leadership development schemes and increase those who have completed core skills competencies.

Critical to the success of this approach will be ensuring that we equip our managers with the skills and tools to identify talent across our diverse workforce and to facilitate an active approach to bringing people forward. We will develop and deliver new middle management development offers- providing middle managers with the skills to manage, develop and support a multi-generational, agile, and flexible workforce.

Action 12: We will build on our connections with schools, education providers, third sector and community groups to promote the wide range of roles that we offer and the opportunities that exist to develop long term career pathways. Providing work experience and open days, marketing and promoting opportunities and sharing career stories.

By proactively reaching out to diverse groups we will strengthen our work with partners to create diverse and multiple pipelines of talent. For example, creating renewed connections with ethnic minority groups, Remploy, LGBTQ+ agencies and building on our actions that have supported us to be an accredited disability confident employer. We will strengthen our work with partners to create diverse and multiple pipelines of talent and extend our widening access agenda.

We are thinking differently about how to train, attract, and create development pathways within the principles of the Foundational Economy. Our Action Plans will seek to deliver a sustainable workforce working in partnership with stakeholders to create a more diverse and inclusive workforce that represents our population and our communities.

Action 13: We will strengthen our widening access agenda through the new Aneurin Bevan Apprenticeship scheme with additional cohorts being recruited annually. We will work with employment schemes such as Kickstart and Restart to support widening access for school leavers and the unemployed and will do so across the health and social care sector. This will enhance our traditional offer to upskill staff via Modern Apprenticeship qualifications and support the development of a career pathway from school to retirement.

We are trialling new selection methods in place of traditional interviews to encourage applications from all parts of our population. We are working closely with the Gwent Regional Workforce Board and Career Consortium to develop ways to work together to develop training and employment routes that will support a longer term goal of a whole system workforce.

Action 14: We will build on our success in designing effective **recruitment and retention strategies** through a variety of bespoke recruitment campaigns and enhanced advertising techniques. The re-introduction of international recruitment, along with the aim of being the first choice for student streamlining schemes will ensure a constant flow of talent to support the healthcare needs of the population of the Health Board.

As an Employer of Choice, we support **retention and succession planning** through the development of career pathways, helping staff to see their career journey within our Health Board both now and in the future. We will establish a **Middle Grade Doctor Strategy**, increase opportunities for Management Trainee Schemes, internally and by investing in joint graduate training programmes with Local Authorities.

happy to talk flexible working

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

Core to middle management development offers will be the need to understand the skills to manage, develop and support a multi-generational, agile, and flexible workforce.

Action 15: We will elevate and embed **equality, diversity, and inclusion** in all we do and align our work plans to our values with intersectionality threaded through. There will be open conversations with our staff, including our Black, Asian and minority ethnic colleagues, across all protected areas and the establishment of staff networks (such as race equality, enable, neurodiversity etc), topic cafés (such as menopause) and equality ambassadors within senior teams to drive equality, diversity and inclusion through our workforce areas and service delivery.

There will be a roll-out a new Equality Impact Assessment (EQIA) process to adopt an integrated approach including the Well-Being of Future Generations, Welsh Measures, and socio-economic impact that is also aligned with our values and provides a robust and transparent process to provide inclusive support and services.

Action 16: A key aim is to develop a **Welsh Language Strategy** for the Health Board, centred on the needs of the local population, and providing a clear vision for the implementation of the Standards. We will continue to embed the 'Active Offer' principle and developing our Partner IAITH network to support our Welsh speaking staff to maximise their linguistic skills.

Cynnig Cymraeg

We will ensure new arrangements maintain and promote the provision of services to Welsh speakers – considering the barriers that have had a detrimental impact on Welsh language provision, but also benchmarking against the effective practices identified in the Welsh Language Commissioner's assurance report 2020-21, Stepping Forward.

Action 17: We will define the opportunities of inclusive and diverse **volunteering opportunities** across the life course, encompassing the opportunities for individuals, regardless of age or ability, to derive the well-being benefits of volunteering. The Volunteer Strategy will be a 'care as a currency for careers' in health and social care through an inter/multi-generational programme supporting vulnerable people across our communities.

Employer of Choice Success Measures

- Reduced vacancies
- Reduced reliance on bank and agency workers
- Reduced absence and turnover
- Increased number of apprentices and apprenticeship routes
- Wider implementation of employability schemes e.g., Kickstart and Restart
- Identified a pool of future leaders
- Feedback from development courses
- Training and development activity
- Demographic profile of our people

KEY DELIVERABLES FOR 2022 – 2025

OBJECTIVE 3: WORKFORCE SUSTAINABILITY AND TRANSFORMATION

Objective 3: Workforce Sustainability - ensuring that we have the right workforce models that embed innovative thinking.

Delivering our People Plan centres on having people with the right skills, expertise, in the right place and with the right capacity to deliver the health and care needs of our population. We will build on our success in implementing new and extended roles such as Physicians Associates, Nurse Associaties and the number of new roles to support our COVID-19 response. We will continue to create capacity through reviewing skill mix, developing existing and creating new advanced and extended roles and learning from our experiences through the pandemic to transform our workforce models to provide person-centred care linked to our health prevention priorities.

Workforce Sustainability

- Develop strategic workforce planning across our systems
- Develop a Health Care Support Worker Strategy
- Work collaboratively with partners to deliver the workforce plans to support new models of care and the outcome framework for the Regional Integration Fund.
- Work with NCNs to accelerate care closer to home opportunities
- Integrated workforce planning in line with the IMTP and the population needs analysis.
- Work with the GPSB/RPB partners to build sustainable models for the health and social care system.
- Step change in workforce analytics to inform planning, decision making and redesign.
- Implement a suite of electronic systems for medical staff improving efficiency and intelligence for workforce planning.
- Evolve and embed an Agile/Hybrid working culture.
- Develop a digitally ready workforce using the best technological solutions for patients and staff

Action 18: Workforce sustainability plans. Core to this priority is our ability to develop strategic workforce planning across our systems.

We will focus on skill mix, development of new roles and maximising the contribution of the unregistered workforce. Sitting alongside this will be a new **Health Care Support Worker Strategy** addressing issues across both health and social care. Our work will focus on training, education, and opportunities so there is seamless care, closer to home which supports admission avoidance. The strategy will also consider the learning from the pandemic and the need to have an agile and flexible workforce that is multi-skilled to support our health prevention agenda including responding to surges in demand for vaccination, testing etc.

Action 19: The recent success of the Primary Care Transformation Programme will be extended to support and develop place-based care models throughout the Health Board area. Working closely with the Regional Partnership Board, Gwent Careers Consortium, Gwent Workforce Board, and stakeholders such as the Research, Innovation, Improvement and Communication Hub, we will work collaboratively to deliver the workforce dimensions to support new models of care and the outcome framework for the Regional Integration Fund. The Transformation Programme will also support the Foundational Economy Action Plan.

Action 20: Our work with the Neighbourhood Care Networks, work will sit alongside the national expectation on delivering the accelerated cluster development programme and the alignment of investment plans under the RPB We will make greater investment in collaborative work with other networks and groups such as and the plans for the Care Closer to Home models. Redesigning community services will build on these plans ensuring the prudent workforce models, reduce duplication or omissions and continue to grow graduated models of care models.

[insert dashboard image here]

Action 20: We will introduce a suite of workforce analytic dashboards to underpin and inform decision making. We will scope and plan to implement interoperable medical workforce E-Systems, which includes systems for job planning, rostering and locum and agency. The anticipated benefits will enable effective rostering, forecasting, better governance, resource utilisation and support robust workforce reporting and optimisation.

Action 21: Agile and Hybrid Working/New Ways of Working - will continue to build on areas of good practice in terms of agile working. Our strategy will be considered alongside the Estate Strategy to create more agile working spaces based on a minimum standard which has been set from feedback we have received from our agile staff surveys. The work plan also recognises the cultural and leadership challenges and will require careful influencing and responding to the issues being raised by teams.

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

[insert image of the GUH agile working area here]

Workforce Sustainability Success Measures

- Reduced vacancies and turnover
- Right-sized staffing models in line with service demand and capacity
- Reduced reliance on bank and agency workers
- Successful roll out of medical e-systems
- Improved workforce metrics and analysis
- Better equipped, skilled and adaptable workforce to work in agilely where and when this is possible
- Closer partnership working and workforce prioritisation of actions across health and social care

The detailed plans to support each of the 3 objectives can be found in Appendix 1. (To follow on finalisation)

MAKING IT HAPPEN

Delivering the ambition of the plan will need the shared committed of us all. Understanding and valuing the contribution of all our staff, workers and partners will be critical to the success of our objectives. A communication strategy will support the launch of this plan along with regular communications to update on progress, challenges, and any changes we have needed to make along the way. Our communications strategy will enable a dialogue with our people to test the reach and impact of the actions of the People Plan. Taking care to check in that our staff are:

- Working in a safe, healthy, and supportive environment enabling them to be at their best.
- Clear about the direction of the organisation and understand what they can contribute and what they can expect as an employee of the Health Board.
- Supported with the space, expertise, and time to grow, experience, and deliver exception care.
- Engaged, motivated and resilient
- Flexible, adaptable, and innovative – encouraged to finding new ways to deliver services in a changing environment.
- Acting in a more agile way, using technology to deliver services differently and reducing reliance on traditional ways of working and meeting our decarbonisation delivery plan.
- People focussed – ensuring patients, partners, contractors, and colleagues always receive the best service and are treated with respect and inclusivity.
- Demonstrating leadership – managers demonstrate visible, fair, and compassionate leadership ensuring staff are supported and empowered to give their best; and
- Our communications strategy will engage people with our values of personal responsibility and a passion for improvement.

The Health Board support various mechanisms for staff voice to be listened to including our intranet, local staff forums, regular communications with Trade Unions partners and local and national staff surveys. In addition the Health Board continues to work towards a culture that encourages the raising of any concerns by staff to be embedded into 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 mechanism for early warning of concerns. Effective mechanisms to support staff feel that they have the freedom to speak up protects patients and ensures staff have an improved experience of working with us. Encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon is key to the communication strategy in support of this People Plan. Where staff feel that they may need support in raising concerns the NHS Wales Raising Concerns Procedure provides guidance and support for them to do so (link to policy).

Shared Commitment

The Health Board will...

- Protect and prioritise staff wellbeing
- Design workforce plans that ensure we have an inclusive workforce, reflective or our communities, with the right staff to meet the requirements to support our service models
- Continue to recognise that staff are our greatest asset
- Continue to listen to, and learn from, our staff
- Create the conditions for teams, individuals, organisation, and our communities to grow
- Develop an appropriate and skilled workforce now and in the future
- Embed a culture that is true to our values
- Deliver national policy within the local context

The role of the Individual is to...

- Live the Health Board's values and behaviours and commit to continuous personal growth
- Actively contribute to a positive experience of our service users
- Promote and embrace equality
- Promote self-care, health & wellbeing.
- Raise concerns when this is necessary
- Promote healthy working relationships with colleagues

The role of the Manager is to...

- Demonstrate compassion to each other and service users
- Promote Equality, Diversity, and Inclusion
- Engage and actively listen to staff and consider any appropriate action
- Engage and actively listen to staff
- Take an active role in the care and growth of their staff and teams.
- Instil in teams the ethos of health working relationships

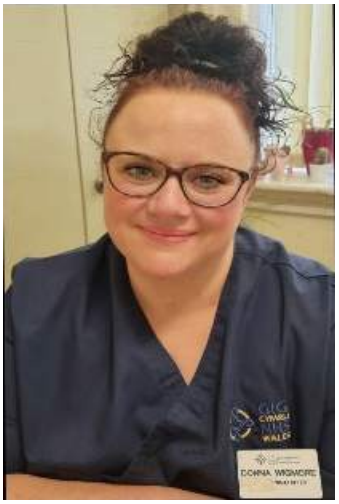
OUR PEOPLE STORIES

My name is Donna Wigmore, and I began my career within ABUHB in 2006.

My first role was as a Healthcare support worker on Sycamore ward at St Woolos Hospital and I later progressed to the Orthopaedic Department at the Royal Gwent Hospital in the same position. It was during my time here that I made the decision along with the support of my ward manager to undertake my nursing degree and I qualified in 2015.

Since becoming a Registered Nurse, I have spent the first few years as a band 5 in the Orthopaedic speciality developing my skills and knowledge. Following this I was fortunate to take on a pilot in the Trauma Assessment Unit within the Orthopaedic department. I then felt ready to apply for the role of Deputy Ward manager and have spent time on both Orthopaedics and Care of the Elderly.

In September of 2020 I was successful in achieving the post of Ward Manager of Oak ward at County hospital where I remain today. This has been my most challenging yet rewarding role to date, as I have managed a team through the Covid 19 pandemic. This role has allowed me to combine all my experiences in an area I am passionate about. I am supported by my Senior Nurse to develop my passion of improving patient experience as well as guiding the team to provide person centred care.



DONNA WIGMORE

Rgistered Nurse

Aneurin Bevan University Health Board

CLARA KNIGHT

Administrative Apprenticeship

Aneurin Bevan University Health Board

My name is Clara Knight, and I am currently undertaking an Administrative Apprenticeship role within the Recruitment Team at Aneurin Bevan University Health Board.

I joined in December 2021 and have enjoyed every second since. My role currently involves the recruitment and onboarding of Immunisers and Immunisation Support to the Mass Vaccination Centres across South East Wales. This includes carrying out the on boarding process, including adding applications to the TRAC system, collating documents from the candidates, arranging Pre-Employment Checks, and forwarding their details to payroll and training. I am looking forward to learning and gaining additional experience within the Recruitment Team within various work streams that the Health Board offers.

I believe this Apprenticeship has helped me gain a vast amount of experience in a short amount of time and I am looking forward to learning a lot more whilst undergoing my apprenticeship. I am excited to continue to progress with my NVQ Qualification, and I believe this apprenticeship will encourage me to gain the desired skills and knowledge to enable me to further my career within the Health Board.

My name is Lyn Puckett and I wanted to share my journey of working in ABUHB.

I started working in the Health Board in 1993 as a part time evening domestic its primary role was to clean areas of the hospital out of hours. From this I moved on to become a ward hostess where I was allocated a ward and the role was to provide food and beverages to patients, ward, office, and corridor cleaning. This enabled me to have patient interaction on the medical floors in Nevil Hall hospital. It was at this point I started to become interested in becoming a HCSW and joined the nurse bank.

As a HCSW on the bank I visited several wards and gained a lot of exposure to life events of our patients during this time I noticed the role of the RN and started to research how I could undertake my nurse training and applied to University of Glamorgan and subsequently completing this to become a Registered Nurse in 2001.

LYN PUCKETT

Rgistered Nurse

Aneurin Bevan University Health Board

As a RN I commenced by professional career on a colorectal ward where I consolidated my learning putting theory to practice with great support of my peers.

A secondment opportunity arose to become a facilitator for a cohort of overseas nurses this was to provide academic and pastoral support for them to achieve their competencies to enable them to register with the NMC. It was during this time I became interested in becoming an RCN Steward allowing me to support members through difficult times.

My career development took a further turn 2007 when I was successful in securing band 6 role in A&E which was a very interesting opportunity and gave me exposure to all aspects of emergency care. This was a very rewarding role and was well supported with good induction package and a tight team who were all willing to share their knowledge, skills, and experience. It was at this point I decided to undertake a leadership & management course to enable me to have the skills in place for a management position.

I became a ward manager in 2015 in Ysbyty Aneurin Bevan (YAB) where I worked with an amazing team, we implemented the first nurse led community unit in the Health Board which was a success as part of the graduated care model.

I now currently work as a corporate trade union representative for the Royal College of Nursing this enables me to provide the voice of nurses and HCSW at a strategic level and to provide staff side support to the nursing agenda.

I also support members locally with difficulties they may have.

On reflection I have been very privileged to be supported throughout my career by some excellent role models who have invested their time and knowledge to shape my future.

ROSS ANDREWS

Estate Manager

Aneurin Bevan University Health Board

I started my career in the NHS 6 years ago as a Band 2 maintenance assistant at NHH where I had already started self-funding training to become an electrician.

After 6 months in post, I was fortunate enough to gain one of two development posts that only come up once every two years. This Band 3 role was at RGH which allows you to complete a modern apprenticeship (in my case; to become a fully qualified electrician) and allowed me to not only finish my studies, but to work alongside the specialist contractors from many different engineering disciplines that work in a healthcare setting.

Following the successful completion of this development role (and gaining a part time BSc in Natural Sciences self-funded) I was again fortunate enough to gain a Band 5 trainee estates manager role at Llanfrechfa Grange within the Clinical Futures GUH client project team as the Works and Estates representative. This allowed me to be an active part of the GUH project, being responsible for the building services (mechanical, electrical and public health) and the technical commissioning of all these systems (which confirms the building services are compliant and safe to use) for the hospital ensuring the Health Board not only have a high-quality build but is adequately maintainable.

During the incredible journey of the construction process, I completed a BEng Building Services Engineering (funded by the Health Board), various Authorised Persons engineering courses, gained a wealth of invaluable work and life experience from top class engineers and transitioned into my current 8A Estates Manager post after building the GUH Works and Estates department up ready for the go live date.

OUR WORKFORCE AND ORGANISATIONAL DEVELOPMENT VISION & PROFESSIONAL STANDARDS

Our Vision:

"WORKING IN PARTNERSHIP WITH STAFF SIDE REPRESENTATIVES AND LISTENING TO THE VIEWS, IDEAS AND CONCERNS OF ALL OUR STAFF."

Underpinned by our values, we are dedicated Workforce & Organisational Development Professionals committed to making a difference through:

Committed to wellbeing	Putting People at the heart of our practices	Continuous Improvement
Working together in partnership with staff side colleagues and partner organisations	Developing the knowledge, skills, and experiences to meet the challenges now and in the future	Excellence in all we do
Thinking and doing things differently to ensure we maximise the best possible care and outcomes for the diverse community we servce	Empowering individuals and teams to deliver high quality outcomes	Living compassionate values and putting innovation, integration and transformation at the forefront of everything we do

Professional Bodies and Associations

- HPMA - HR in the NHS - Wales
- Professional Standards | CIPD
- Health and Social Care Workforce Strategy - HEIW (nhs.wales)
- British Psychological Society
- Health and Care Professions Council
- British Association Counselling and Psychotherapy
- Nursing & Midwifery Council (NMC)
- Faculty of Occupational Medicine

GOVERNANCE AND REPORTING ARRANGEMENTS

A review of this Plan will take place quarterly to ensure it remains fit for purpose and is addressing the most important needs now and emergent. The Delivery Plan will be reviewed against priorities to assess progress against key measures of success and impact.

This will be supported by:

- Quarterly update report to the People and Culture Committee
- Updates to Executive Team, Trade Union Partnership Forum, Local Negotiating Committee, and our workforce
- Regular data reporting through dashboards
- Risk Register updates
- External benchmarking

With feedback from:

- Managers, staff, and stakeholders
- Staff engagement channels
- Staff surveys
- Partnership meetings
- External reviews
- Regional Partnership Board
- Community Health Council
- Voluntary Sector

APPENDIX

- 01: Delivery Framework

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

WWW.ABUHB-SWYDDI.CO.UK
WWW.ABUHB-JOBS.CO.UK

happy to talk flexible working

#TRAINWORKLIVE
TRAINWORKLIVE.WALES

Dyfodol Clinigol
Clinical Futures

STEP INTO HEALTH

PEOPLE PLAN 2022/25

DELIVERY FRAMEWORK

Putting People First

1.0 INTRODUCTION:

The People Plan 2022 – 2025 for Aneurin Bevan University Health Board, following Board approval will be launched into the Health Board during May 2022.

In support of the plan and its delivery, this paper sets out the approach to the Delivery Framework which will be core to the assurance processes and the monitoring of performance.

The Delivery Framework aims to set out how we will ensure the delivery of the People Plan 2022 - 2025, whilst recognising the impact that the pandemic has had on business as usual and reinforces the importance of performance at individual, team, directorate or whole Health Board level and within our regional arrangements. It will ensure that performance is everyone's business and is being captured, monitored and reported appropriately. This will enable us to understand our progress, learn from what works and what needs more attention or alternative plans. Importantly, we will communicate progress against the framework to staff and gather feedback as we progress.

The Plan is underpinned by the Health Board's core values:

And the vision of the Workforce and Organisation Development team:

'To support and enable the workforce to develop a dynamic organisation that cares, learns and improves through a culture of high trust and collaboration'.

2.0 STRUCTURE OF THE PEOPLE PLAN:

The Health Board's People Plan 2022 – 2025 is our workforce and organisation development strategy and sets out our ambitions, recognising that there is a direct correlation between staff wellbeing and patient outcomes. The plan will focus on the following 3 core objectives:

- An exemplar for Staff Health & Wellbeing, creating an environment for staff to feel proud to work for the Health Board and are included, engaged, and have a sense of belonging. This is underpinned by our pillars of wellbeing (sense of control, purpose, fairness, belonging, cared for, and valued).

- Employer of Choice, building on the reputation of the Health Board is a great place to train, work and grow.

- Creating opportunities for Workforce Sustainability and Transformation ensuring that we have the right workforce models that embed innovative thinking.

Sitting below these core objectives are 22 actions, and a level of detail to ensure close monitoring on delivery and accountability. These actions are spread over the 3 year period, which will enable focus, prioritisation and flexibility to adjust to any changes in context. Clearly, by their nature some actions will be more contained in terms of delivery, whilst we anticipate that others will have a longer life span i.e. over the 3 year period.

The Framework should be read alongside other Health Board policies and procedures including; Personal Appraisal and Development Reviews, Medical and Nursing Revalidation, and those policies to enhance an individual's contribution to being the best they can be in undertaking their role.

The delivery of the People Plan is a shared commitment and will require collaborative working to ensure we enable the system, structures and people to adapt. Therefore workforce, finance, informatics, governance will be key enablers in delivering the transformation and will be based on the following principles as an underpin:

- We work with others to listen co-create
- Individuals understand their role and are accountable
- Individuals and teams are empowered and have appropriate levels of delegation
- That we have a persistent focus on driving improvement and productivity

In support of the Delivery Framework there will be a refreshed Workforce and Organisational Development Dashboard that will be aligned to the People Plan. This will be shared with the organisation on a monthly basis and will visually describe the Health Board's position against the Delivery Plan and the Ministerial targets that are relevant to the WOD function.

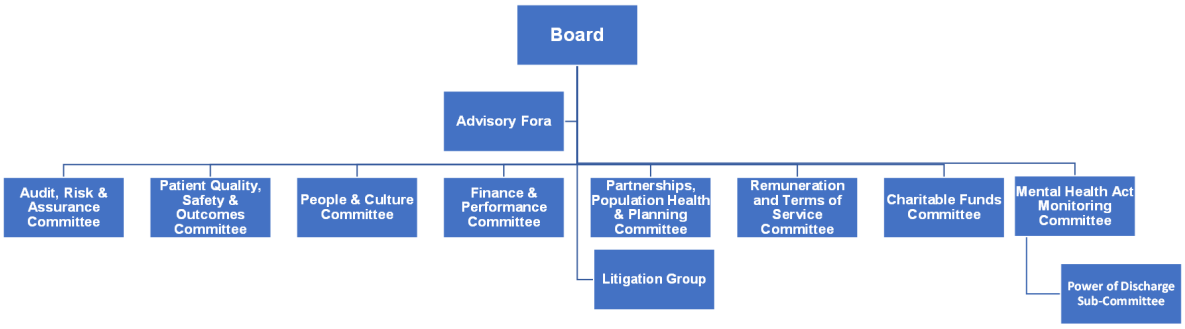
3.0 GOVERNANCE:

The Health Board has a strong organisational commitment to good governance, which includes having a clear vision and focus on public service values in everything the organisation does and with its partners.

The Health Board is committed to continuing to be a learning and developing organisation to ensure that the health services we provide and commission are of the highest standard for our population. A key focus for the Health Board is the health and well-being of both staff and the population.

The Health Board has to ensure that its governance and assurance arrangements are clear and the Board Assurance Framework clearly maps the current profile of risks and required sources of assurance.

The People Plan delivery will be overseen via the People and Culture Committee as part of the Board Assurance Framework as set out below:



The Executive Team will oversee the performance of the People Plan in addition to the assurance process undertaken by the Committee. There will also be quarterly updates presented to the Trade Union Partnership Forum, the Local Negotiating Committee and the Health System Leadership Group.

This quarterly reporting will cover:

- the action status
- key metrics – targets and performance
- how are we doing?
- what actions are we taking?
- the quarter's achievements
- Review of any issues or risks.

This reporting will be summarised into a regular staff communication so that all staff are aware of what has been delivered and what they can expect to see next, and how they can feedback to the ongoing progress of the People Plan.

At a local level and within the Workforce and Organisation Development Division, there will be constant monitoring of delivery and a month review at the Divisional Days. This review will include any emerging opportunities and risks, with the corporate and local risk registers being aligned and reconciled.

The Executive Team will also determine areas that should be reviewed with greater scrutiny because of escalation or increasing risks and will be part of the Escalation process.

As appropriate, it will also be important that partners are also updated and this will become part of the emerging structure as part of the Regional Integrated Funding changes and the realignment of the partnership structures under the Regional Partnership Board and Gwent Workforce Board.

4.0 ESCALATION PROCES:

The Health Board continues to mature with established systems and processes for escalation. The trigger points for prioritisation and escalation in these areas, can be summarised as follows:

- **Green** objective/target achieved
- **Amber** missing objective/target but on agreed performance improvement trajectory
- **Red** persistently not meeting objective/target and highly unlikely to meet objective/target within specified period

Performance that is deemed off track may require additional attention, scrutiny and reporting and may involve some of the following actions:

- An action plan with detailed information and a trajectory for improvement and review points for assessment by the Director of Workforce and Organisational Development.
- The Chief Executive, Deputy Chief Executive, together with other Executive Directors (individually or collectively) are likely to become more personally involved in deep-dive meetings to discuss performance, recovery and to provide additional levels of support and assurance.

5.0 Summary:

In summary, the Delivery Framework will be under regular review and will evolve as we move through the People Plan delivery.

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

Any questions?

If you have any questions, please contact:

Aneurin Bevan University Health Board

@AneurinBevanUHB

@ABUHBJobs

@AneurinBevanUHB

Sharepoint

PUTTING PEOPLE FIRST

2022/25

PEOPLE PLAN

Scan to check out the full people plan

Our people plan 2022-2025, Putting People First outlines the three year forward view, of the Workforce & Organisational Development Division priorities. It sets out how we will drive, lead, and support the organisation to build on our successes in relation to our values, workforce improvement capability, and expertise with a clear focus on wellbeing, inclusion, and engagement of our people. Key actions and milestones set out how we will achieve this through a shared commitment of working together.

STAFF HEALTH & WELLBEING

Creating an environment for staff to feel proud to work for the Health Board and are included, engaged, and have a sense of belonging.

EMPLOYER OF CHOICE

Building on the reputation of the Health Board is a great place to train, work and grow.

WORKFORCE SVUSTAINABILITY

Ensuring we have the right workforce models that embed innovative thinking.

Aneurin Bevan University Health Board

Annual Assurance Report on Compliance with the Nursing Staffing Levels (Wales) Act 2016

Executive Summary

The purpose of the report is to provide an annual review and position of current status relating to medical, surgical and paediatric ward nurse staffing levels covered under the implementation of the Nurse Staffing Levels (Wales) Act 2016 (NSLWA). It outlines the measures taken to assure the Board regarding compliance with the requirements of the Act.

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 service. The report, therefore, outlines the actions taken to comply with Section 25A.

The Board is asked to consider the extraordinary and unprecedented pressures the Health Board has encountered during the last reporting period which would have made it exceptionally difficult to be fully compliant with the Act. The relentless pressure associated with repurposing wards and the opening and closing of additional capacity to manage the pandemic and winter pressures has at times made the tracking of all metrics associated with 25B wards extremely challenging.

The Chief Nursing Officer for Wales wrote to Health Boards' in December 2020 to clarify expectations and explain certain dispensations permissible during the pandemic when enacting the NSLWA. This included permission not to proceed with the All-Wales bi-annual acuity audit in January 2021. Due to the significant challenges facing the Health Board associated with the pandemic, opening of Grange University Hospital and the reconfiguration of the ELGH's, a local acuity audit and re-calculation was undertaken to ascertain appropriate nurse staffing levels.

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

Executive Sponsor: Rhiannon Jones - Executive Director of Nursing

Report Author: Linda Alexander - Assistant Director of Nursing

Report Received consideration and supported by :

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

Date of the Report: 10th May 2022

Supplementary Papers Attached:

- Annual Assurance Report 2021-22
- Appendix A – Summary of Establishments

Purpose of the Report

To provide assurance to the Board that Aneurin Bevan University Health Board (ABUHB) is able to meet the requirements of the Nurse Staffing Levels (Wales) Act (NSLWA) and for the Board to approve the report for submission to Welsh Government.

Background and Context

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

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

In accordance with section 25B, the duty to calculate nurse staffing levels currently applies to adult acute medical, surgical, and paediatric inpatient wards. Several all-Wales work streams have been progressing over recent years to enable the Nurse Staffing Level to be extended to other settings, to include:

- District Nursing
- Health Visiting
- Mental Health Inpatients and Care Homes

ABUHB submitted its first impact assessments for Health Visiting and Mental Health to Welsh Government in February 2022. Following submission, a letter was received from the Chief Nursing Officer (CNO) for Wales articulating a need to pause and reflect on the approach taken to date by the All-Wales Nurse Staffing Programme and to re-set the direction going forward. A decision has been taken not to publish the Mental Health or Health Visitor principles or commission biannual returns at this time. The pause also extends to the district nursing principles.

Each Health Board has a duty to use the triangulated approach to calculate the nurse staffing level for each adult acute medical, surgical and paediatric inpatient ward and to record the nurse staffing review, to evidence the method of calculation and the outcome.

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: -

- **NOTE** the required nurse staffing establishments for all 25B wards

- **NOTE** the impact of the Covid-19 Pandemic on the bi-annual recalculations.
- **NOTE** the progress made with the implementation of the Act and further work underway.
- **APPROVE** the report for submission to Welsh Government.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The biggest risk to the implementation of the Act previously related to RN vacancies compounded by the Covid-19 Pandemic. The most significant risk now, due to a very successful recruitment campaign, is a very new and inexperienced nursing workforce.
Financial Assessment, including Value for Money	Extensive use of temporary staffing to maintain nurse staffing levels.
Quality, Safety and Patient Experience Assessment	Nurse Staffing Act sets into law an obligation for Health Boards in Wales to ensure there are sufficient nurse staffing levels to meet the needs of patients receiving care. The evidence unequivocally identifies that having the right number of registered nurses and the right skill mix reduces patient mortality and improves patient outcomes.
Equality and Diversity Impact Assessment (including child impact assessment)	All Wales statutory guidance for implementation. Aligns to relevant staff polices for recruitment and retention of staff.
Health and Care Standards	Contributes to compliance with the Health and Care Standards: safe care, effective care, dignified care, timely care and staff and resources.
Link to Integrated Medium Term Plan/Corporate Objectives	Links to annual plan in terms of implementation of the NSLWA 2016 – ensuring a substantive and reliable workforce.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	
Glossary of New Terms	
Public Interest	No reason not to be available to the Public

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee 6th April 2021 to 5th April 2022	
Health Board	Aneurin Bevan University Health Board (ABUHB)
Date annual assurance report is presented to Board	Presented to Executive Team: 5th May 2022 To be presented to Board: 25th May 2022

	Adult acute <u>medical</u> inpatient wards	**Adult acute <u>surgical</u> inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	Lowest - 19 Highest - 24	Lowest - 9 Highest - 13	1
During the last year the number of occasions (for section 25B wards) where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	4 – wards repurposed to support Covid-19 pathways	4 - wards repurposed to support Covid-19 pathways	1 (50 beds) The extension of the second duty of the Nurse Staffing Levels (Wales) Act 2016 to paediatric inpatient wards, required a review and calculation prior to coming into force on 1 October 2021.

The process and methodology used to calculate the nurse staffing level	For each inpatient ward (both adult and paediatric) where Section 25B applies a systematic process has been followed to review and recalculate the nurse staffing levels. The practice to calculate the nurse staffing levels includes a detailed professional discussion with the nursing management team for each ward, with full engagement from Divisional Finance and Workforce Business Partners. The methodology deployed aims to ascertain the total number of staff required to provide sufficient resource to deploy a staffing level appropriate to the individual ward. This process is activated for every 25B ward, regardless of whether there is a proposed increase, decrease, or no change to the ward establishment. Professional discussions consider: • Current ward bed numbers and speciality. Consideration is given as to whether each ward should remain under the statutory reporting requirements of section 25B of the Act and if additional wards require to be included. • Existing agreed establishment, including those members of the team not included in the core roster, but who provide valuable support in managing the ward, to include: ➢ ward assistants, ➢ rehabilitation assistants ➢ roster creators • Patient acuity data: ➢ Acuity is determined by utilising the evidence based Welsh Levels of Care Tool. It consists of 5 levels of acuity ranging from level 5 where the patient is highly unstable and at risk, requiring an intense level of continuous nursing care on a 1:1 basis; to level 1 where the patient's condition is stable and predictable, requiring routine nursing care. • Care quality indicator data, to include:

- Pressure ulcers
- Medication incidents
- Patients falls
- Infiltration/extravasion injuries specific to paediatric wards.
- Complaints about nursing care
- Compliments
- Performance & Development Review (PADR) compliance
- Mandatory training compliance and sickness
- Patient flow/activity
- Use of temporary staffing

Additionally, when considering the required establishment, workforce data and analysis ensures the Ward Manager has supernumerary status and a 26.9% uplift required to manage annual leave, sickness and study leave embedded into the establishment.

A summary of the above is presented by the Head of Nursing, via a "Challenge and Support" meeting, to the Deputy Director of Nursing and the Executive Director of Nursing. Professional discussions have placed significant emphasis on the impact of opening the Grange University Hospital (GUH) and the phenomenal complexities associated with working in a global pandemic and the relentless, substantial workforce challenges associated with this.

By way of reminder, a letter was received into the Health Board from the CNO in December 2020 which confirmed, due to the impact of the 2nd surge of the Covid 19 pandemic, the routine bi-annual All Wales audit would not proceed in January 2021. However, considering the repurposing of the ELGH's and the opening of the GUH it was agreed a local level acuity audit would be undertaken in January 2021. This was followed by a re-calculation of ward establishments, utilising the triangulated approach to determine appropriate nursing establishments. This audit and re-calculation clearly demonstrated the need to allow new establishments and the purposing of wards to settle before any significant changes were applied to ward establishments.

The January 2021 recalculation exercise demonstrated that despite in-depth workforce modelling in preparation for opening GUH, the added intricacies associated with repurposing wards, winter capacity

	requirements and recalculation of nurse staffing levels has added significant complexities into applying the full triangulated methodology prescribed within the Act. The tracking of all changes to ward establishments and the required funding to support establishments has proven exceptionally difficult. Professional judgment has continued to be at the centre of all decisions with regards nurse staffing levels. In June 2021, the All-Wales bi-annual acuity audit progressed as per statutory requirements. This confirmed the findings of the January 2021 audit and identified changes required to the establishments. The additional requirement was as a consequence of: – Ward layout *(GUH as an example)* and single room occupancy – Patient acuity *(and extent of Covid demand)* together with increased enhanced care requirements – Complex COVID-19 pathways – Additional capacity – Service development *(reset and recovery)* The Challenge and Support meetings which followed the June 2021 audit indicated a total of 17 wards under Section 25B required amendments to previously agreed planned rosters. In full compliance with the statutory requirements, the outcome of these meetings influences the agreed establishment. The agreed and adjusted nursing establishments aligned to the 17 wards are outlined. These amendments were fully supported by the Executive Team and subsequently presented to and agreed by the Board on the 24th November 2022. The following tables illustrates the agreed amendments to establishments following the June 2021 recalculation:

Scheduled Care						
Ward	**Budgeted Pre-Calculation**			**Post-Calculation Requirement**		
	RN WTE	**HCSW WTE**	**Total WTE**	**RN WTE**	**HCSW WTE**	**Total WTE**
C0	21.17	20.16	**41.33**	26.85*	25.17*	**52.02**
B0	21.17	20.16	**41.33**	26.85*	25.17*	**52.02**
A0	21.17	20.16	**41.33**	26.85*	25.17*	**52.02**
D3E	15.48	22.37	**37.85**	16.48	21.37	**37.85**
4/2	15.48	19.58	**35.10**	15.48	22.74	**38.22**

*slight amendments to establishments to that presented to Board November 2021 due to a re-calculation error.

Unscheduled Care						
Ward	**Pre-Calculation**			**Post-Calculation**		
	RN WTE	**HCSW WTE**	**Total WTE**	**RN WTE**	**HCSW WTE**	**Total WTE**
A2	17.06	16.78	**33.84**	19.91	16.78	**36.69**
A4	24.01	19.58	**43.59**	26.86	22.38	**49.24**
4/4	15.48	13.98	**29.46**	21.18	13.98	**35.16**
3/4	15.48	13.98	**29.46**	15.48	22.42	**37.90**
D4E	16.75	22.42	**39.17**	16.75	25.22	**41.97**
D4W	15.58	22.42	**37.90**	15.48	25.22	**40.70**
B3	13.79	20.22	**34.01**	15.48	25.21	**40.69**
C4E	15.48	22.42	**37.90**	15.48	25.22	**40.70**
C5E	15.48	13.98	**29.46**	15.48	16.78	**32.26**
C6W	15.48	22.42	**37.90**	18.33	22.42	**40.75**
Bargoed	18.06	16.78	**34.84**	18.06	22.42	**40.48**
Oakdale	18.06	16.78	**34.84**	18.06	19.58	**37.64**

NB: For more detail of individual wards and their calculated nurse staffing levels, refer to the annual assurance report.

Informing patients	Patients must be informed of the nurse staffing level on each ward where sections 25B to 25E of the Act pertain and should also be informed of the date the nurse staffing level was presented to Board. At the entrance of each s25B in-patient ward across the Health Board, a poster displays the planed establishment and the date presented to Board. The re-purposing of wards as a consequence of the Covid pandemic did make this incredibly challenging and on occasions we were non-compliant. The posters are bi-lingual, as required. Patients must have access to 'frequently asked questions' on the Nurse Staffing Levels (Wales) Act 2016 and associated regulations, which includes how to raise concerns about nurse staffing levels. Again, this is accessible both in English and Welsh.

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

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

Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards</u>		**407.44**		
		Number of Wards:	**RN (Wte)**	**HCSW (Wte)**
	Required establishment (WTE) of <u>adult acute medical and surgical wards</u> calculated during first cycle (May)	32	538.24	553.61
	WTE of required establishment of <u>adult acute medical and surgical wards</u> funded following first (May) calculation cycle	32	538.24	553.61
	Required establishment (WTE) of <u>adult acute medical and surgical wards</u> calculated during second (Nov) calculation cycle	33	594.1	641.6
	WTE of required establishment of <u>adult acute medical and surgical wards</u> funded following second (Nov) calculation cycle	33	594.1	641.6

The above table shows a significant increase in both Registered Nurses and Health Care Support Workers (includes band 4 Assistant Practitioners) compared with the previous Annual Assurance report, presented in May 2021 for all 25B wards. This increased establishment reflects the additional requirements both to open the GUH and the further requirements to increase establishments following the June 2021 acuity audit.

Consistent with the Clinical Futures model most acute wards in the Royal Gwent and Nevill Hall Hospitals and the Ysbyty Ystrad Fawr have changed purpose beyond previous recognition. It must be acknowledged in reviewing the agreed establishments for Autumn 2021 they bear little resemblance to those of Autumn 2020.

Patient Acuity

As previously stated, patient acuity is one of the main drivers for the increased nursing establishments. ABUHB has observed, over the last four years, a significant increase in patient acuity within the majority of 25B wards. Patients are requiring a higher level of care – in particular, level 4 and 5 enhanced care. This necessitates an increased workforce to ensure patients receive safe and effective care.

The acuity trend demonstrated in the below table is not isolated to ABUHB. A recent benchmarking exercise has demonstrated a similar trend across Wales:

	January 2018	June 2018	January 2019	June 2019	January 2020	July 2020	January 2021	June 2021	Trend
Level 1: routine care	6445	4262	2586	1801	1376	766	302	284	↓
Level 2: pathway care	9236	7632	7522	5338	6213	4068	2405	3227	↓
Level 3: complex care	7132	8073	11,176	10931	12080	9497	7969	10,611	↑
Level 4: urgent care	1344	1677	2310	3805	4186	3886	4593	5802	↑

Level 5: one-to-one care	302	397	371	622	951	894	1303	1617	↑

Vacancy Position

The Health Board has a clear recruitment strategy and workforce plan, with targeted and focused nurse recruitment which is refreshed regularly with the involvement of the Divisions, Workforce and OD and support of the Executive Team. It must be acknowledged that despite significant efforts by the Health Board to reduce vacancies and the introduction of new and innovative roles – for example, the Core Care Model, together with a proactive approach to incentivised pay rewards, there remains a substantial reliance on temporary staffing.

Such a significant reliance on temporary staffing carries risk in terms of patient quality, safety and service delivery. This has become ever more evident in many of the complaints and concerns received and reviewed by the Health Board in regards the care provided by agency workers. It also considerably increases the job demands placed on already exhausted substantive staff. Those unfamiliar with the Health Boards policies, procedures and processes may at times be considered a distraction to permanent staff which can have an impact on service quality due to delays and interruptions. The use of temporary staff can also be unreliable, affect perceptions of fairness and have an impact on permanent staff morale.

The Board has previously been apprised of the significant workforce recruitment strategies and workforce re-design undertaken within ABUHB, which has placed a significant focus on the 'prudent Registered Nurse'. Significant to note, the Executive Team has also acknowledged the necessity, to convert the current reliance on temporary staffing to substantive staffing to meet the agreed establishments.

In addition, following Executive approval several 25B wards have commenced the process of additional HCSW recruitment ensuring the Health Board is taking all reasonable steps to meet the required establishments. This now needs to be reflected in the funded establishments.

It must be acknowledged that despite significant workforce challenges, the well-recognised national shortage of Registered Nurses and the challenge of managing a global pandemic the Health Board has seen a significant improvement in Registered Nurse vacancies over the last four years. In 2018, at the commencement the WG reporting period against compliance with the NSLWA, the Health Board reported a significant Registered Nurse vacancy position = 309.73 WTE. This was considered one of the highest risks associated with implementing the requirements of the Act and was featured on the Corporate Risk Register. This vacancy position increased to 365.07 WTE in June 2019, with a significant reduction in 2021 = 165 WTE.

The tables below demonstrates RN vacancies over a four-year period:

Year	WTE RN Vacancies
2019	365WTE
2020	296WTE
2021	165WTE
2022*	196WTE*

*To note, 50WTE OSN's and 36 WTE streamlining students are currently being on-boarded, which will reduce WTE vacancy reported above for 2022.
** There has been an increase in demand due to additional capacity, MVC, TTP and Recovery Programme

The table below demonstrates some of the reasons why vacancies have increased over the last year. Numerous vacancies are associated with increased establishments required to deploy an

appropriate nurse staffing level to 25B wards. Other vacancies have arisen to support existing services in particular the Health Boards emergency and assessment areas.

Area	RN WTE	HCSW WTE
NSLWA (25B Wards)*	33*	34*
Emergency department	20	
Minor Injuries Unit	10.42	10.56
SAU	5.16	
Transfer Specialist	6.0	
TOTAL	**74.58WTE**	**44.56WTE**

Workforce Implications

The dynamic and rapidly changing pace attributed to the recurrent COVID-19 waves, winter pressures, additional capacity and absenteeism, has required ABUHB to proactively consider ways of maintaining sufficient nurses to allow time to sensitively care for patients and meet their health needs, ensuring all reasonable steps are taken to maintain agreed nurse staffing levels, as per the Act.

The first COVID-19 surge saw an overwhelming response in terms of staff redeployment. The deployment was rapid and effective. Amid the escalation of subsequent COVID-19 surges the redeployment of staff has proven difficult, the reasons being multifactorial. In response to this, a Deployment Process and Principles Protocol has been developed and agreed by the Executive Team, which includes a deployment risk assessment. The risk assessment has been developed congruent to the known COVID Harms. It is designed to support services to assess the impact of staff deployment on both emergency and "normal" service provision, specifically the impact of

	reducing or ceasing services for patients. These principles support Divisions to identify the workforce which can be released for deployment and enables managers to navigate the process. **Recruitment Strategy** The agreed establishments require a focused recruitment strategy. Recent recruitment by means of Overseas Nurses and Student Streamlining has been successful, yielding enough suitable applicants to reduce significantly the Health Boards vacancies. Recruitment to these posts are following the standard NHS recruitment process. In addition to this: • ABUHB is fully engaged in the Once for Wales OSN Recruitment Campaign and currently in the process of onboarding a further 50 OSN' with plans to increase this further. • Adverts will be placed with the RCN as part of the Health Board's annual subscription, which will include listings on the RCN jobs website and the RCN bulletin. • Promotion through social media platforms using a targeted approach, e.g. geographical areas. • A series of recruitment events has been re-established, for example the recruitment wheel, highlighting the opportunities across the Health Board. • Marketing products, to include recruitment videos, are in development promoting the benefits and opportunities of working in ABUHB. • Continue with the successful HCSW recruitment campaign and embed the apprenticeship approach to HCSW career development.

Extent to which the required establishment has been maintained within <u>paediatric inpatient wards</u> NB: Second cycle: Autumn 2021: following June audit	**Period Covered .....**			
		Number of Wards:	**RN (Wte)**	**HCSW (Wte)**
	Funded establishment (WTE) of <u>paediatrics inpatient</u> wards <u>prior</u> to 1st October 2021	**1 (50 beds)**	**70.22**	**17.00**
	Required establishment (WTE) of <u>paediatrics inpatient</u> wards calculated during second calculation cycle (Nov)	**1 (50 beds)**	**70.22**	**17.00**
	WTE of required establishment of <u>paediatrics inpatient</u> wards funded following second (Nov) calculation cycle	**1**	**70.22**	**17.00**
	Accompanying narrative: The significant pressures of the Covid-19 pandemic unsurprisingly disrupted the work of the All Wales Nurse Staffing Group. Despite this, the Government remained committed to ensuring the necessary legal steps were in place to facilitate the extension of the Act. On the 23rd February 2021 the Senedd Cymru passed the Nurse Staffing Levels (Extension of Situations) (Wales) Regulations 2021. The obligations and timetable for extension of the duty for the Health Board are: • The duties under section 25B of the Act must now include paediatric inpatient wards. • The actions already in place for adult acute medical and surgical inpatient wards since April 2018 will now also need to be applied to paediatric in-patient wards. • Due to the disruption of the Covid-19 pandemic, these regulations will come into force on 1 October 2021. It is worth noting that despite not going live until October 2021, the reporting dates have remained aligned to the existing reporting schedule for adult acute medical and surgical wards. This is due to			

	the fact the three-year reporting period is tethered to the date of the Act's commencement, not the coming-into-force date of these regulations. Therefore, this first annual report and three yearly reports to Welsh Government on paediatric wards will be missing the first six months of the period. In Summary, the Paediatric team have undertaken a very thorough re-calculation, the outcome of which has been presented to the Executive Team in September 2021. Whilst the Health Board remains in a state of flux relating to the Covid pandemic, it has been deemed appropriate for the funded rosters to remain unchanged. A further All Wales acuity audit proceeded in January 2022 which provided essential intelligence with regards acuity, as it stands the establishment for this ward remains appropriate.
Extent to which the planned rosters has been maintained	When the second duty of the Nurse Staffing Levels (Wales) Act 2016 came into force in April 2018, there was no consistent solution to extracting all data explicitly required under section 25E of the 2016 Act. Health Boards across Wales were using a variety of e-rostering and reporting systems. During the first reporting period Health Boards in Wales worked as part of the All Wales Nurse Staffing Programme, to enhance the Health Care Monitoring System (in lieu of a single ICT solution) to enable each organisation to demonstrate the extent to which the nurse staffing levels across the Health Board have been maintained. NHS Wales is committed to utilising a national informatics system that can be used as a central repository for collating data to evidence the extent to which the nurse staffing levels have been maintained and to provide assurance that all reasonable steps have been taken to maintain the nurse staffing levels required. The last 3 years has seen extensive work undertaken to inform the development of the Safecare system. The implementation of this national IT system will ensure consistency in recording and reporting data across organisations and support the 'Once for Wales' approach'. For the first reporting period (April 2018-April 2021) ABUHB, together with all other health boards in Wales, provided narrative to describe the extent to which the nurse staffing levels have been maintained to meet its statutory reporting requirement under Section 25E of the Act. During the latter part of the second reporting period (April 2021-April 2024) due to a robust national IT system being implemented, it is anticipated that Health Boards can collate, review and report information relating to the extent that nurse staffing levels have been maintained. In addition, Health Boards

	will be able to demonstrate the extent to which the planned roster has been maintained and whether the deployment of nurse staffing was appropriate to meet the needs of patients sensitively. Each Health Board is at different stages of implementing this IT system. ABUHB is in the very early stages of implementation. A pilot of the new system will be commencing in Nevill Hall Hospital at the end of May 2022, with a plan to fully roll-out over the next reporting period. To note, over the last several months the Health Board has had access to Power BI, an analytical tool, which can be utilised to demonstrate the extent to which rosters have been maintained. ABUHB have progressed with this data source to capture acuity and roster statistics for all 25B wards daily. Due to the inconsistency of reporting with Power BI, reasons being multifactorial, it is considered the rapid roll out and embedding of SafeCare will provide a far more robust and consistent approach to capturing data and will provide the necessary assurance to Board going forwards.
Process for maintaining the Nurse staffing level	Processes to manage and escalate nurse staffing deficits are now well established to ensure all reasonable steps have been followed to maintain nurse staffing levels, which includes: • A ratified Nurse Staffing Operational Policy, the purpose of which is to standardise and inform staff groups of their responsibilities and of processes and procedures for ensuring appropriate and carefully considered nurse staffing in all areas. Specifically the overarching duty, s25A, is referenced within the Policy. • A weekly reporting and escalation process by which staffing deficits across the Health Board are reported to include: ➢ Filled and unfilled Registered Nurse (RN) shifts against planned rosters ➢ Filled and unfilled Health Care Support Worker (HCSW) shifts against planned rosters ➢ Percentage of substantive staff versus agency staff populating rosters to gauge quality, safety and continuity of care. ➢ Serious incidents considered to have been attributed to a deviation from the planned ward nursing roster.

	• RN and HCSW pools on each acute site to support deployment of staff – taking all reasonable steps to ensure planned rosters are maintained on a backdrop of significant absenteeism and fluctuation in capacity required in response to Covid and Winter. • A workforce tracker is presented to the Executive Team detailing progress on recruitment, bank and agency usage, turnover and absenteeism. • Formal reviews have been undertaken to consider and re-align nursing establishments in specialist areas, to include, ED, SAU, MIU. • A monthly Strategic Workforce (NSLWA) meeting is held with representation from all clinical Divisions, with the purpose of overseeing the implementation of the Act and monitoring key workforce and staffing metrics. • Daily review of nurse staffing levels – to manage and mitigate risk. • Unfilled shifts escalated to bank/agency at the earliest opportunity to give best opportunity of securing staff. • Clear Divisional escalation procedures to ensure and manage timely escalation of unfilled shifts • Introduction of incentives to support rosters and encourage substantive and bank staff to undertake additional shifts. • On occasion, there has been a requirement to reduce capacity to maintain appropriate staffing levels. • The development of new and innovative roles has been crucial in maintaining nurse staffing levels across the Health Board.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	**Total number of incidents/ complaints during last year**	**Number of closed incidents/ complaints during current year**	**Total number of incidents/ complaints not closed and to be reported on/during the next year**	**Increase (decrease) in number of closed incidents/ complaints between previous year and current year**	**Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained**	**Number of incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor**
Hospital acquired pressure damage (grade 3, 4 and unstageable)	**36**	**54**	**7**	**Increase**	**3**	**0**
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	**37**	**40**	**8**	**Increase**	**0**	**0**
Medication errors never events	**2**	**0**	**0**	**Decrease**	**0**	**0**
Any complaints about nursing care	**128**	**209**	**18**	**Increase**	**6**	**0**

NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)

The metrics provided indicate a notable increase in Health Care Acquired Pressure Ulcers (HAPU) over the last reporting period. This is attributed, in part, to:

- A transition over to a new reporting system during 2021-22. Qlik was previously utilised to extrapolate data to populate the quality indicators within the assurance report. Currently there is no linkage between the new Datix system and Qlik. A workstream is being progressed to re-establish this connection to ensure a consistent approach to capturing data.
- Increased acuity
- Increased Length of Stay

- Significant reduction in elective activity
- Reliance on temporary staffing to manage additional capacity, the pandemic and winter surge.
- HAPU's total numbers are both for unavoidable and avoidable. Therefore the total number includes all HAPU's recorded as unavoidable harm.

A significant increase in nursing complaints is also observed. It is important to note, most complaints are only partially related to nursing. The predominate theme relates to poor communication and telephones not being answered, which is not solely a nurses responsibility.

The later 6 months of the year saw a significant reduction in complaints relating to nursing care. Board has previously been appraised of the initiatives introduced to support communication with families and relatives. It is envisaged that a significant improvement will be realised within this metric as visiting is reinstated across the Health Board.

The new Datix system will capture complaints relating to nursing care in a more robust and meaningful manner, which will also support the future reporting requirements of the Act.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in Paediatric inpatient wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	**Total number of incidents/ complaints during last year**	**Number of closed incidents/ complaints during current year**	**Total number of incidents/ complaints not closed and to be reported on/during the next year**	**Increase (decrease) in number of closed incidents/ complaints between previous year and current year**	**Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained**	**Number of incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor**
Hospital acquired pressure damage (grade 3, 4 and unstageable)	**N/A**	**0**	**0**	**N/A**	**0**	**0**

Medication errors never events	**N/A**	**0**	**0**	**N/A**	**0**	**0**
Infiltration/ extravasation injuries	**N/A**	**2**	**0**	**N/A**	**0**	**0**
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents)	**N/A**	**0**	**0**	**N/A**	**0**	**0**
Any complaints about nursing care	**N/A**	**0**	**0**	**N/A**	**0**	**0**

NOTE: Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)

Additional quality metrics, in terms of patient and staff experience, are collated and considered within the paediatric recalculation.

Patient feedback has been described as excellent, with an overall satisfaction of 9.2/10. Examples of feedback include:

- Always able to speak with a nurse
- Very friendly
- Approachable staff
- Supportive
- Reassuring
- Attentive

Staff Satisfaction:

In general, the staff satisfaction survey indicated both Registered Nurses and HCSW's were satisfied in their work and their ability to manage workload. There is however additional work required to modify the staff survey and provide education in its purpose, prior to the next recalculation to improve compliance with completion.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained	
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	By way of assurance, the Health Board has in place: • A well embedded process to investigate all Grade 3, 4 and unstageable Health Care Acquired Pressure Ulcers (HAPU's) through root cause analysis (RCA). • The RCA considers a range of variables which may have contributed to the incident, of which one is the maintenance of the planned nursing roster and whether this directly contributed to the development of the HAPU. • Any HAPU's considered to have been deemed avoidable are reported to Welsh Government and are considered at the Redress Panel, enabling a process of reflection and learning. • All falls resulting in fracture or head injury are reported via Datix and to the Delivery Unit, Welsh Government. • A Falls Review Panel is well established, where all variables are considered, to include nurse staffing levels, any falls deemed avoidable are taken for consideration to the Redress Panel. • Organisational shared learning events have taken place in relation to falls. • Complaints is a complex metric to capture due to the multi-faceted nature of complaints. To date there are ?? recorded complaints, during the last reporting period, whereby nurse staffing levels has either partially or wholly contributed to the complaint. It is important to note there are still outstanding incidents which require a root cause analyses to determine causation which fit this reporting period.

Conclusion & Recommendations	The Covid pandemic has undoubtedly continued to place unprecedented pressure on the Health Board with regards patient acuity, dependency and complexity. The rapid and frequent repurposing of wards to manage Covid pathways has been challenging coupled with substantial absenteeism. The gravity of the circumstances means it impossible to implement a fully triangulated approach every time a ward was repurposed, so professional judgement was pivotal to ensuring safe staffing. In conclusion, ABUHB has: • Clear processes in place to identify, investigate and escalate, from Ward to Board, any deviations from the planed roster and any potential harm as a consequence. • Has introduced new and innovative ways of working to strengthen and stabilise the workforce – focusing on safe and effective delegation to improve patient safety and quality. • Embraced the apprenticeship approach to HCSW career development. • Focused on significantly reducing the vacancy factor. • Complied with the extension of the Act to paediatrics. • Ensured the reporting requirements for the NSLWA is incorporated into the Once for Wales Concerns Management System. **Next Steps** • Appoint a Nurse Staffing Programme Lead to co-ordinate the implementation of nurse staffing related law and strategy. • Constantly review and carry out comprehensive and systematic reviews of all nurse staffing levels, being particularly mindful of the new establishments agreed relating to the opening of GUH and revised ELGH's. • Commence an All Wales approach to the rollout of a new rostering system, in meeting the requirements the NSLWA. • Embed reliable data capture systems to meet statutory reporting requirements relating to 'the extent to which the nurse staffing level has been maintained' which will be enabled by the introduction of SafeCare.

APPENDIX A: SUMMARY OF REQUIRED ESTABLISHMENT

Health Board:	Aneurin Bevan University Health Board
Period reviewed:	**Start Date:** October 2020 **End Date:** September 2021
Number of Ward where section 25B applies:	**Medical Number:** 21 **Surgical Number:** 12 * incorrectly reported as 13 in November 2021 submission

MEDICAL

Ward	Required establishment at the start of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the start of the reporting period	Required establishment at the end of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the end of the reporting period	Bi-annual calculation cycle reivews and reasons for any changes made			Any reviews outside of bi-annual calculation, if yes, reasons for any changes made		
	RN WTE	**HCSW WTE**		**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
C5E	15.49	21.06	Yes	15.48	16.78	Yes	Yes	Yes	Specialty changed to sub-acute stroke	Yes	Yes	Opening of GUH Initial CF model indicated requirement of 13.98WTE HCSW
D4E	16.75	19.62	Yes	15.48	25.17	Yes	Yes	Yes	EFU ambulatory unit currently closed High levels of enhanced care	No	No	
D4W	15.48	22.41	Yes	15.48	25.17	Yes	Yes	Yes	High levels of enhanced care	No	No	
C4W	15.48	15.42	**Closed**									
C4E	15.48	22.42	Yes	15.48	25.22	Yes	Yes	Yes	High levels of enhanced care	No	No	
C6E	19.34	14.58	Yes	15.48	22.42	Yes	Yes	No		Yes	Yes	Re-purposed from acute respiratory to medical ward
C6W	21.17	15.38		18.48	22.42	Yes	Yes	No		Yes	No	Re-purposed from high care respiratory – to endocrine
4.1	22.18	13.98	**Closed**									
4.3	15.48	23.41	Yes	15.48	22.42	Yes	Yes	No	Now COTE	No	No	
4.4	16.5	20.42	Yes	21.18	13.98	Yes	Yes	No	Previously acute respiratory – now sub-acute respiratory	Yes	No	
1/2	15.48	18.22	**Closed**									
Risca 3/1	18.32	19.58	Yes	18.32	19.58	Yes	Yes	No		No	No	
Oakdale 2/1	18.06	16.78	Yes	18.06	19.9	Yes	Yes	Yes	Purpose changed – first calculation	Yes	No	Multiple re-purposing to manage Covid pathways
Bargoed	18.06	16.78	Yes	15.48	22.42	Yes	Yes	Yes	Purpose changed – first calculation	Yes	No	Multiple re-purposing to manage Covid pathways
3.1	17.22	14.38	Yes	15.48	22.42	Yes	Yes	No	Now COTE – previously elective Orthopaedics	Yes	No	Re-purposed

3.2	14.48	19.92	Yes	15.48	22.42	Yes	Yes	No	Now COTE – previously T&O	Yes	No	Re-purposed
3.3	14.48	19.92	Yes	15.48	22.42	Yes	Yes	No	Now COTE – previously acute surgical	Yes	No	Multiple re-purposing
3.4	14.48	19.92	Yes	15.48	22.42	Yes	Yes	No	Now sub-acute stroke – previously acute surgical	Yes	No	Re-purposed to stroke rehabilitation
A2	18.32	16.78	Yes	19.91	16.78	Yes	Yes	Yes	Acuity ward layout	Yes	No	New Ward – initial calculation pre-opening
A4	24.01	19.58	Yes	26.85	22.37	Yes	Yes	Yes	Acuity ward layout	Yes	No	New Ward – initial calculation pre-opening
C4	29.7	19.58	Yes	29.7	19.58	Yes	Yes	No		Yes	No	New Ward – initial calculation pre-opening
B4	19.32	17.4	Yes	19.32	17.4	Yes	Yes	No		Yes	No	New Ward – initial calculation pre-opening

SURGICAL												
Ward	Required establishment at the start of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the start of the reporting period	Required establishment at the end of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the end of the reporting period	Bi-annual calculation cycle reivews and reasons for any changes made			Any reviews outside of bi-annual calculation, if yes, reasons for any changes made		
	RN WTE	**HCSW WTE**		**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
D3E	24.01	22.37	Yes	16.48	21.37	Yes	Yes	Yes	Now a 30 bedded elective surgical ward Previously cardiology	Yes	No	Multiple re-purposing
D2E	21.17	15.38	Yes	12.64	11.19	Yes	Yes	Yes	Now urology ward and UAU	Yes	No	Multiple re-purposing D2E moved to D2W
4.2	19.34	17.58	Yes	15.48	22.42	Yes	Yes	No	Now COTE	Yes	No	Multiple re-purposing
D2W	17.23	13.98	Yes	13.91	5.59	Yes	Yes	No	16 bedded DOSA ward – previously 30 bedded elective ortho	Yes	No	Multiple re-purposing
D5E	11.8	2.8	**Closed**									
D5W	15.9	17.87	Yes	15.48	22.37	Yes	Yes	No	Now 28 bedded surgical ward – was urology/max-fax/ENT	No	No	
C7E	18.75	15.38	**Closed**									
C5W	18.75	15.38	Yes	15.51	19.58	Yes	Yes	No	Now step-down Orthopaedic ward – previously acute Orthopaedic ward	Yes	No	Multiple re-purposing
C7W	19.76	13.98	Yes	15.48	18.18	Yes	Yes	Yes	Now an elective Orthopaedic ward – previously acute surgical ward	Yes	No	Multiple re-purposing
D7E	11.64	15.73	Yes	12.46	11.19	Yes	Yes	Yes		Yes	No	Multiple re-purposing
OSU	16.92	8.38	Yes	16.92	8.38	Yes	Yes	No		Yes	No	Re-purposed to ambulatory trauma
0A *incorrectly reported Nov 2021	21.17	20.16	Yes	26.85	25.17	Yes	Yes	Yes	Acuity Ward layout	Yes	No	New Ward – initial calculation pre-opening
0B*incorrectly reported Nov 2021	21.17	20.16	Yes	26.85	25.17	Yes	Yes	Yes	Acuity Ward layout	Yes	No	New Ward – initial calculation pre-opening
0C* incorrect reported Nov 2021	21.17	20.16	Yes	26.85	25.17	Yes	Yes	Yes	Acuity Ward layout	Yes	No	New Ward – initial calculation pre-opening
A3 - Gynae	20.18	11.48	Yes	20.18	11.48	Yes	Yes	No		Yes	No	New Ward – initial calculation pre-opening
2.4	14.8	9.68	**Closed**									
B7	12.42	8.32	**Closed**									

ADDITIONAL WARD OPENED/RE-PURPOSED TO MANAGE COVID-19												
Ward	Required establishment at the start of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the start of the reporting period	Required establishment at the end of the reporting period		Is the Senior Nurse / Charge Nurse supernumerary to the required establishmnent at the end of the reporting period	Bi-annual calculation cycle reivews and reasons for any changes made			Any reviews outside of bi-annual calculation, if yes, reasons for any changes made		
	RN WTE	**HCSW WTE**		**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
D6E	N/A	N/A	**Closed**									
D6W	15	7.6	**Closed**									
D7W	N/A	N/A	**Closed**									
B3	13.76	19.62	Yes	21.17	19.58	Yes	Yes	Yes	Opened as Additional capacity	Yes	Yes	Re-purposed (additional capacity) Ward layout
B6N	N/A	N/A	**Closed**									
Eye Ward	N/A	N/A	**Closed**									
Glan Usk	N/A	N/A	**Closed**									
Llanfoist	N/A	N/A	**Closed**									

Aneurin Bevan University Health Board

TRADE UNION PARTNERSHIP FORUM ANNUAL REPORT

Executive Summary

The Health Board and the Trade' Unions have a common objective in ensuring the effective delivery of high quality healthcare services to patients. The organisation's 'Trade Union Recognition and Partnership Agreement' provides the framework within which the Health Board and the Trade Unions work together to achieve this objective. The Trade Union Partnership Forum (TUPF) as an advisory group of the Board is one of the formal forums for discussion and developing an understanding of the issues faced by the Health Board and its workforce.

The purpose of this report is to provide an overview of partnership working from the Chair of Staff Side and a summary of the work undertaken by the TUPF over the past year. It outlines the key issues discussed by the Forum, with a summary of work for 2021/22.

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

Executive Sponsor: Glyn Jones, (Interim) Chief Executive and the Joint Chair of the TUPF

Report Author: George Puckett, Staff Side Chair

Report Received consideration and supported by:

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

Date of the Report: May 2021

Supplementary Papers Attached: None

Purpose of the Report

The purpose of this report is to provide an overview of partnership working from the Chair of Staff Side and a summary of the work undertaken by the TUPF over the past year. It outlines the key issues discussed by the Forum during the past twelve months, a focus of the work for 2020/21, the links to the IMTP and the successful implementation of Clinical Futures.

The Trade Union Partnership Forum operates as a key advisory group of the Board, reporting directly to the Board with responsibility for engaging with staff organisations

on key issues facing the organisation. The TUPF provides the formal mechanism for consultation, negotiation and communication between staff organisations and management, embracing the TUC principles of partnership. It provides an opportunity to have detailed discussions about matters of particular importance to the Health Board and the staff it employs e.g. service change plans.

This group is jointly chaired by the Staff Side Chair for Trade Unions and the Chief Executive.

Background and Context

The Health Board and the Trade Unions have a common objective in ensuring the effective delivery of high quality health care services to patients. The organisation's 'Trade Union Recognition and Partnership Agreement' provides the framework within which the Health Board and the Trades' Unions work together to achieve this objective.

Our local TUPF operates in the context of the Welsh Partnership Forum which is a tripartite group, sponsored by the Welsh Government which consists of representatives from;

- The recognised healthcare trade unions for NHS Wales;
- Representatives of senior management for NHS Wales;

The main purpose of the Welsh Partnership Forum is the development, support and delivery of workforce policies on a national, regional and local level. The Welsh Partnership Forum provides strategic leadership on partnership working between employers and employee representatives.

Assessment and Conclusion

KEY TOPICS

The Forum provides an excellent opportunity for managers and Trade Unions across the Health Board to meet and enter into dialogue on a number of strategic issues impacting on delivery of services and the workforce. There are a set of standard agenda items that are considered and discussed at each meeting, these are listed in Table 1 below:

Agenda items discussed during the year (not exhaustive)
• Update on Clinical Futures, including; - Grange University Hospital (GUH) and on-going changes. - Covid Recovery and the impact on services and staff well-being - Agile Working - Integrated system of Health, Care and Well-being
• IMTP
• Wales Collaborative
• Integrated Performance Dashboard
• Workforce Performance Dashboard
• Financial Report
Papers for information
• Workforce & OD Policy Group Briefing

• Draft Board Minutes	
• Health & Safety Committee Minutes	
Additional Agenda items considered	
• Covid-19 Workforce Risk Assessments - Staff testing	• New Smoking Legislation
• Employee Well-being Surveys	• Staff forum concerns
• Equality Diversity & Inclusion	• Kick Start and Apprenticeships

In addition, agenda items include items directly related to staff well-being such as an update on supporting staff who are victims of domestic abuse and the scope of the new 'Violence Against Women, Domestic Abuse and Sexual Violence' legislation.

AREAS OF JOINT WORKING

Where issues are highlighted that require joint working, task and finish groups are set up to report back to TUPF. Over the last year these have included, but not limited to:

- Covid-19 catch up meetings with W&OD and managers, this included the review of the Covid -19 Workforce dashboard, Frequently Asked Questions and staff testing as well as developing bespoke Covid-19 protocols and staff communications.
- Agile Working toolkit.

ACHIEVING POSITIVE CHANGE IN PARTNERSHIP

The last year has again created unprecedented circumstances as a result of the Covid-19 pandemic which required exceptional levels of support from lead staff side representatives.

Partnership working has been compromised by certain senior management who have chosen not to engage with TUs from the outset; examples are the advanced stages of the planning of the SDEC at GUH and possible changes to County Hospital. This has resulted in some tense and difficult discussions with all concerned, and almost resulted in a withdrawal by TUs from engagement. It has only been with the open discussions we have with the CEO, WOD Director (both past and present) and their colleagues we have been able to ensure staff concerns were fully understood and alternative options considered and applied.

Some concerns have also been raised with the Trade Unions from members. These related to what appear to have been independent actions undertaken locally by some managers that did not have the robust communication, engagement and inclusion of staff and Trade Union representatives, that we would normally expect. Whilst, these are small in number they have caused additional stress to staff alongside work for those supporting the process, together with TUs ensuring adequate support is in place for members affected. Staff feel these managers are not reprimanded for their actions which are outside ABUHB principles of inclusion and engagement.

It is recognised that without established partnership working the Health Board would not be in a position to deliver on its key objectives and ensure safe and effective patient care and a positive environment for the well-being of our staff.

Key to achieving these positive outcomes are:

- Well-informed lead trade union representatives to further strengthen staff communication from the initial stages through to completion of any service change and where appropriate, provide assurance to staff during significant periods of change and uncertainty.

- A mutual understanding of the Health Board's financial and service delivery position and the challenges it presents.

- Constructive debate and joint solution finding to explore ways to increase cost effectiveness whilst safeguarding employment and patient care as a priority. An example of this would be discussions in relation to Service Change Plans and their implications in relation to the application of the national organisational change policy.

- Supporting local manager/staff discussion on their service(s), to discuss openly option appraisals on both improvement in delivery and staff well-being.

The following principles for effective partnership working are essential, and need to be applied in all cases for success:

- Managers ensuring they communicate effectively and in a timely and transparent way. Without this an environment of uncertainty and distrust could be created within the workforce.

- Ensuring local Trade Union Representatives are afforded adequate time to engage in the strategic and operational agendas.

- Ensuring Trade Union colleagues are engaged at an early stage in problem discussions, as well as change management. This will prevent an adverse impact on partnership working and on delivering effective change.

Specific issues that have needed attention over the past year include;

- Safe working environment for staff i.e. adequate and correct PPE
- Awareness and application of Covid-19 Workforce Risk Assessments requirements for both staff and managers
- Temporary redeployment of staff during the pandemic including the development of Health Board Deployment Principles
- Child Care issues
- The provision of accommodation for staff where they were unable to or it was unsafe for them to return home
- High levels of staff absence and shielding
- Well-being support for staff

Specific issues that need attention going forward in 2022 include;

- Build on work undertaken in partnership during 2021 that has significantly reduced employee relation investigation timelines to support staff well-being. This will ensure investigations are firmly scheduled to prevent delays to ensure the

well-being of all staff involved are not compromised by unnecessary delays. It has noted of late these are taking longer.
- Priority given to have dedicated investigation officers to perform this duty.
- Review and refresh our redeployment protocols to ensure that appropriate relocation of staff that does not compromise their substantive duties and responsibilities. Failure to explore this puts further pressure on remaining staff and compromises service delivery.
- Ongoing development of the staff Well-being offer

KEY AREAS OF FOCUS FOR ONGOING YEARS

Embedding partnership working at the earliest opportunity at a departmental level and ensuring managers understand their responsibility to work in partnership locally and the roles and responsibilities of Trade Union members. This will ensure all parties are included in early arrangements for future planning of meetings, workshops etc. to maximise attendance and reduce delays.

Highlighting "Hotspot" areas where concerns have been raised, enabling a deep dive approach to resolve inappropriate, unsafe or unhealthy working practices.

Ensuring we continue to improve and consistently apply the principles listed above to maintain the high standards of partnership working that already exist within the Health Board. This will ensure the Health Boards partnership model will continue to support and enhance service change. A joint statement from the Interim Chief Executive and Staff Side Chair reemphasising the commitment to partnership working by the Health Board will be shared with the launch of the People Plan. In addition, a TUPF development session will be utilised to debate and agree key working practices and behaviours which will embed the principles of the statement in what we do.

The TUPF will also continue to provide and develop its role in challenging the organisation, and encouraging its members, to ensure that:

- Working environments are safe and fit for purpose, including agile/hybrid working initiatives.
- Individuals are appraised and engaged with the organisation's strategic vision through mechanisms such as PADRs.
- Improved efficiencies; both organisational and individual.
- Performance is delivered through engaged service and workforce redesign and team working.
- Service change(s) are discussed at the earliest opportunity by all parties.

Recommendation
The Board is asked to note the content of the paper and to continue supporting partnership working on all organisational workforce issues.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Failure to ensure staff and Trade Unions are involved early discussions around service change and redesign may result in increases in grievances and disputes.
Financial Assessment, including Value for Money	There are no financial implications within this paper.
Quality, Safety and Patient Experience Assessment	The Health Board and the Trade Unions have a common objective in ensuring the effective delivery of high quality health services to patients.
Equality and Diversity Impact Assessment (including child impact assessment)	An equality impact assessment screening has been undertaken with no negative impacts identified.
Health and Care Standards	This report contributes to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The IMPT is a core item considered by the TUPF each time it meets.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Effective partnership working is linked to the Health Board's Wellbeing Objective 7. Specifically, developing our staff to be the best that they can be with high levels of employee well-being.
	Long Term –The work of the TUPF supports and drives effective policy development and wellbeing of staff which contributes to a positive impact on patient care and the wider population.
	Integration –As representatives of a large workforce the TUPF recognises the important role it plays in ensuring the wellbeing of the Workforce and their ability where appropriate to support the wellbeing goals of partners.
	Involvement – The work of the TUPF takes account of the diversity of the membership, staff and population served to ensure policy and service change is equitable.
	Collaboration – The TUPF works in collaboration with Welsh Partnership Forum and other relevant stakeholders as appropriate to the areas it is working on.
	Prevention –The TUPF recognises the role it plays in the wellbeing of the workforce through partnership working to ensure effective engagement, policy and service change.
Glossary of New Terms	No new terms.
Public Interest	There is no reason why this document cannot be made public.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 25th May 2022 Agenda Item: 4.6

Aneurin Bevan University Health Board

Strategic Partnerships Update Report

Executive Summary

This paper provides an overview of the current activity of the regional strategic partnerships in which the health board is a statutory partner. This paper describes the Gwent Public Services Board's recent publication of the final Gwent Well-being Assessment, the process for production of a Well-being Plan and work underway to establish Gwent as the first 'Marmot Region' in Wales. In addition the paper provides an overview of key work streams of the Gwent Regional Partnership Board, including an update on the partnership funding model, additional work areas that have emerged in recent months, and the learning and outcomes from the delivery of the Integrated Winter Plan 2021-22.

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

Executive Sponsors:
Dr Sarah Aitken, Director of Public Health & Strategic Partnerships
Dr Chris O'Connor, Interim Director of Primary Care, Community & Mental Health

Report Author: Stuart Bourne, Consultant in Public Health
Roxanne Green, Asst. Director of Partnership & Integration

Report Received consideration and supported by :

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

Date of the Report: 13/05/22

Supplementary Papers Attached:

Purpose of the Report

To provide ABUHB Board Members with an update on the current activity of Gwent Public Services Board (PSB) and Gwent Regional Partnership Board (RPB).

Background and Context

Gwent Public Services Board is responsible, under the Wellbeing of Future Generations (Wales) Act (2015), for overseeing the development and implementation of a Local

Wellbeing Plan for the Gwent area that demonstrates the five ways of working defined in the Act. Gwent Public Services Board (PSB) has eight statutory member organisations (including ABUHB), as well as nine other invited bodies who share the aims of the PSB and who help deliver the Local Wellbeing Plan. Gwent PSB was created in September 2021, following the amalgamation of five local authority PSBs. Further information about the work of Gwent PSB is available at: http://www.gwentpsb.org/en/

Gwent Regional Partnership Board (RPB), established under the Social Services and Wellbeing Act (Wales) 2014, brings together ABUHB, the five local authorities of Gwent along with regional third sector representation to meet the care and support needs of people in their area. RPBs are tasked with improving the well-being of the population, and the way in which health and care services are delivered. The RPB has an established portfolio of funded activity that has been under review during recent months, pending confirmation from Welsh Government on the future funding model. This work has identified over £19million of services that needs to be sustained across the RPB system, with recognition that work is needed to improve the joint and seamless care pathways across the system to achieve better outcomes and whole system performance.

Assessment and Conclusion

Gwent Public Services Board

Gwent PSB last met on 10th March 2022. At that meeting, the PSB:

- Discussed and approved a final version of the Gwent Well-being Assessment
- Agreed to establish Gwent as a 'Marmot Region'
- Discussed the public sector response to the humanitarian crisis in Ukraine
- Agreed to explore future options for the Gwent Test, Trace, Protect Service
- Received an update on the Gwent Community Safety Review
- Determined the future work programme and lead officers

A copy of the final Gwent PSB Well-being Assessment is available at: https://www.gwentpsb.org/en/well-being-plan/well-being-assessment/.
The Assessment provides an analysis of social, economic, environmental and cultural wellbeing in Gwent. It recognises positive features in the region, such as Gwent's diverse economy and rich culture, but also some of the challenges in terms of inequalities associated with socio-economic deprivation and the pressure on natural resources.

To respond to the findings of the Well-being Assessment, Gwent PSB is working on the development of a Well-being Plan. In producing the plan, it has been agreed that there will be a focus on three themes: health inequalities (inc housing), the environment, and community cohesion.

Organisational leads for each of the three themes have been identified. The Health Board is leading on health inequalities with Tai Calon Community Housing, Natural Resources Wales is leading on the environment, and Gwent Police, GAVO and the Office of Police and Crime Commissioner are leading on community cohesion. Work is currently underway to develop a 'response analysis' for each of the three themes. The response analysis will reflect on the findings of the Well-being Assessment, examine the extent and efficacy of work already happening, and provide recommendations for further action.

The three response analyses will be discussed at the next PSB meeting on 30th June 2022, when approval will be sought to use each as the basis for development of the Gwent PSB Well-being Plan. A draft of that plan will be published for public consultation at the end of September 2022, with a final version agreed by the PSB in March 2023, meeting the statutory requirement to publish a local well-being plan no later than 12 months after each local authority ordinary election.

The health inequalities response analysis is being led by the ABUHB Director of Public Health, with the analysis being undertaken by Gwent Local Public Health Team. It is being drafted to align with the decision of Gwent PSB to become a Marmot Region. This means that the actions to address health inequalities will be viewed through a social determinants of health model as expressed through eight Marmot principles. These principles are:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities;
- Strengthen the role and impact of ill-health prevention;
- Respond to climate change;
- Address structural racism.

Gwent plans to be the first area in Wales to become a Marmot Region, following on from other cities and regions, including Manchester, Coventry, and Cheshire and Merseyside. By becoming a Marmot Region Gwent PSB is committing to a determined and joint effort to true partnership working across of number of areas to improve the lives of all, but in a way that is proportionate to the level of need. The Health Board is funding the initial phase of the proposal by partnering with University College London Institute of Health Equity.

Over the course of 2022/23, a programme of work will be established under Gwent PSB to explore each of the eight principles and agree where action is required to address the underlying socioeconomic differences in life expectancy and healthy life expectancy in Gwent. This work is being facilitated and supported by the UCL Institute of Health Equity with involvement from Professor Sir Michael Marmot. An update paper on the Marmot Region work will be presented to the next meeting of Gwent PSB on 30th June 2022.

The main focus of discussion at the next meeting in June will be sign off of the three response analysis documents.

Gwent Regional Partnership Board

<u>RPB Programme & Funding Model</u>
Welsh Government has made a 5 year commitment of revenue funding for Regional Partnership Boards. This revenue funding, now known as the Regional Integration Fund (RIF), brings together previous funding streams provided to RPBs into one source of strategic revenue funds, providing £26.8m for Gwent annually, from April 2022 to March 2027. The funding model comprises four key elements introducing a tapering approach during the course of the 5 year programme. The tapering approach is intended to

promote sustainability, with the expectation that partners in receipt of funding provide the resource match to reflect the tapered element as outlined below.

1. Fully Funded National Priorities Fund (100% WG funded - £2.825m)
   Ring fenced funding provided to Regional Partnership Boards at 100%, no tapering or resource match required for initiatives within this category. This includes Dementia ringfenced funding, and the Integrated Autism Service.

2. Acceleration Change Fund (90% funded via RIF, 10% tapering)
   Funding to test and develop new models of care, for a maximum period of 2 years. Following robust evaluation these models can be considered to move into the embedding fund

3. National Delivery Model Embedding Fund (70% funded via RIF, 30% tapering)
   Projects successfully tested can move into the embedding fund with a clear business case for sustainability. Embedding funding can be received for a maximum of 3 years. If appropriate, projects can move into the mainstreaming fund at the end of this period.

4. 50/50 Integrated Mainstreaming Fund (50% funded via RIF, 50% tapering)
   After a project has concluded its three years funding under the Embedding Fund it should now be ready to be mainstreamed. Partners must agree and commit resources to ensure that the project or model of care will be sustained long term. This fund will take the shape of a recurrent pooled fund with partners contributing 50% and Welsh Government contributing the remaining 50%

The key message identified within the Welsh Government RIF guidance is the requirement for Regional Partnership Boards to utilise funding to deliver a programme of change over the next 5 years. There is emphasis on the learning from both the Integrated Care Fund and the Transformation Fund, and the desire to create sustainable system change through the integration of health and social care services. The Regional Integration Fund is described as a key lever to drive change and transformation within the health and social care system, with Regional Partnership Boards tasked to consider how they deploy their collective resources, including both partnership funding and wider core resources to meet their objectives.

The key features and values of the Regional Integration Fund are identified as:

- A strong focus on prevention and early intervention
- Developing and embedding national models of integrated care (also referred to as models of care within the guidance)
- Actively sharing learning across Wales through communities of practice
- Sustainable long term resourcing to embed and mainstream new models of care
- Creation of long term pooled fund arrangements
- Consistent investment in regional planning and partnership infrastructure

The models of care referenced within the guidance have been developed with the intention of ensuring citizens experience an effective and seamless service, with the intention of nationally embedded models of care as an output of the Regional Integration Fund. The models of care are identified as:

- Community based care – prevention and community coordination

- Community based care – complex care closer to home
- Promoting good emotional health and wellbeing
- Supporting families to stay together safely, and therapeutic support for care experienced children
- Home from hospital services
- Accommodation based solutions

Significant work has been undertaken within the Regional Partnership Board to develop plans for use of the Regional Integration Fund. These plans reflect the learning from the existing funded portfolio (from both the Integrated Care Fund and Transformation Fund) and wider system challenges, and will bring to fruition 18 strategic regional programmes aligned with both the priorities of the Regional Partnership Board agreed in July 2021 (see Appendix 1) and the models of care established within the RIF Guidance. The next meeting of Gwent RPB on 16 June 2022 will consider the draft plan ahead of wider circulation

As an additional enabler to seamless care, Welsh Government capital funding is also available to Regional Partnership Boards with a significant focus on accommodation solutions that enable integrated service delivery, particularly the establishment of integrated hubs and wellbeing centres. Welsh Government final guidance associated with RPB capital funding streams is still in development; however, interim guidance (see Appendix 2) has been developed and shared widely across the Gwent RPB to support early engagement and the development of a pipeline of potential schemes within Gwent.

Regional Partnership Boards will be required to develop 10 year capital strategies and plans. To support regional joint approaches a range of capital strategic needs assessments will be undertaken for a wide range of vulnerable population groups. This work will be facilitated by a newly established Integrated Capital Planning Group, and will be delivered within the 2022-23 period..

Given the broad scale development work needed across the partnership to develop and deliver new programmes of transformation change, Gwent RPB has agreed to use the time up to December 2022 as a development period to enable outcomes focussed planning across all programmes, to provide clear benefits realisation plans and financial sustainability plans.

Welsh Government has also introduced an Accelerated Cluster Development programme that places emphasis on alignment with the role and work of Regional Partnership Boards. To support a joint approach to the development of the RPB and Accelerated Cluster Development programmes of work, an Integrated Governance Working Group has been established to ensure synergistic developments. The first meeting of this group will take place on 25 May 2022, with initial membership comprising ABUHB Director of Corporate Governance, Assistant Director of Partnership & Integration, Gwent RPB Regional Lead, Deputy Director of Planning, Accelerated Cluster Development Lead. Draft terms of reference will be considered at this first meeting, and formal reporting arrangements into respective partnership organisations agreed.

<u>Integrated Winter Plan</u>
The Health Board winter plan was developed in alignment with the All Wales Health and Social Care Winter Plan 2021-22, following the priorities established. This was then integrated with the social care response to that plan to develop a Gwent Regional Winter

Plan under the governance of the Regional Partnership Board. The RPB agreed that implementation of the Regional Winter Plan would be overseen by the Community Care Sub-Group reporting to the RPB.

Whilst the plan is outlined against the national priorities below, thematically there are three key components to the plan:

1. Additional human resource within our system
2. Additional bed capacity (hospital/community)
3. Additional third sector contracts

Priority 1 within the plan focusses on the vaccine and immunisation booster programme, and the revised approach to test, trace and protect services. COVID-19 vaccine uptake rates by care staff were reviewed on a weekly basis by the Community Care Sub Group to ensure health and social care collaboration to achieve high uptake by the care workforce.

Priority 2 and 7 centred round prevention and keeping people well. Communications in this respect were undertaken via ABUHB and through the Gwent Warn and Inform Group under the Gwent Strategic Co-ordination Group that was standing for much of the winter period. As a key component of the Health Board's restart and recovery, and to support respiratory pathways as part of winter resilience, a spirometry hub was successfully established in December 2021 to provide direct access via GP referrals.

Activity to support **Priority 3** – maintaining safe health services – provided for additional capacity across the system, ensuring mental health support was available in our emergency department at GUH and extended working hours to provide additional Older Adult Psychiatric Liaison. In recognition of the system pressures and workforce constraints within the system, there was emphasis within Priority 3 on creating additional capacity to support flow within the system. The ability to discharge patients from hospital was significantly impacted by the capacity constraints faced by social care.

A Step Closer to Home pathway was established to utilise available care home capacity to provide step down care for patients who were unable to return home without support. A pathway was developed with social care colleagues to support decision making for patients suitable for the pathway. On average 12 patients have been supported via this pathway every month. It was intended patients would be placed on this pathway for approximately 6 weeks, in alignment with existing step down utilisation, but the social care capacity constraints in the community resulted in an average length of stay of 12 weeks for patients.

A Step Closer to Home Unit in a community hospital was created to facilitate patients to progress along the pathway. The recruitment of community reablement assistants enabled some patients to be discharged home for further assessment. The Health Board's complex care team also provided assistance with the commissioning of community packages of care to further support patient discharge. A direct admission pathway from primary care to a community hospital ward was also tested as part of the winter plan.

A review of the Step Closer to Home pathway is currently underway by colleagues from health and social care to define the optimum model aligned with the wider step up/down

capacity across the region. The outcome of this review will be reported to the Health System Leadership Group early July, followed by the Gwent Adult Strategic Partnership.

Priority 4 –the Gwent Regional Winter Plan placed significant emphasis on improving the resilience of the domiciliary care sector in support of the 'Maintaining our Social Care Services' priority in the All Wales Winter Plan. Existing packages of care were reviewed to release capacity where possible along with Gwent Regional Partnership Board providing over £1million to support an increased salary for community care staff. This additional payment was intended to mitigate further loss of workforce capacity over the Christmas retail period, when retail sector pay rates are significantly higher than that of the care sector. In partnership, a number of alternative approaches were tested, such as a micro enterprise pilot within one of our localities, and support for additional specialist equipment via our regional GWICES service.

Priority 5 – Supporting the wellbeing of our Health and Social Care Workforce has been a key consideration of the plan and regularly discussed within the Community Care Sub-Group. ABUHB has implemented additional wellbeing support for its workforce.

Priority 6 – Supporting unpaid carers was a key component of the social care restart and recovery programmes, and reflects the existing work and commitments of the Regional Partnership Board. Additional grants have been made available to unpaid carers, and alternative respite solutions offered where viable.

Priority 8 – Working in partnership – The Community Care Sub-Group reviewed weekly figures regarding the workforce position within social care, and sought to maximise the use of the Step Closer to Home Pathway to support discharge from hospital.

A winter plan reflection session was held with service leads across health and social care, to review the success of the winter plan and key elements that we would seek to repeat during any further period of system resilience. This session identified the wide range of activity in developing revised models of delivery that need to be further developed via ABUHB IMTP Priorities and the RPB Strategic Programmes. The learning from implementation of the Regional Winter Plan was incorporated into the response sent by Gwent RPB to Welsh Government following the system reset period. A copy of this response, and associated action plan, is attached as Appendix 3a and 3b respectively.

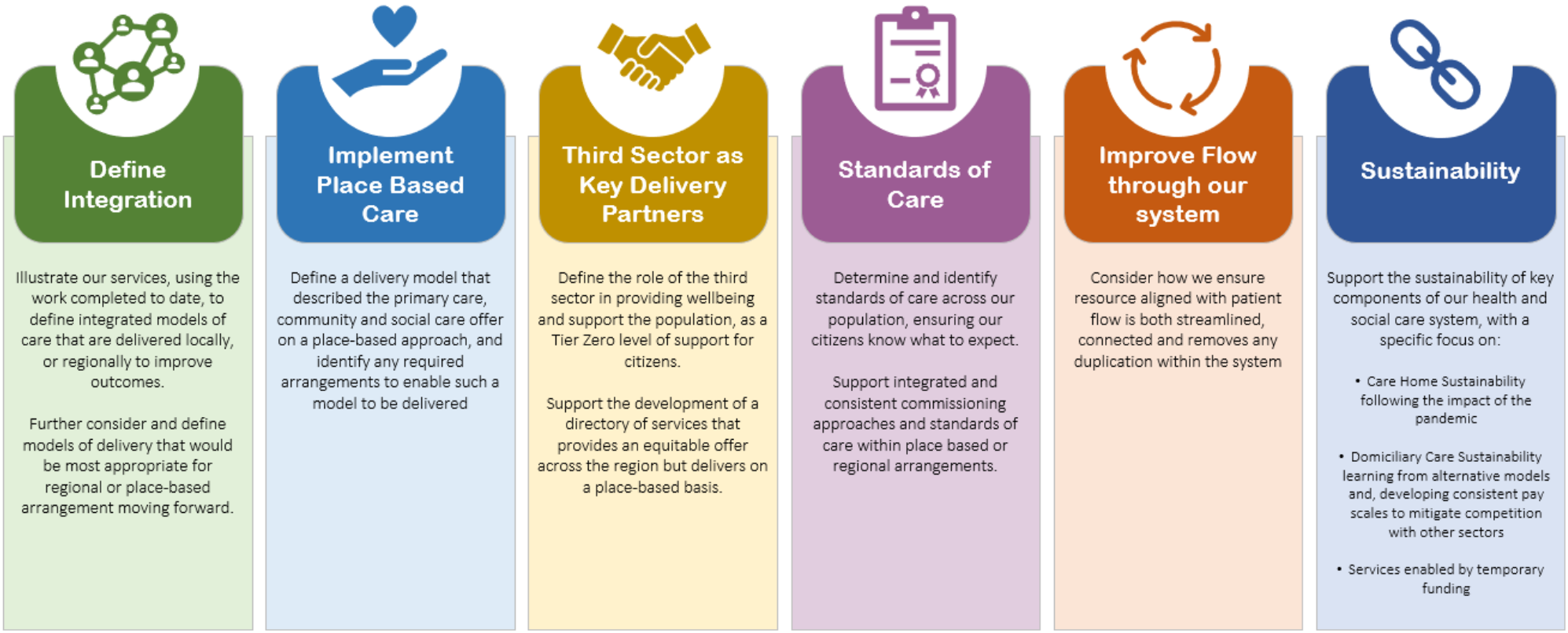
An assurance report will be provided on the effectiveness of the winter plan to Gwent Regional Partnership Board in July 2022, to include findings from the review of the Step Closer to Home Pathway.

Recommendation
ABUHB Board members are asked to note the contents of this paper.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The purpose of the Marmot Region programme of work is to mitigate the risk of widening health inequalities

Financial Assessment, including Value for Money	The Marmot Region work programme is funded from existing budgets. Widening health inequalities is a financial risk to the Health Board which this work is intended to mitigate
Quality, Safety and Patient Experience Assessment	The programme of 'Marmot Region' workshops is being designed in a way to enable residents to participate, learning from the 2019 Building a Healthier Gwent programme
Equality and Diversity Impact Assessment	The work programme directly addresses health inequalities
Health and Care Standards	The work programme directly addresses providing access to health promotion services proportionate to population need
Link to Integrated Medium Term Plan	Links to the IMTP core strategic priority to reduce health inequalities
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** The Gwent Well-being Plan will cover a period of five years and respond to some of the long term issues affecting health and well-being in Gwent.
	Integration – Gwent PSB is a partnership body looking to align and integrate the response of partners to issues of common concern.
	Involvement – A wide range of stakeholders are engaged in the work of Gwent PSB.
	Collaboration – Both the Well-being Assessment, the Well-being Plan and the Marmot Region work will be subject to public engagement and collaboration.
	Prevention – The PSB is working to address some of the underlying structural issues at the root of health inequalities
Glossary of New Terms	N/A
Public Interest	N/A

Appendix 1: Gwent RPB Strategic Priorities



Established by Gwent Regional Partnership Board [7 July 2021]

Appendix 2

Gwent Regional Partnership

Interim Capital Guidance 2022-23

Gwent Regional Partnership Board
Partnership & Integration Portfolio Management Office

Welsh Government have made significant capital funding available to Regional Partnership Boards across several funding streams, provided as part of a 4 year capital programme in the first instance. The funding will support Gwent RPB to provide a range of solutions to promote independence, wellbeing and care closer to home. This will include the introduction of additional/refurbished housing stock targeted at our vulnerable population groups, and a range of solutions supporting a place-based care approach, including the introduction of integrated wellbeing centres and hubs.

It is our intention to develop an integrated 10 year capital strategy and associated programme of work, and the RPB have identified Q1-Q3 within 2022-23 as a development period for this purpose. Whilst this work is undertaken, and in acknowledgement of the complexities of delivering capital schemes, this interim guidance is provided with a specific focus on developing a Year 1 programme for the 2022-23 financial year, whilst the more detailed development work is undertaken.

To ensure we have a consistent mechanism for capital development, a single regional approach and process has been established to support the assessment, consideration and utilisation of capital funding opportunities as described within this guidance.

To maximise funding opportunities, where possible, a mixed approach that brings other funding to scheme delivery is welcomed, such as the inclusion of:

- Sustainable Communities for Learning Programme – Community Schools
- Substance Misuse Capital Fund
- Land For Housing
- Social Housing Grant
- Regeneration Funding
- Health capital funding
- Organisational/private finance

All partnership investment must be utilised to support at least one of the following vulnerable population groups:

- Older people with complex needs
- People living with Dementia
- Unpaid carers
- Children with Complex Needs
- People with Learning Disabilities, neurodiverse and neurodevelopmental conditions
- People with emotional and mental wellbeing needs

Whilst we are inviting schemes that can be delivered in the 22-23 financial year, we appreciate that many capital programmes will need to be delivered over a longer period. As such, if your schemes need to be funded over multiple financial years, you are welcome to identify a phased approach within your application, such as:

- Acquisition
- Acquisition and Construction

- Construction
- Refurbishment

Funding Objectives

Objective 1: Housing with Care	Housing and accommodation that will be let as social rented tenancies, including: • Extra care housing and other kinds of housing for older people with care and support needs • Supported living accommodation for adults with neurodevelopmental conditions, such as a learning disability or ASD, possibly accompanied by physical disabilities, who are able to live independently with care and support • Supported housing for other groups with care and support needs, for example, adults with mental illness or young people with support needs, such as those leaving care.
Objective 2a: Intermediate and Short-medium term care settings	A wide range of accommodation solutions from emergency bed spaces to short term reablement, and medium term move on settings, including: • Residential accommodation for children and young people with higher needs and/or challenging behaviour in order to bring children and young people back from, or avoid, out of area placements • Short to medium term accommodation for adults with higher needs and/or behavioural challenges in order to bring them back from or avoid out of area placements, including secure accommodation. • Intermediate care settings in the community, e.g. step up/step down, reablement and rehabilitation flats, training and moving on settings, assessment centres with emergency or short term beds, etc. • Short term respite settings to benefit unpaid carers, but primarily providing for cared for vulnerable population groups (Service users will not hold tenancies in these settings).
Objective 2b: Rebalancing the residential care market	Complimentary to the above, objective 2b supports rebalancing the care home sector away from cost to quality, from outputs to outcomes, and from profit towards social value. Such as: • Grow in-house provision, which can include expansion of inhouse care homes (additional beds), upgrades to facilities to bring them in line with regulation to enable them to be re-registered as a not for profit provision. • Support for local authorities to bring failing provision back under local government management • Increasing residential care capacity where there are identified gaps/shortages of provision.

Objective 3: Development of Integrated Health and Social Care Hubs and Centres	Supporting the delivery of seamless services through creating local single points of access and co-location of staff and services delivering integrated care pathways. Further definitions will be developed for 'hubs' and 'wellbeing centres'. The following principles are applicable for this interim guidance: • Planned co-location of services bringing practice and cultural change to enable seamless delivery (should not only consider health and social care capital infrastructure, but also leisure centres, shop fronts, schools, etc.) • Supporting development of a hub and spoke network of integrated facilities across a locality • Enabling a no wrong door principle: people supporting to access the services they need wherever they first enter the network • A graduated response recognising support delivered through hubs can range from Information, Advice and Assistance, through to more complex health and social care services. • Town Centre First: consider whether town centre sites could provide suitable locations for the delivery of integrated services. • Decarbonisation: project business cases will need to evidence how the investment will support a Net Zero Wales, by demonstrating areas such as low carbon energy use and energy efficiency measures.
Objective 4: Minor Projects	Minor projects can have a significant and disproportionately beneficial impact compared with their cost. This funding, up to a maximum of £100,000 per project, can be used for a range of purposes in alignment with this guidance, including: • Repairs, refurbishments and improvement to existing housing with care or intermediate care settings • Equipment and adaptations to existing homes not supported by other WG grants • Digital aids, monitoring and assistive technologies *Please note this funding cannot be used to purchase vehicles, or convert technology infrastructure from analogue to digital.*

Application Process

Applications submitted under this guidance are required to be submitted electronically to the Partnership & Integration Portfolio Management Office (PMO): ABB.PartnershipPMO@wales.nhs.uk

Please use the attached application template. Applications are welcome as a formal application, or as expressions of interest to support a collaborative approach and early dialogue for business case development. You are required to indicate on the application form the status of your organisational consideration. Any application that is pending organisational consideration, will only be discussed as part of programme development, and will not be formally considered by Gwent Regional Partnership Board for submission to Welsh Government until organisational approval is provided.

As a broad overview of the process, the following touch points are applicable:

1. PMO review of application
2. Early consideration by the Regional Integrated Capital Planning Group
3. Consideration by relevant strategic programme/strategic partnership
4. Recommendations submitted to RLG/RPB for approval (only applications with organisational approval will progress to this stage)
5. RPB Capital Investment Plan submitted to Welsh Government for approval

Once your application is received, you will be provided with a reference, and a broad timeline of the above process.

Appendix 3a: RPB Response following System Reset

Your ref/Eich cyf:

Our ref/Ein cyf: Cllr PC/PD

Date/Dyddiad: 26th April 2022

Please contact/Cysyllter â: Cllr Paul Cockeram

Direct line/Llinell ffôn: 01495 761691

Direct fax/Llinell ffacs:

Email/Ebost: GwentRegionalPartnershipBoard @ torfaen.gov.uk

FAO Judith Paget, Director General Health and Social Services

Dear Judith

Ref: National Health and Social Care Risk Summit – Next Steps and Required Action

I write to you as Chair of the Gwent Regional Partnership Board to set out the steps taken across the region whilst undertaking a two-week system reset (2 March to 16 March). As suggested, we used the agreed actions from the recent National Health & Social Care Risk Summit to review our local systems and set out in appendix 1 of your letter dated 22 February 2022. The RPB has linked closely with the Chair of the Gwent Community Care Subgroup as they have led on the system reset on behalf of the region.

Risk Summit

The Gwent Community Care Subgroup (CCSG) established under the Local Resilience Framework at the start of the pandemic, includes a range of key partners supporting health and social care delivery. A CCSG workshop was organised on 25 February to undertake a risk summit and consider actions and progress against the agreed priorities following the national risk summit. The CCSG has been working towards several the identified priorities since the start of the pandemic including a joint hospital discharge policy, a step-down bed policy with local care homes (A Step Closer to Home) and use of Welsh Government Winter Planning funding to support domiciliary care sector etc. It was felt the appropriate and relevant partners were available to undertake a local risk summit through a CCSG workshop.

Action Plan: 'System response plan to inform the national system reset'

Following the risk summit workshop an action plan template was produced and populated with key actions and updates. The action plan was then shared widely with identified leads across health and social care and included as appendix 1 to this letter. This action plan will now form the basis of the suggested RPB 'system response plan to inform the national system reset' and we will share with the RPB for agreement, adoption, delivery, and monitoring.

Integration and Partnership working

As highlighted in your letter, health and social care partners have been working tirelessly over the last few months and throughout the pandemic. Several the suggested actions are core partnership business and included recently in Regional Partnership Board, ABUHB and local authority Winter Plans and the CCSG work programme. A Strategic Coordination Group was re-established under the local resilience framework during the autumn of 2021, in response to many of the identified issues. As part of this process a multi-agency performance 'dashboard' was developed to include key system pressure measures from Gwent

Police, South Wales Fire Service, Welsh Ambulance Service Trust, ABUHB and Social Care. The performance dashboard will be maintained during the new financial year 2022/23 and increase responsiveness of partners.

Challenges requiring a national approach

Despite the extraordinary efforts of health, social care and partners across Gwent, there are a number of challenges which require a national approach and we ask that you raise them on our behalf and discuss approaches in relation to:

- Minimum wage for care sector – the workforce has been under significant pressure with a number of front-line workers leaving the profession and levels of pay cited as a major reason, especially for domiciliary care staff; we recognise the efforts by Welsh Government but this still falls short.
- Whole system change requires strengthening and we will benefit from a national approach to improve understanding between medical consultants and social care colleagues in relation to hospital admission and discharge, and measured risk. We have developed 'Home First' model but this needs to be across the whole system and similar models driven nationally.
- Focus on Hospital discharge is key but as identified in our performance dashboard, 20% unallocated domiciliary care hours are for people in hospital and 80% in the community; and without increased support in the community, people's needs will increase and may require hospital admission. We have also received returned packages of care from providers who are unable to deliver support (Over 60 packages and 700 hours per week in the last 6 months).
- Vacant care home beds are an issue for some care homes across the region and long-term financial stability challenging. Coupled with covid outbreaks and capacity to accept new placements, care homes are highlighting their long-term viability is at risk and a long-term strategy is required.
- Care home providers have continually raised insurance as an issue with costs increasing significantly and, in some cases, insurance brokers pulling away from the care home sector; again, this requires a national discussion and solution.

In your role as Director General Health and Social Services, we would value your support in raising these issues at a national level and further discussing what support can be provided at a regional level. The RPB will continue to oversee and coordinate actions to progress the priorities highlighted through the national system rest, and as suggested through a regional system reset action plan.

Yours sincerely

Cllr Paul Cockeram

Chair, Gwent Regional Partnership Board

Appendix 3b: System Reset Action Plan

HEALTH BOARD

Actions	Responsible Lead Organisation	Pressure Points/Barriers/ Risks Capacity/Resource	Timescale	Impact on the cared for, service & staff	Agreed Measures
Continuous improvement in ambulance patient handover times in line with the Minister for Health and Social Services' letter to Chairs of 17 February 2022.	ABUHB	Staffing pressures across the whole of the health and social care system has an impact on patient handover times and capacity. There has also been increased demand on health services due to Covid 19 pressures, which has added more challenges in the system.	Ongoing	• More positive patient experience • Increase patient safety • Reduce risk of people awaiting an ambulance in the community • Staff able to take appropriate breaks • Improved work life balance for staff • Improved staff health and wellbeing.	Number of people conveyed to a hospital by ambulance care, within 15 minute target time frame.
Progress to date	The COVID-19 pandemic has provided unprecedented pressures on the healthcare system, however, ABUHB continue its commitment and goal to ensure people in Gwent are receiving good quality care, which is provided safely and effectively, in line with recognised standards. HIW completed a review in 2020/2021 to explore how the risks to patients' health, safety and well-being were being managed, whilst they were waiting for an ambulance to arrive. HIW makes clear that handover delays are not directly an ambulance service problem, but symptomatic of problems across the entire health and social care system. We are continuing to work across partnerships in Gwent to provide whole system solutions to these issues around recruitment and regional programmes to support returning patients home from hospital when ready.				
Next Steps	• Review current pathways and reinforce use of those pathways for WAST clinicians. • Improvement in timely discharge of patients from hospital to assist patient flow (including new GP led discharge on wards). • Improvement to patient flow through hospitals to improve bed availability and trolley space capacity within ED				
Reduce waits in Emergency Departments	ABUHB	Staffing pressures across the whole of the health and social care system Increased demand due to Covid 19 pressures.	Ongoing	• Improve staff wellbeing	ABUHB targets for waits
Progress to date	We have been working in partnership to maintain flow, and for patients to be discharged in a timely way once their treatment is complete. This includes daily Complex Care lists to focus on bottlenecks. We have been working to help reduce long-stay patients, and support care closer to home to prevent further visits to the Emergency Departments.				
Next Steps	• Maximising use of the Direct Access Pathway by encouraging GPs to access this route				

	• Looking at the possibility of an advanced nurse practitioner being placed at the hospital front door. • Improvement to patient flow through hospitals to improve bed availability and trolley space capacity within ED • Improvement in timely discharge of patients from hospital to assist patient flow.				
Focus on Internal Delays	ABUHB	Staffing pressures across the whole of the health and social care system Increased demand due to Covid 19 pressures.	On going	• Reduce blockages in the system • Reduced internal waiting times • Improve patient experience • Reduction in bed numbers and associated costs.	Number of people moved first time to right place
Progress to date	Regularly check the complex list to ensure it is accurate and where patients can be appropriately moved. Regularly assess internal procedures for maximum efficiency.				
Next Steps	• Continue to ensure that the complex list is as accurate as possible. • Wider stakeholders beyond PCCS jurisdiction including Acute colleagues • Work with acute services to ensure that transfers occur accurately and expediently • Remind stakeholders of existing parameters and agreed actions in place. • Professional flow chart to be recirculated • concerns to be raised to Divisional Nurse expediently • Patients are transferring out of hours and also inappropriately				
Prioritise resources towards Hospital Discharge (which may include the redeployment of some resources/ staff into the community)	ABUHB	Staffing pressures across the whole of the health and social care system. Need to have the available appropriate staff to redeploy. Increased demand due to Covid 19 pressures	On going	• Reduce blockages in the system • Reduced internal waiting times • Improve patient experience	• Length of Stay • Number of people discharged
Progress to date	We Implemented the Home First Hospital Avoidance programme which exceeded the target of 25 discharges per week. Reviewing 5 months of data, this equated to 31 discharges a week. This would give a total of 1612 discharges per annum: an aggregated saving of £3.2 million. With the additional investment to scale up the service, Home First is costing approximately £1.7 million per annum to operate, giving a crude return on investment of £1.5 million.				
Next Steps	• NCN leads to participate in consultant led ward rounds/MDM across all sites in order to support decision making to transfer someone home. This will be a collaborative approach with key involvement from members of the borough and hospital directorate teams • List to be generated of all consultants and CD/NCN lead availability • NCN/CD advised of meeting/ward round and provided with all information at teams meeting with Divisional Director • Discharge Liaison Nurses will be moved from Acute services for the period and focus on the 'so what'. Ensuring that actions are captured and followed up				

	• Stakeholders made aware that NCN/CD will be in attendance and desired outcomes • Information will be prepared and shared with team ahead of attendance at MDT. This will be produced from the complex list and will have relevant information included • Following MDM/WR collate information regarding actions agreed • Ensure actions are allocated and followed up • Follow up to be undertaken at regular and agreed intervals. • In reach to Community Hospitals from CRT and DN Teams to increase communication and expedite discharges • Learning across all groups to be captured and shared • Step Closer to Home Unit (SC2Hu) - protect space to enable the swift transfer of people to participate in additional rehabilitation prior to transfer home. • Continue to monitor progress and articulate • Introducing the Direct Transfer Pathway which will support patients to move from acute to community hospitals within 24hrs of admission for a 3-5 day stay				
Recognise the impact on primary care and ensure that action is focussed on resilience and helping avoid admission	ABUHB	Staffing pressures across the whole of the health and social care system. Increased demand due to Covid 19 pressures.	On going	• Improve blockages in the system. • Provide earlier support and interventions.	• Number of people attending/admitted via ED • Number of people directly admitted or transferred via DAP/DTP • Number of referrals • Reduction in conveyance
Progress to date	Continue to strengthen and develop an integrated health and social care system and pathway. Continue to promote alternative solutions to hospital admissions, through early intervention and prevention models. We have been reviewing the role and functions of Occupational Therapists and how we increase capacity in the community. Redirecting OT capacity from secondary care in hospitals to Home First at the hospital front door. GPs have a triage approach to move patients through the primary care system. They have been experiencing increased demand in services of up to 20% and providing face to face appointments where they are clinically appropriate. We have been promoting alternatives to A&E and GP Services such as pharmacy support and using triage systems to support demand.				
Next Steps	• Future RPB workshop to link RPB Area Plan to Integrated Partnership Board Plans, NCN plans. • Improve blockages in the system. • Provide earlier support and interventions.				

SOCIAL CARE

Actions	Responsible Lead Organisation	Pressure Points/Barriers/ Risks Capacity/Resource	Timescale	Impact on the cared for, service & staff	Agreed Measures
Focus on increasing capacity in domiciliary care	Social Care	Staffing pressures across the whole system – 61 packages of care returned totalling over 700 hours per week, staff leaving sector Recruitment to domiciliary care roles is a national issue due to wages not reflecting the level of responsibility and registration requirements. Increasing needs of people requiring additional hours on packages of care. Increased high demand on services due to Covid-19 pressures. The requirement to drive coupled with the cost of running a vehicle is a significant barrier to the sector.	On going	• Staff currently exhausted and facing severe pressures. If capacity could be increased this would improve staff wellbeing and improve support for people with care and support needs. • On 14th March 2022 Local Authorities reported that 3741 hours of domiciliary care per week remained unallocated.	Increase in number of domiciliary care workers. Increase in number of Occupational Therapists (RPB Winter Plan).

Progress to date	• Additional WG funding used to provide cash incentives to the existing workforce to aid retention (RPB Winter Plan
	• Lobbying for pay increase for domiciliary care workers and improved terms and conditions.
	• Revisiting and risk assessing care packages and every opportunity to support people with ongoing care needs
	• Supporting 'We Care' campaign as well as recruitment roadshows and campaigns across Gwent to promote the sector.
	• Gwent College Consortium is exploring ways to incentivise domiciliary care work through:
	  ○ Work placements
	  ○ Recruitment to staff banks
	  ○ Development of a shared apprenticeship framework				

	• Proposal drafted and sent to a high-profile car insurance firm to seek support for H&SC students with the cost of driving lessons and car ownership. Micro Care pilot in development with Monmouthshire LA to support community care capacity and potentially increase DP take up.				
Next Steps	• Continue with retention/recruitment key priority RPB planning • Continue with review of all care packages with risk assessment • Promote care as a career and identify current role model carers to engage with young people • Continue to work with College Consortium.				
Maximise available care home capacity and consider options to rebalance residential provision to nursing care / step down	Social Care	Challenging during the pandemic when staff leaving professions, care home outbreaks and staff shortage and fatigue Adoption 'A Step Closer to Home' policy Some teams redeployed to support this.	On going	• Reduce blockages in the system.	Improved care home capacity
Progress to date	'A Step Closer to Home' pathway aims to expedite timely, safe discharge and post-discharge support for individuals deemed medically fit to leave hospital on completion of treatment. The purpose of commissioning short term beds in care homes and temporary community care provision is to provide an interim solution for individuals who are deemed medically fit and no longer require an acute hospital bed, but still require care services until their onward destination or the Local Authority / CRT care package or long-term placement becomes available. To date the pathway has supported 80 discharges to care homes or a community package of care with daily referrals being received.				
Next Steps	• Wider Care Home review as part of RPB Market Stability Report required under SSWB Act. • Continue to promote care as a career through 'We Care Campaign'. • Continue to engage with care home providers through weekly webinars.				
Prioritise resources towards hospital discharge and prevent admission.	Social Care	Staffing issues/Recruitment and retention. Resource issues.	On going	• Reduce blockages in the system	Less people admitted to hospital
Progress to date	The Gwent Adult Strategic Partnership have worked very closely with local care home and domiciliary care providers during the pandemic to provide information, advice, and guidance in relation to the numerous challenges such as care home visiting, testing of staff and vaccination processes.				
Next Steps	• Need to review hospital discharge risk assessment to ensure medics provide decisions in relation to medical fitness but not to decide on packages of care (remains with social care leads).				

	• Reviewing discharge criteria/paperwork documentation • Clear Comms to medics etc (possibly from Social Care Directors) • We have also developed an action plan going forward within the Gwent Adult Strategic Partnership to focus on hospital discharge, new models of care and to identify success factors and good practice we can scale up.				
Consider current services commissioned through the Third Sector for expansion and impact	Social Care	Staffing and resource issues Need the third sector and community structure to develop this work further.	On going	• Improved outcomes for people. • Fewer blockages in the system. • Less pressure on staff.	Improved early intervention and prevention community resources.
Progress to date	We have been mapping of pathways including the role of the voluntary sector with some regional and local links established e.g Britis Red Cross, Hospice of the Valleys The Discharge to Assess model values the input from informal agencies and looks at a whole person approach to health and care.				
Next steps	• We will continue to work across the partnerships and take a multi-agency approach to further develop safe well-planned discharge to impact recovery, wellbeing, and independence. • Continuous discussion with Third Sector Umbrella organisations at RPB • Allocation of Regional Integration Funding across third sector				

HEALTH & SOCIAL CARE

Actions	Responsible Lead Organisation	Pressure Points/Barriers/ Risks Capacity/Resource	Timescale	Impact on the cared for, service & staff	Agreed Measures
National summit to be followed by urgent local and regional to ensure systems readiness and deploy actions with immediate effect	Health and Social Care	We have a variety of systemic, workforce challenges and complex citizen needs, due to Winter and pandemic pressures exacerbating an already difficult field to recruit in.	Complete	• Improved partnership working and collaboration • Focus on priorities set out in 'Reset' plan	• Agreed System response Plan (see below).
Progress to date	• Gwent Summit complete and actions agreed for the 2-week System Reset period. • Established Community Care Sub Group set up at start of pandemic under Local Resilience Framework – group coordinated summit				
Next Steps	• Produce, agree, and monitor System Response Plan (see below)				
Each RPB area to formulate a system response plan to	Health and Social Care	• Various strategic drivers – RPB Winter Plan, CCSG action plan	On going	• Improved partnership working and collaboration	• Agreed System response Plan

inform the national system reset (including the points above)		following reflective reviews, individual partner's Winter Plans		• Focus on priorities set out in 'Reset' plan	
Progress to date	• This Reset plan forms the System Response Plan.				
Next Steps	• We will continue to work in partnership on current work to improve hospital discharge that has been ongoing prior and during the pandemic. • During the 2-week System Reset, GP colleagues joined hospital consultants/senior doctors at ward rounds from 7th – 16th March and will work in partnership to support decision making to move patients home more expediently. Previous evidence has shown that GP's can bring a different dynamic to an MDM by describing a community approach to the appropriate management of risk. The GPs will attend MDM and/or ward rounds across all sites. It is then planned that Discharge Liaison Nurses will be realigned to the community hospitals between 7 – 18 March to follow up on decisions made in MDM and support more people to go home. The DLN team will bring additional challenge to those people waiting over 21 days and ensure that steps to discharge are expedited in order that we improve patient experience by reducing length of stay. • In addition to this we will: - Maximising use of the Direct Access Pathway by encouraging GPs to access this route - Introduce the Direct Transfer Pathway, which will support patients to move from acute to community hospitals within 24hrs of admission for a 3-5 day stay - Continuing to ensure that the complex list is as accurate as possible, and that individuals for community hospitals are identified the day before when possible and transferred expediently within agreed hours				
Ensure all organisational risk registers and business continuity plans have been updated to reflect the current operational pressures and business continuity plans in place	Health and Social Care	• Individual partners will complete and monitor risk assessments	On going	• Identify and share risk across partners	
Progress to date	Individual local authority partners and ABUHB have completed previously as part of corporate risk agendas and updated throughout the pandemic and continues, to reflect pressures in the system.				
Next Steps	• Continue to review and consider a regional risk assessment under the RPB.				
Make risk based decisions about the deployment of resources	Health and Social care	See above	On going	• Identify and share risk across partners	
Progress to date	See above.				
Next Steps	• Consider RPB regional risk assessment				

Mobilise speed of response to ensure focus on immediate action	Health and Social care		On going	• Effectively and responsive partnership working.	
Progress to date	• At the start of the pandemic a CCSG sub group was established and continues to meet. Where required, the group met 3 times a week to mobilise response across health and social care				
Next Steps	• The CCSG continues to meet • The RPB meets frequently and are currently considering the use of the new Regional Integration Fund to implement new models of care, as set out in Welsh Government guidance.				
Health boards and third sector to commission and maximise third sector contracts to provide support to patients/ carers at home	Health and Social care	Staffing pressures and available resource	On going	• Effectively and responsive partnership working.	
Progress to date	The RPB have ensured a targeted allocation of Integrated Care Funding to third sector partners and third sector umbrella organisations are RPB members				
Next Steps	• RPB to ensure third sector funding through new RIF funding and coordination of third sector resources working umbrella organisations				
Maximise support to unpaid carers	Health and Social Care	• Carers have been adversely affected during pandemic especially in relation shielding and lack of respite. • Large amount of resources required given number of unpaid carers.	On going	• Improve the health and wellbeing of carers • Support the vital role of unpaid carers in our communities.	
Progress to date	• We continue to support the unpaid carers agenda through the Gwent Carers Board and other strategic partnerships that sit under the RPB. We provided information and support to carers during the pandemic and national carers week as well as administering the Carer's small grant scheme • The Gwent Carers Hub received over 758 referrals during 2020/21 with more than 1483 carers accessing the various services available through Gwent Carers Hubs. • Carers Assessments provided under SSWA. Dementia Carers support available • To further support life alongside caring, it was identified that carers (particularly during Covid) would benefit from 1:1 support to provide mental health and wellbeing support. The Gwent partnership funded a counselling service to provide a confidential support service to help carers deal with the significant and emotional challenges of caring through an 8-week support plan. Initially face to face counselling was the preferred method of delivery and a private space had been identified at the Carers hub. In light of ongoing Covid restrictions, this accessibility was enhanced to include online and telephone support.				

	• Carers Support services are available in each local authority and Carers Trust South East Wales (CTSEW) have been delivering a series of FREE wellbeing workshops for unpaid carers in partnership with Elemental Health. Funded by WG. • It's Cool to Care book written by young carers in Gwent on their real-life experiences was distributed to schools across the region.
Next Steps	• Continue to support and engage with carers through regional Carers Board. • Continue with Foundation Tier Mental Health programme • Continue to promote Melo website. • The RPB to ensure focus on carers and effective use of new Regional Integration Funding in relation to unpaid carers.

WAST

Actions	Responsible Lead Organisation	Pressure Points/Barriers/ Risks Capacity/Resource	Timescale	Impact on the cared for, service & staff	Agreed Measures
Reducing sickness absence from the current high level	WAST	• Resource issues • Staffing issues • Level of demand in the system	On going	• Boost team morale • Improve staff shortages	
Progress to date	Staff have been working hard and have been striving to deliver services to patients in very challenging circumstances. We continue to review the effectiveness of current processes in place for staff to provide feedback for service operation and working practices.				
Next Steps	• Continue to support work around the mitigation around short falls of staff. • Continue to review the effectiveness of current processes in place for staff to provide feedback for service operation and working practices. • Review current pathways and reinforce use of those pathways for WAST clinicians.				
Implementing roster changes to unlock additional capacity within agreed timescales	WAST	• Under resourced • Workload increasing	On going	• Staff will be less fatigued • Improve team morale	
Progress to date	Roster Reviews continue to progress to achieve demand led rosters for ABUHB EMS and ACA/UCS.				
Next Steps	• The improvements in CSD and expansion of 111 will support from a national programme of work.				
Implementing a revised rest break policy	WAST	Resources Demand in the system	On going	• Improved wellbeing of staff	
Progress to date					

Next Steps	• Revisit workforce policies				
Maximise contracts with third sector and independent sector providers	WAST	Resources Demand in the system	On going	• Improved support to cared for	
Progress to date	• Support Hear and Treat to increase the referrals back into primary and community care. • Ensure effective use of the PRU. Improve admission avoidance targeting low acuity 999 calls. • Continue to support Cohorting resources at GUH.				
Next steps	Continue with above				

Aneurin Bevan University Health Board

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) Update Report – May 2022

Purpose of Report	
The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the Welsh Health Specialised Services Committee (WHSSC) as a Joint Committee of the Board.	
The Board is asked to: *(please tick as appropriate)*	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	
Executive Sponsor: Interim Chief Executive	
Report Author: Interim Chief Executive	
Report Received consideration and supported by:	
Date of the Report: 11th May 2022	

Supplementary Papers Attached:

1) Chair's Summary of the Joint Committee Meetings held 15th March and 10th May 2022

2) WHSSC's Integrated Commissioning Plan 2022-25, approved by the Joint Committee on 8th February 2022

3) Chair's Summary of WHSSC's Quality and Patient Safety Committee meeting held 30th March 2022

Background and Context

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 the joint planning of Specialised and Tertiary Services on behalf of Health Boards in Wales. It acts as a subcommittee of the individual Health Boards.

In establishing WHSSC to work on their behalf, the seven Health Boards recognised that the most efficient and effective way of planning these services was to work together to reduce duplication and ensure consistency.

The Joint Committee is led by an Independent Chair, appointed by the Minister for Health and Social Services, and membership is made up of three Independent Members, one of whom is the Vice Chair, the Chief Executive Officers of the seven Health Boards, Associate Members and a number of Officers. The Standing Orders of each of the seven Health Boards include the Governance Framework for WHSSC, including a Scheme of Delegation as published on the WHSSC website Schedule 4 (nhs.wales).

Whilst the Joint Committee acts on behalf of the seven Health Boards in undertaking its functions, the responsibility of individual Health Boards for their residents remains and they are therefore accountable to citizens and other stakeholders for the provision of specialised and tertiary services.

Specifically, the role of the WHSSC Joint Committee (as set out in Standing Order 1.1.4 Schedule 4 (nhs.wales)) is to:

- Determine a long-term strategic plan for the development of specialised and tertiary services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging treatments and services and advise on the designation of such services;
- Develop national policies for the equitable access to safe and sustainable, high quality specialised and tertiary healthcare services across Wales, whether planned, funded and secured at national, regional or local level;
- Agree annually those services that should be planned on a national basis and those that should be planned locally;
- Produce an Integrated Commissioning Plan, for agreement by the Committee following the publication of the individual LHB's Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of specialised and tertiary services at a national level, and determining the contribution from each LHB for those services (which will include the running costs of the Joint Committee and the WHSST) in accordance with any specific directions set by the Welsh Ministers;
- Establish mechanisms for managing the in-year risks associated with the agreed service portfolio and new pressures that may arise;
- Secure the provision of specialised and tertiary services planned at a national level, including those to be delivered by providers outside Wales; and
- Establish mechanisms to monitor, evaluate and publish the outcomes of specialised and tertiary healthcare services and take appropriate action.

Each of the seven Health Boards has agreed a Memorandum of Agreement (https://whssc.nhs.wales/publications/governance/whssc-memorandum-of-agreement-2021/) in respect of the Joint Committee and in doing so have agreed that each Health Board recognises the following principles, aligned to the agreed Standing Orders:

- the Management Team will be held to account by the Joint Committee for the delivery of a strategy for the provision of specialised and tertiary services for Wales as well as providing assurance that the systems of control in place are robust and reliable.
- that any decision taken and approved by the Joint Committee in respect of the provision of the Relevant Services is binding on the constituent LHBs and may not be undermined by any subsequent decision or action taken by a constituent LHB.
- that each individual LHB is responsible for the people who are resident in their area. This means that the Joint Committee of which each Chief Executive is a member is acting on behalf of the 7 LHBs in undertaking its role.

- that their respective Chief Executives have an individual responsibility to contribute to the performance of the role of the Joint Committee and to share in the decision making in the interests of the wider population of NHS Wales. At the same time, they acknowledge their own Chief Executive's individual accountability to their constituent LHB and their obligation to act transparently in the performance of their functions.
- that each Chief Executive as a member of the Joint Committee will require the Management Team of the Joint Committee to ensure that, in the timetabling of the annual work programme, sufficient time will normally be allowed to enable each Chief Executive to consult with their own LHB and appropriate local partners and stakeholders.
- that when an individual Chief Executive is unable to attend a meeting of the Joint Committee, he/she will appoint in advance and identify to the Committee Secretary a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

Assessment and Conclusion

This report provides an update regarding business undertaken during the last reporting period.

The Joint Committee held its most recent meeting on 10 May 2022. The papers for the meeting are available at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/20222023-meeting-papers/public-agenda-bundle-jc-may-2022/
A summary of the business held is outlined as follows:

Presentation

1. Genomics Delivery Plan for Wales

Items for Consideration and/or Decision:

2. Chair's report – noted,
3. Managing Director's report – for noting, including reference to consultation and engagement on 3-year Genomics Delivery Plan, with stakeholder comments by 20th May 2022,
4. Appointment of Interim Chair for all-Wales IPFR Panel – Dr Ruth Alcolado (currently Vice Chair) approved as Interim Chair until July 2022,
5. Neonatal transport – outline report from Delivery Assurance Group, which should provide greater assurance in the delivery of the Neonatal Transport Service,
6. Draft Mental Health Specialised Services Strategy 2022-2028 – to be circulated for comments between 10th May and 6th June 2022; final strategy publication in October 2022,
7. Preparedness for COVID-19 Inquiry – noted,
8. Disestablishment of the Learning Disability Advisory Group – approved the disestablishment of this Joint Committee sub-group, as oversight of this work now undertaken by Welsh Government Social Services function,
9. Annual Governance Statement 2021-22 – approved,
10. Sub-Committee Annual Report 2021-22 – noted,
11. Sub-Committee Terms of Reference (Information Governance, Quality & Patient Safety and Management Group) – approved.

Items for Information:

1. Activity report for Month 11 – 2021-22 – planned care recovery plans to be considered at next Joint Committee meeting,
2. Financial report Month 12 – 2021-22 – year-end outturn position noted,
3. Corporate governance matters – noted,
4. Report from the Joint sub-committees – noted.

This report also provides, as supplementary papers, a Chair's Summary of the Joint Committee Meeting held on 15th March 2022 (attachment 1) and WHSSC's Integrated-Commissioning Plan 2022-25 as approved by the Joint Committee (attachment 2).

Recommendation

The Board is asked to receive this report for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are no key risks with this report.
Financial Assessment, including Value for Money	There is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	A quality, safety and patient experience assessment has not been undertaken for this report as it is for assurance purposes.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has not been undertaken for this report as it is for assurance purposes only.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to the Plan associated with this report, however the work of the Joint Committee contributes to the overall implementation and monitoring of health board IMTPs.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within the Joint Committee's considerations, where appropriate.
Glossary of New Terms	IPFR – Individual Patient Funding Requests WHSSC – Welsh Health Specialised Services Committee
Public Interest	This report is written for the public domain.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) JOINT COMMITTEE MEETING BRIEFING – 15 MARCH 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 15 March 2022. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings

The minutes of the meetings held on the 11 January 2022, 18 January 2022 and 8 February 2022 were **approved** as a true and accurate record of the meetings.

2. Action log & matters arising

Members **noted** the progress on the actions outlined on the action log.

3. Neonatal Transport Update

Members received an update report on progress to establish an Operational Delivery Network (ODN) for the neonatal transport service.

Members noted that the Joint Committee (JC) had supported that Swansea Bay University Health Board (SBUHB) host the ODN and the intention was that the ODN would be in place by January 2022. However, due to operational pressures and the ongoing pandemic progress had been delayed and the intended "go live" date for the ODN had moved to June 2022.

Members **noted** the report.

4. Chair's Report

Members received the Chair's Report and **noted**:

- No chairs actions had been undertaken since the last meeting,
- An update on the substantive appointment of a Chair for the Welsh Renal Clinical Network (WRCN),
- An update on WHSSC Independent Member (IM) Remuneration,
- Attendance at the Integrated Governance Committee (IGC) 28 February 2022; and
- 1 to 1 Meetings with Health Board (HB) CEOs.

Members **noted** the report.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** updates on:

- The SBUHB Welsh Centre for Burns; and
- The De-escalation of Cardiac Surgery at SBUHB from Level 4 to Level 3.

Members **noted** the report.

6. Implementing a 12 Week Clinical Pathway for the Management and Treatment of Aortic Stenosis

Members received a report seeking support for the implementation of a 12 week clinical pathway for the management and treatment of aortic stenosis.

Members (1) **Noted** the report; and (2) **Supported** in principle the implementation of a 12 week clinical pathway for the management and treatment of aortic stenosis.

7. WHSSC Process for Responding to the Ministerial Measures

Members received a report providing an overview of the recently received Ministerial measures and which proposed a process through which WHSSC could respond.

Members **noted** the new Ministerial priority measures and the process through which WHSSC will respond to them.

8. Major Trauma Update

Members received a report providing an update on the performance and key issues in the Major Trauma Network covering south, mid and west Wales.

Members **noted** the report.

9. Disestablishment of the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group

Members **noted** that this agenda item had been deferred until the next meeting.

10. All Wales Individual Patient Funding Request (IPFR) Panel Update

Members received a report providing an update regarding proposals to change the terms of reference (ToR) of the All Wales Individual Patient Funding Request (IPFR) Panel. The report also proposed that an engagement process is undertaken related to future changes to the ToR as well as arrangements for a strengthened governance structure for the Joint Committee's sub-committee.

Members discussed the ongoing risks to WHSSC and it was agreed that Dr Sian Lewis (SL), Managing Director, WHSSC would meet with Nick Wood, Deputy Chief Executive NHS Wales, Welsh Government (WG) to discuss how to progress the IPFR Governance issue as a matter of urgency within WG; and that the WHSS Team would write to Andrew Evans, Chief Pharmaceutical Officer, WG expressing the Joint Committee's concerns and to provide him with a copy of the meeting report.

Members (1) **Noted** the progress made and the proposed changes to the All-Wales IPFR WHSSC Panel Terms of Reference (ToR), which are being discussed with Welsh Government, (2) **Noted** the progress made following discussions with Welsh Government regarding urgent changes to the existing NHS Wales Policy "Making Decisions on Individual Funding Requests (IPFRs)", (3) **Supported** that the WHSS Team undertake an engagement process around proposals to change the All-Wales IPFR WHSSC Panel ToR; and (4) **Approved** an uplift to the Direct Running Costs (DRC) budget by £57K per annum to fund the additional governance resource within WHSSC.

11. Corporate Risk Assurance Framework (CRAF)

Members received the updated Corporate Risk Assurance Framework (CRAF) which outlined the risks scoring 15 or above on the commissioning teams and directorate risk registers.

Members (1) **Approved** the updated Corporate Risk Assurance Framework (CRAF); and (2) **Noted** that a follow up risk management workshop will be held in summer 2022 to review how the Risk management process is working, and to consider risk appetite and tolerance levels across the organisation.

12. WHSSC Joint Committee Annual Plan of Committee Business 2022-2023

Members received the Joint Committee's Annual Plan of Committee Business for 2022-2023 that outlined the annual business cycle for the work of the Committee.

Members **approved** the Joint Committee's Annual Plan of Committee Business for 2022-2023.

13. COVID-19 Period Activity Report for Month 9 2021-2022 COVID-19 Period

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity.

Members **noted** the report.

14. Financial Performance Report – Months 10 and 11 2021-2022
Members received the financial performance reports setting out the financial position for WHSSC for months 10 and 11 of 2021-2022. The financial position was reported against the 2021-2022 baselines following approval of the 2021-2022 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in January 2021.

The financial position reported at Month 11 for WHSSC was a year-end outturn forecast under spend of £14,058k.

Members **noted** the report.

15. 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.

16. Other reports
Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Audit & Risk Committee (ARC),
- Management Group (MG),
- Quality & Patient Safety Committee (QPSC),
- Integrated Governance Committee (IGC),
- All Wales Individual Patient Funding Request (IPFR)Panel; and
- Welsh Renal Clinical Network (WRCN).

17. Any Other Business (AOB)
Members received verbal updates on:

- The Annual Committee Effectiveness Exercise for 2021-2022 which will be circulated at the end of March 2022 and all members were encouraged to complete the online survey; and
- Recognition that Ian Phillips, Independent Member (IM) WHSSC, would be resigning from his position, as he had been appointed as the substantive Chair of Welsh Renal Clinical Network (WRCN).

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 10 MAY 2022

The Welsh Health Specialised Services Committee held its latest public meeting on the 10 May 2022. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings
The minutes of the meeting held on the 15 March 2022 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising
Members **noted** the progress on the actions outlined on the action log.

3. Genomics Presentation
Members received an informative presentation on the All Wales Genomics Laboratory and how the Wales Infants and Children's Genome Service (WINGS) had pushed the boundaries of genomic testing in Wales to an unprecedented scale using whole genome sequencing which had the capacity to sequence the entire DNA structure of the human body in a matter of hours.

Members noted the Watson family's patient story (publically available on the BBC website) which shared their first hand experience of using the WINGS, when their baby suffered from breathing difficulties and complications to her nose and airways.

Members **noted** the presentation.

4. Chair's Report
Members received the Chair's Report and **noted**:

- An update on the proposal for an interim Chair of the Individual Patient Funding Request (IPFR) Panel,
- Attendance at the Integrated Governance Committee (IGC) meetings on the 30 March 2022 & 19 April 2022; and
- Attendance at key meetings.

Members **noted** the report.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- That WHSSC had been successful in publishing an article in the Applied Health Economics and Health Policy Journal on a "A Case Study on Reviewing Specialist Services Commissioning in Wales: TAVI for Severe Aortic Stenosis",
- The first two NRP (Normothermic Regional Perfusion) organ retrievals undertaken by the the Cardiff Transplant Retrieval Service,
- The stakeholder engagement being undertaken on the Genomics Delivery Plan for Wales,
- The positive feedback received following the Extension of the FastTrack Process for Military Personnel; and
- The findings of a review into Molecular Radiotherapy (MRT) to guide development of an all Wales MRT service.

Members **noted** the report.

6. Interim Appointment of Chair for the All Wales IPFR Panel

Members received a report proposing that an Interim Chair is appointed to the Individual Patient Funding Request Panel (IPFR) for a 3 month period to support business continuity and to allow sufficient time to prepare for, and undertake, a recruitment process to appoint a substantive Chair.

Members (1) **Noted** the report; and (2) **Approved** the proposal to appoint an interim Chair to the Individual Patient Funding Request Panel (IPFR) for a 3 month period to support business continuity and to allow sufficient time to recruit a substantive Chair.

7. Neonatal Transport Operational Delivery Network

Members received a report providing an update from the Neonatal Transport Delivery Assurance Group (DAG) established to provide commissioner assurance on the neonatal transport service.

Members (1) **Noted** the information presented within the report; and (2) **Received assurance** that there were robust processes in place to ensure delivery of the neonatal transport services.

8. Draft Mental Health Specialised Services Strategy for Wales 2022-2028

Members received a report presenting the draft Mental Health Specialised Services Strategy for Wales 2022-2028, and seeking endorsement for its circulation through key stakeholder groups for comment.

Members (1) **Noted** the draft Mental Health Specialised Services Strategy for Wales 2022-2028, and provided comments on the document,

(2) **Noted** that the draft Mental Health Specialised Services Strategy for Wales 2022- 2028 would be circulated through a comprehensive stakeholder list in a bilingual format for comment and that the suggested date of between 10 May and 6 June 2022, would be reviewed and extended; and (3) **Noted** that it was anticipated that the final strategy would be published during Winter 2022, and will be brought back to the Joint Committee for approval.

9. Preparedness for the COVID-19 Inquiry
Members received a report providing an update on WHSSC's preparedness for the COVID-19 Public Inquiry.

Members **noted** the report.

10. Disestablishment of the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group
Members received a report providing a brief overview of the work that had been undertaken by the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group and which was seeking support to disestablish the advisory group, as there was no longer a requirement for it to be established as a sub group of the Joint Committee.

Members (1) **Noted** the work undertaken by the Joint Committee's sub group the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group, (2) **Approved** the proposal to disestablish the NHS Wales Mental Health and Learning Disability Collaborative Commissioning Group; and (3) **Noted** that the work of the group had been incorporated into the Inclusion and Corporate Business Division within Social Services in Welsh Government (WG), and that further consideration was required on the system of oversight of health board commissioned LD placements.

11. Annual Governance Statement 2021-2022
Members received the Annual Governance Statement (AGS) 2021-22 for retrospective approval.

Members (1) **Noted** the report, (2) **Noted** that the Draft Annual Governance Statement (AGS) was endorsed at the Integrated Governance Committee (IGC) on 19 April 2022 and the draft was submitted to CTMUHB in readiness for the 29 April 2022 deadline set, (3) **Approved** the WHSSC Annual Governance Statement (AGS) 2021-2022, (4) **Noted** that the WHSSC Annual Governance Statement (AGS) 2021-2022 will be included in the CTMUHB Annual report being submitted to Welsh Government and Audit Wales by 15 June 2022, recognising that it had been reviewed and agreed by the relevant sub committees of the Joint Committee; and (5) **Noted** that the final WHSSC Annual Governance Statement (AGS) will be included in the Annual Report presented at the CTMUHB Annual General Meeting (AGM) on 28 July 2022.

12. Sub-Committee Annual Reports 2021-2022

Members received the Sub- Committee Annual Reports for the reporting period 1 April 2021 to 31 March 2022 which set out the activities of each sub-committee during the year and detailing the results of reviews into performance.

Members **noted** the Sub-Committee Annual Reports for 2021-2022.

13. Sub-Committee Terms of Reference

Members received the updated Terms of Reference (ToR) for the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC) and the Management Group (MG) for approval.

Members noted that ToR for the sub-committees of the Joint Committee were reviewed on an annual basis in line with Standing Orders and to ensure effective governance.

Members noted that ToR for the Welsh Renal Clinical Network (WRCN) were approved by the Joint Committee on 18 January 2022, and discussions were ongoing with Welsh Government concerning updating the ToR for the All Wales IPFR panel.

Members (1) **Noted** that the Terms of Reference were discussed and approved at sub-committee meetings on 30 March 2022 and 28 April 2022; and (2) **Approved** the revised Terms of Reference (ToR) for the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC) and the Management Group (MG).

14. COVID-19 Period Activity Report for Month 11 2021-2022

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity.

Members (1) **Noted** the report; and (2) **Agreed** to hold an extended session on activity reporting at the next meeting of the Joint Committee in July to scrutinise provider recovery reports.

15. Financial Performance Report – Month 12 2021-2022

Members received the financial performance report setting out the financial position for WHSSC for month 12 2021-2022. The financial position was reported against the 2021-2022 baselines following approval of the 2021-2022 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in January 2021.

The financial position reported at Month 12 for WHSSC was a year-end outturn under spend of £13,112k.

Members **noted** the report.

16. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

17. Other reports

Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Audit & Risk Committee (ARC)
- Management Group (MG),
- Quality & Patient Safety Committee (QPSC),
- Integrated Governance Committee (IGC),
- All Wales Individual Patient Funding Request (IPFR)Panel; and
- Welsh Renal Clinical Network (WRCN).

2022-02-08 WHSSC Joint Committee (Public) Extraordinary

Tue 08 February 2022, 09:00 - 09:30

Agenda

09:00 - 09:00
0 min

1. PRELIMINARY MATTERS

0.0 Agenda (Eng) JC 08 February 2022.pdf (1 pages)

1.1. Welcome and Introductions

Oral *Chair*

- To open the meeting with any new introductions and to **note** and record any apologies

1.2. Apologies for Absence

Oral *Chair*

1.3. Declarations of Interest

Oral *Chair*

- To **note** and record any declarations of interest outside of WHSSC Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for the meeting

09:00 - 09:00
0 min

2. ITEMS FOR CONSIDERATION AND/OR DECISION

2.1. Integrated Commissioning Plan 2022-2025

Att. *Director of Planning*

- To **note** the discussions at Management Group on 20 January 2022 and their support on a revised risk profile;
- To **note** that the actions supported by Management Group reduced the total uplift required for non-recurrent funding for the 2022-2023 ICP to 4.97%, down by 1.6% (£11.4m) from the previous iteration of the ICP presented in December;
- To **note** that Management Group were supportive of the plan for approval by Joint Committee;
- To **approve** the Integrated Commissioning Plan 2022-2025;
- To **approve** the plan as the basis of information to be included in Health Board IMTPs; and
- To **approve** the plan for submission to Welsh Government in response to the requirements set out in the Welsh Government Planning Guidance.

2.1.1 Integrated Commissioning Plan 2022-2025.pdf (6 pages)
2.1.2 Appendix 1 Integrated Commissioning Plan 2022-2025.pdf (136 pages)

09:00 - 09:00
0 min

3. CONCLUDING BUSINESS

3.1. Any Other Business

Oral *Chair*

3.2. Date of Next Meeting (Scheduled)

Oral *Chair*

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WHSSC Joint Committee Meeting held in public
Tuesday 8 February 2022 at 09:00 hrs

Microsoft Teams

Agenda

ITEM		LEAD	PAPER / ORAL	TIME
1.0	**PRELIMINARY MATTERS**			
1.1	Welcome and Introductions	Chair	Oral	09:00 – 09:05
1.2	Apologies for Absence	Chair	Oral	
1.3	Declarations of Interest	Chair	Oral	
2.0	**ITEMS FOR CONSIDERATION AND/OR DECISION**			
2.1	Integrated Commissioning Plan (ICP) 2022-2025	Chair	Att.	09:05 – 09:25
3.0	**CONCLUDING BUSINESS**			
3.1	Any Other Business	Chair	Oral	
3.2	Date of Next Meeting (Scheduled) - 15 March 2022 at 13:30hrs	Chair	Oral	

Report Title	Integrated Commissioning Plan (ICP) 2022-2025	**Agenda Item**	2.1
Meeting Title	**Joint Committee**	**Meeting Date**	08/02/2022
FOI Status	Open/Public		
Author (Job title)	Director of Planning		
Executive Lead (Job title)	Director of Planning		

Purpose of the Report	The purpose of this report is to present for approval the WHSSC Integrated Commissioning Plan (ICP) 2022-2025, and support its onward submission to Welsh Government.				
Specific Action Required	RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☐

Recommendation(s)

Members are asked to:

- **Note** the discussions at Management Group on 20 January 2022 and their support on a revised risk profile;
- **Note** that the actions supported by Management Group reduced the total uplift required for non-recurrent funding for the 2022-2023 ICP to 4.97%, down by 1.6% (£11.4m) from the previous iteration of the ICP presented in December;
- **Note** that Management Group were supportive of the plan for approval by Joint Committee;
- **Approve** the Integrated Commissioning Plan 2022-2025;
- **Approve** the plan as the basis of information to be included in Health Board IMTPs; and
- **Approve** the plan for submission to Welsh Government in response to the requirements set out in the Welsh Government Planning Guidance.

WELSH HEALTH SPECIALIST SERVICES
INTEGRATED COMMISSIONING PLAN (ICP) 2022-2025

1.0 SITUATION

The purpose of this report is to present for approval the WHSSC Integrated Commissioning Plan 2022-2025 (ICP), and support its onward submission to Welsh Government.

2.0 BACKGROUND

The Joint Committee (JC) was asked to consider the Integrated Commissioning Plan (ICP) at its meeting on 11 January 2022. At that meeting the Joint Committee resolved to:

- **Approve** the Integrated Commissioning Plan (ICP) 2022-2025 in principle as the basis of the information to be included in the Health Board IMTP's;
- **Agree** to refer the ICP back to Management Group on 20 January 2022 for further discussion on the financial allocation and tables; and
- **Schedule** an extraordinary JC meeting in February 2022 to formally approve the ICP in readiness for submission to Welsh Government by the end of February deadline.

This report updates Joint Committee on the outcome of the discussion at Management Group, the revised financial position in the ICP and Management Group's approval to refer the revised ICP to Joint Committee for approval.

3.0 ASSESSMENT

Following the Joint Committee meeting further work was undertaken by the WHSS Team regarding the risk profiling of the financial plan within the ICP.

Management Group members received a report presenting a revised approach to managing the financial risk for the Integrated Commissioning Plan (ICP) 2022-2023 and were asked to review the approach and to agree an appropriate level of financial risk that could be recommended.

The Management Group had a detailed discussion on the report and considered action in three key areas and a revised approach to the handling the English Recovery Fund (ERF). Management Group considered:

- performance – taking a more balanced approach whereby investment in areas of over-performance remain but must be assumed to be offset by any under-performance against pre-pandemic contracted levels of activity;

- slippage on new schemes – year 1 financial requirement for new developments to be based on a lower starting assumption of 25% of planned full year costs in order to reflect the time lag for formal approval of business cases and the recruitment lag inherent in all staff related components of developments, adjusted to account for the particular nuances of the individual scheme to allow for the circumstances where a specific scheme of such importance that it needs to accelerated – for example, for service sustainability and stabilisation; and
- slippage on prior year schemes – the slippage analysis for 2021-2022 showed a number of schemes with elements of slippage extending beyond the first year and so all current and prior year schemes had been further examined to identify slippage potential into 2022-2023 which had yielded further slippage on difficult to recruit posts; and
- A revised approach to the handling of the ERF.

Management Group supported the approach noting that this resulted in the following:

- recurrent performance adjustments totalling £3.2m had been made, but those had been reduced as a non-recurrent underperformance provision of £2.25m which was included for services where underperformance was expected;
- the full year effect of prior commitments with ongoing recruitment vacancies had been reduced by £470k;
- the cost pressure provision for growth in the Genetics Test Directory had been removed as WG had confirmed they would fund test directory activity above the original business case level as part of the wider genomics strategy;
- the cost pressure provision for major trauma activity had been removed as it had been presented into strategic priorities as part of the wider major trauma development priorities;
- Clinical Impact Assessment Group (CIAG) and Prioritisation schemes had been reviewed for likely impact resulting in a reduction in required funding of £304k;
- strategic specialist priorities had been reduced by £2.574m as a result of a review of first year requirements and considering time for extra capacity for schemes to come online and recruit to the required standards;
- the COVID-19 recovery and sustainability allocation had been reduced by £4M by assuming the ERF would be at 40% of 2021-2022 forecast levels on the basis of a stable ERF threshold and non-recurrent backlog looked to have delivered in the first half of 2021-2022.

Noting that these actions reduced the total uplift required for non-recurrent funding for 2022-2023 ICP to 4.97%, down by 1.6% (£11.4m) from the previous iteration of the ICP presented in December, Management Group were supportive of the plan for approval by the Joint Committee. The plan and the financial tables are presented at ***Appendix 1***.

Joint Committee members will also see in the plan an additional section on the approach to handling the new Phase 1 Measures that have been published by Welsh Government. This change can be found on page 12.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the discussions at Management Group on 20 January 2022 and their support on a revised risk profile;
- **Note** that the actions supported by Management Group reduced the total uplift required for non-recurrent funding for the 022-2023 ICP to 4.97%, down by 1.6% (£11.4m) from the previous iteration of the ICP presented in December;
- **Note** that Management Group were supportive of the plan for approval by Joint Committee;
- **Approve** the Integrated Commissioning Plan 2022-2025;
- **Approve** the plan as the basis of information to be included in Health Board IMTPs; and
- **Approve** the plan for submission to Welsh Government in response to the requirements set out in the Welsh Government Planning Guidance.

Governance and Assurance	
Link to Strategic Objectives	
Strategic Objective(s)	Development of the Plan Governance and Assurance Implementation of the Plan
Link to Integrated Commissioning Plan	This report presents the Integrated Commissioning Plan 2022-2025
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Care for Those with the greatest health need first Choose an item. Choose an item.
Institute for HealthCare Improvement Quadruple Aim	Improving Health of Populations Reducing the per capita cost of health care Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	There are implications for the implementation of the plan for QP&S. These will be managed via existing mechanisms. A detailed implementation plan will be developed prior to 1 April 2022, and include any necessary actions.
Finance/Resource Implications	There are implications for the implementation of the plan for finance and resourcing. These have been explored in detail with finance leads from across Health Boards and with Management Group. Funding will be managed via existing mechanisms. A detailed implementation plan will be developed prior to 1 April 2022, and include any necessary actions.
Population Health	Whilst the ICP focusses on the commissioning of specialist services for the Welsh population, WHSSC has an interest and perspective regarding earlier clinical pathways and efforts regarding population health. It will where appropriate contribute to discussions and influence actions that impact population health and may in turn reduce the need for some specialist provision in future years.
Legal Implications (including equality & diversity, socio economic duty etc)	The ICP has been developed within the context of all legal implications placed upon WHSSC. The strategic section of the plan sets out WHSSCs commitments to the delivery of these.

Long Term Implications (incl WBFG Act 2015)	The plan takes account the requirements of the Well-being of Future Generations Act and makes commitments as to its contribution towards these.
Report History (Meeting/Date/ Summary of Outcome	CDGB – November 2021 – **supported** Finance Sub-Group December 2021 – **supported** Management Group December 2022– **supported** Joint Committee – 11 January 2022 – **supported** Management Group 18 January 2022 – **supported**
Appendices	Appendix 1 – Integrated Commissioning Plan 2022-2025 & Financial Tables

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

WELSH HEALTH SPECIALIST SERVICES

INTEGRATED COMMISSIONING PLAN (ICP)

2022–2025

TABLE OF CONTENTS

FOREWORD

During what has been an extremely challenging two years for the Welsh NHS, we are proud to present the Specialised Services Integrated Commissioning Plan (ICP) 2022-2025, on behalf of the seven Health Boards in Wales.

Whilst our plan is ambitious, and aims to regain a position of pre-COVID-19 activity, it also appreciates the position that provider organisations in both England and Wales are experiencing. As such it also commits us to working with Health Boards and Trusts, to jointly understand demand, capacity and activity available for the population of Wales, whilst driving forward systems to enable equity of access and provision for all Welsh residents through a flexible approach to redistribution, outsourcing and innovative means of new and additional provision.

Within the forthcoming period, and specifically that of this plan, our commitment is to strengthen our commissioner led, provider informed strategy, which in itself will also signal a shift towards strengthening strategic prioritisation, investment and sustainability.

We could not present this plan without acknowledging the commitment and expertise of the WHSSC team who continue to work to develop relationships across Wales and England on behalf of the seven Welsh Health Boards in order to secure specialist services for the population of Wales.

_____ _____

Sian Lewis
Managing Director

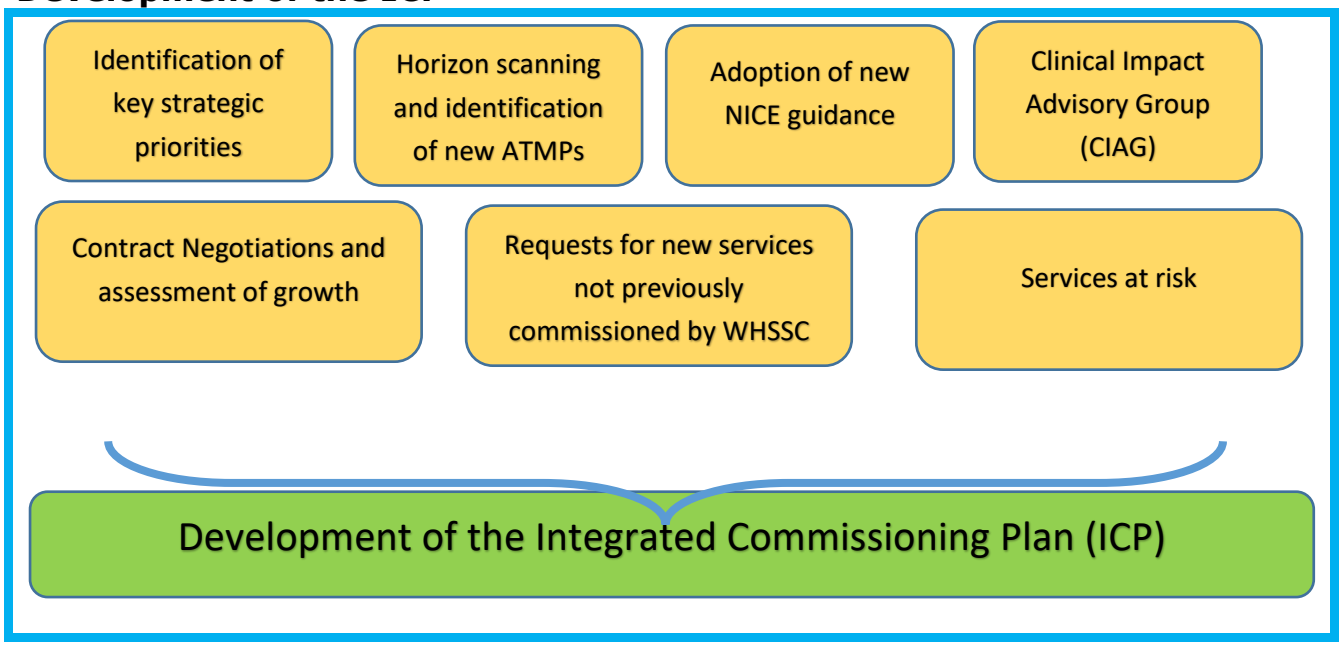
Kate Eden
Chair

EXECUTIVE SUMMARY

Once again, this plan was written within the challenging context of COVID-19 recovery, the sustained management of the pandemic and the need to recover specialist services provision for the population of Wales. This plan includes the following sections, a summary of which is provided below:

Introduction, Requirements and WHSSC Profile
The Integrated Commissioning Plan (ICP) is developed on behalf of the seven Health Boards (HBs) in response to NHS planning guidance, requiring all to develop Integrated Medium Term Plans that seek to align plans for service finance and workforce across NHS Wales. The WHSSC ICP takes account the wide range of national and ministerial priorities and makes commitments as to how it will ensure contribution to each of these. This section also offers information on WHSSC, how it is governed, how it works with stakeholders in the development of the ICP, and how it organises its business, as well as celebrating the achievements of the last ICP, which is supported in detail in Appendix A.

Development of the ICP



This section of the ICP takes the reader through the main processes that have informed the development and priorities of the ICP. The outcomes of these processes are also outlined along with a new section this year on a range of additional services that WHSSC have been asked to take within its portfolio. Each year the ICP signals some of its strategic priorities. These are bulleted below and outlined in detail in the ICP itself:

Developing a Specialist Services Strategy for NHS Wales	Development of a Specialised Mental Health Strategy
Development of a Specialist Paediatric Strategy	Enhancing Major Trauma provision
Intestinal Failure Review	Neonatal Cot review
Commissioning specialist services for the North Wales population	Ensuring Equity for Powys residents
All Wales PET Programme	

This section is supported by Appendix C which offers a visual representation of the areas of investment signalled within the ICP.

Recovery Profile and Actions
This year, the ICP contains a profile of recovery of the main specialist service areas. It notes that the main challenges are in South Wales, with areas of particular concern being:

- Bariatric Surgery
- Cardiac Surgery
- Plastic Surgery
- Neurosurgery
- Paediatric Surgery

The ICP signals a commitment to continue to work with providers in NHS Wales and NHS England to continually assess the position through established contracting mechanisms, and to seek to secure alternate pathways for Welsh residents were possible.

Commissioning Priorities
This section of the ICP takes the five commissioning team areas and those of the Welsh Clinical Renal Network (WCRN), and sets out the priorities that will be delivered within each of them through the timeframe of this plan. Each of the commissioning portfolios have an associated work plan, the headline dates of which are contained in this section of the ICP.

Governance Risk and Assurance
This section of the ICP outlines the mechanisms that are in place within WHSSC to ensure good governance, effective management of risk and assurance through to Joint Committee.

Funding the ICP
In the final section of this plan, detailed arrangements are set out as to how all of the commitments signalled within the ICP will be resourced. This section is supported by detailed financial tables included within the appendices.

1.0 INTRODUCTION

Each year Welsh Government issues planning guidance which places a requirement on organisations within NHS Wales, for the development of integrated plans, that seek to align; service, workforce and finance. This plan responds to that guidance, and seeks to present a cohesive plan for the commissioning of Specialised Services for the people of Wales. The ICP is developed by the Welsh Health Specialised Services Committee (WHSSC) on behalf of the seven Health Boards (HBs) in Wales, and is the basis upon which (HBs) will plan for specialist services provision within their Integrated Medium Term Plans (IMTPs).

2.0 WHSSC PROFILE

WHSSC is a Joint Committee of the seven HBs, set up to plan and commission a full range of specialised services for the Welsh population. The Joint Committee is hosted by Cwm Taf Morgannwg University Health Board (CTMUHB) on behalf of each of the seven HBs in Wales, and is comprised of:

- A remunerated chair appointed by the Minister for Health and Social Services
- Three Independent Members (IMs) - (a vice chair and two non-officer members) two of whom are drawn from the IMs of the HBs, and one selected as an Audit lead from CTMUHB, (in accordance with the hosting agreement between WHSSC and CTMUHB)
- The Chief Executive of each HB
- Various executive officers of WHSSC employed by the host HB
- The Chief Executives of the three Welsh NHS Trusts, who are Associate Members

The purpose of the Joint Committee is to act on behalf of all the seven HBs to ensure equitable access to safe, effective and sustainable specialised services for the people of Wales. This is achieved through working collaboratively on the basis of a shared, national approach where each member works in the wider interest of NHS Wales.

The Joint Committee is supported by five joint sub-committees in the discharge of its functions:

- All Wales Individual Patient Funding Request (IPFR) Panel (WHSSC)
- Integrated Governance Committee
- Management Group
- Quality and Patient Safety Committee
- Welsh Renal Clinical Network

WHSSC's Aim is to ensure that there is:

Equitable access to safe, effective and sustainable specialist services for the people of Wales, as close to patients' homes as possible, within available resources

In order to achieve this aim, WHSSC works closely with each of the HBs (in both their commissioner and provider roles) as well as with Welsh NHS Trusts, providers in NHS England and the independent sector. The commissioning of specialised services is informed through the application of the Prudent Healthcare Principles and the 'Quadruple Aim' identified in the Parliamentary Review of Health and Social Care in Wales.

Organisationally, WHSSC is split into five Directorates; Corporate, Finance, Medical, Nursing and Quality and Planning, these functions come together to create five cross directorate commissioning teams. These commissioning teams are:

- Cancer and Blood
- Cardiac Services
- Mental Health and Vulnerable Groups
- Neurosciences and Long Term Conditions
- Women and Children's Services

WHSSC also commissions the Traumatic Stress Wales service, and the Welsh Renal Clinical Network (WRCN).

Within the period of the last plan, a review into the *Committee Governance arrangements at WHSSC* took place, the recommendations of which are being progressed. These include the need to recognise the complexity of the Independent Member role within WHSSC and the consideration of remuneration in this regard.

WHSSC'S service profile has grown considerably over recent years, however its infrastructure has remained static. In order to reflect this growth "in responsibility" this plan makes provision for a small growth in WHSSCS direct running costs.

3.0 KEY WHSSC ACHIEVEMENTS OF INTEGRATED COMMISSIONING PLAN (ICP) 2021-2022

Despite the challenging context of the 2021-2022 implementation period, WHSSC is pleased to share the progress that has been made across all commissioning portfolios against implementation of the ICP 2021-2022. A synopsis of these achievements is outlined in Appendix A.

4.0 STRATEGIC CONTEXT FOR SPECIALISED SERVICES FOR THE POPULATION OF WALES

4.1 Ministerial Priorities & Measures

WHSSC are ambitious about our role in supporting the bold agenda set out in A Healthier Wales (2018) which describes a whole system approach to health and social care. Putting quality and safety above all else is the first NHS Wales core value. This focus has been strengthened more recently through the Health and Social Care (Quality and Engagement) (Wales) Act (2020), the National Clinical Framework for Wales (2021) and the Quality and Safety Framework (2021). Collectively these set out an aspiration for quality-led health and care services, underpinned by prudent healthcare principles, value-based healthcare and the quadruple aim.

This section outlines the eight Ministerial priorities shared through the Director General for Health and Social care correspondence on 09 July 2021, along with WHSSC's commitment and contribution to their achievement. During January 2022, the Minister also issued a range of measures which require reporting upon from April 2022. The measures are structured against the following domains:

- Population Health
- Care closer to home
- Infection, prevention and control
- Six goals of urgent and emergency care
- Access to timely planned care
- Workforce
- Digital and the economy
- Economy and environment

WHSSC will establish a baseline of performance against the measures, and will enable a discussion at Joint Committee on this baseline during March 2022. Position against the measures will be monitored through existing WHSSC mechanisms:

SLA Meetings with providers	Assurance of delivery against measures, discussion on any gap between measure and delivery Agreement on management plan to close gap
Assurance/performance meetings	Proposed that the assurance meetings once again become performance meetings Assessment of each service area against measures Report through pre SLA meetings to inform actual SLA meet

It is important context for the development of this plan to recognise that the UK is still in the midst of a public health emergency in its continued efforts of ***recovering from COVID-19***.

In response to this ministerial priority, WHSSC will:

- Continue to work with providers of specialised services to build confidence and provide reassurance to patients
- Redeploy staff as necessary to the continued recovery efforts
- Understand the potential impact of long COVID-19 on specialist services provision
- Continue to assess longer term harms of COVID-19 and build these into WHSSC planning
- Support staff to engage with recovery efforts such as Test Track and Protect, vaccination and a balance to hybrid working practices

***NHS Recovery*:** Recovery across all part of the system and pathways is a key focus for WHSSC, both in understanding how specialist services will and can recover, and in understanding how recovery interventions in the secondary care part of the pathway may translate into the need for additional tertiary services. WHSSC has a priority to ensure equitable access to service and will seek to work with providers to ensure recovery enables equity of access for all Welsh residents.

In response to this ministerial priority, WHSSC will:

- Continue to work providers to support and performance manage the recovery position for specialist services for Welsh residents
- Seek to drive equity and equality of access for Welsh patients requiring specialist services provision
- Commission innovative ways of working building on developments made through the NHS' COVID-19 response
- Work closely with Welsh Government and providers to promote the use of allocations given to Health Boards for recovery, which positively impacts on the Specialist Services pathway
- Work to foster a collaborative approach across providers for the safe and timely care of patients
- Commission alternative pathways as appropriate

In recognising the importance of the NHS ***working alongside social care,*** WHSSC will:

- Continue to work with Health Boards in understanding their local arrangements for health and care, particularly as they apply to the early part of a patient's pathway and the recovery following a specialist service intervention
- WHSSC will also foster a stronger working relationship with the Assistant Medical Directors Group for primary care in order to ensure issues of this kind are integral developmental discussions when planning and commissioning WHSSC work

A Healthier Wales remains the strategy for health and care, and the ministerial letter makes clear, that there is to be an accelerated emphasis on momentum and change. It offers a clear mandate for the NHS in Wales to use existing mechanisms to move rapidly forward and ensure a 'relentless focus' on improving health outcomes and reducing inequalities, as well as developing appropriate systems and clinical measures that track progress towards 'A Healthier Wales'.

In response to this ministerial priority, WHSSC will:

- Work with Health Boards to focus on equity of provision and equity of outcomes
- Respond to service reviews that identify variance in this regard (e.g. Getting It Right First Time (GIRFT) Cardiac review – commissioned by WHSSC into cardiac surgery)
- Further strengthen our well established and comprehensive information and outcome measurement within WHSSC

The Ministerial priority that relates to ***NHS finance and managing within resources*** recognises the two exceptional years of extra funding that have been allocated due to COVID-19, alongside the continued need for strong financial control, which will assist Governmental discussions and intentions to support the NHS. WHSSC strives to be prudent in its allocation from the seven HBs in Wales for the commissioning of specialised services for the Welsh population, working in accordance with the WHSSC Standing Financial Instructions (SFIs).

In response to this ministerial priority, WHSSC will:

- Continue to work with provider Health Boards to track finance and performance manage against allocation
- Work to enhance financial control minimised as a result of block payments to providers through the response to COVID-19
- Work to understand the financial investment made for recovery and allocated directly to Health Boards to increase intelligence on a) How the allocation has been targeted towards Specialist Services in tertiary centres, and b) How investment in the primary and secondary parts of the pathway may convert into the need for specialist care

Mental health and emotional well-being, is a clear priority within WHSSC, with a strategic emphasis being placed on this area of Specialist provision.

In response to this ministerial priority, WHSSC will:

- Develop a mental health specialist services strategy
- Work with providers to increase quality of provision whilst supporting a shift from traditional and institutional based services
- Support different models of support and intervention (e.g. development of a psychological intervention model rather than a totally psychologist delivered model)
- Place particular emphasis on those areas of high risk/service sustainability (e.g. Eating Disorders, Child and Adolescent Mental Health services (CAMHs), Forensic services)
- Continue to support our staff through enabling access to a broad range of health and well-being support

WHSSC has a dual interest in the ministerial priority of ***supporting the health and care workforce****;* the first is to support its own workforce, and the second to support the workforce of staff delivering specialist services for the population of Wales, from a variety of providers across the UK.

To meet this ministerial priority, WHSSC will:

- Include robust workforce planning assumptions in its service planning based on assessment and projections of demand
- Work to support fragile services through identifying new investment and prioritising accordingly
- Engaging the workforce and wider stakeholders in service change and improvement
- Encouraging innovation in the development and delivery of services
- Enhancing its population health perspective

In addition to these ministerial priorities, this plan also gives due regard to the following Welsh Government areas of priority:

Welsh Language – WHSSC is committed to treating the English and Welsh languages on the basis of equality and we endeavour to ensure the services it commissions meet the requirements of the legislative framework for Welsh Language, including the Welsh Language Act (1993), the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards (No.7) Regulations.

To deliver the work, WHSSC will:

- Ensure equal regard is given to both Welsh and English Language through all of its communication with Welsh residents regarding the provision of specialist services
- Comply with the requirements of the Welsh Language Act

Equality and Diversity – Equality is central to the work of WHSSC and our vision for improving and developing specialised services for NHS Wales. We welcome Welsh Government's distinct approach to promoting and safeguarding equality, social justice and human rights in Wales. WHSSC are committed to complying with the provisions of the Equality Act 2020, and the public sector general duty and the specific duties to promote and safeguard equality, social justice and human rights in Wales. We are committed to ensuring and considering how we can positively contribute to a fairer society through advancing equality and good relations in our day-to-day activities.

To deliver the work, WHSSC will:

- Ensure that through the commissioning of its services that due regard is given to all aspects of equality and diversity, ensuring provision for all regardless of the identification of any protected characteristics

Well-Being of Future Generations Act

WHSSC is committed to contributing towards the achievement of the objectives of the Well-being of Future Generations (Wales) Act aims to improve the social, economic, environmental and cultural well-being of Wales. The WBFG gives us the opportunity to think differently and to give new emphasis to improving the well-being of both current and future generations, to think more about the long-term, to work better with people, communities and organisations, seek to prevent problems and take a more joined-up approach. This Act puts in place seven well-being goals, and we need to maximise our contribution to all seven.

To deliver the work, WHSSC will:

- Commission services which take account of the seven aims of the Act (e.g. commissioning services with resilience to ensure sustainability)
- Assess contribution of WHSSC developments to the Act through its existing reporting and governance structures (evidence of contribution cited on report templates)

Health and Social Care (Quality and Engagement) (Wales) Act 2020 - WHSSC are committed to ensuring that we think about the quality of health services when making commissioning decisions, and are committed to demonstrating compliance with the duty of quality and duty of candour.

To deliver the work, WHSSC will:

- Hold a Quality and Patient Safety Development Day with quality leads and Chairs from Health Boards to fully understand and agree the WHSSC approach to commissioned services
- Continue to contribute to the All Wales work programme on quality and engagement
- Continue to contribute to the work led by the Delivery Unit on incident reporting, learning and continuous improvement

Duty of consultation – WHSSC works on behalf of the seven HBs, and within the guidance on changes to NHS services in Wales to effectively engage and consult on the services it commissions as required. For any necessary service change that WHSSC leads, it will work through the all Wales engagement leads group in order to utilise existing and established mechanisms at HB level.

To deliver the work, WHSSC will:

- Work closely with the Community Health Councils across Wales in order to share developments and seek advice on compliance with the guidance on changes to NHS services in Wales
- Work specifically on the following service changes within the duration of this plan:
    - Introduction of a Thrombectomy service in Wales
    - Potential new provider of services for SABR
    - Developments from Specialist Mental Health strategy
    - Developments from Specialist Paediatric Strategy
    - Engagement and consultation on configuration of Cochlear services
    - Developments in molecular radiotherapy
    - On-going discussions regarding PET
- Work collaboratively with Health Boards in order to work collaboratively across Health Board boundaries, to manage effective change nationally, regionally and specific to providers of tertiary services

Socio-economic duty – Through the commissioning of services, WHSSC will ensure consideration of those with socio-economic disadvantage in order to strive to ensure equal outcomes with the wider Welsh population.

To deliver the work, WHSSC will:

- Include assessment against the components of this duty for WHSSC commissioned services, building into the well- established policy and commissioning processes within WHSSC

Decarbonisation – Within the context of the "Decarbonisation Strategic Delivery Plan for NHS Wales" published in March 2021, WHSSC is committed to reducing the carbon footprint through mindful commissioning of services that take account the decarbonisation agenda, enabling enhanced digital and virtual access for patients, and through ethical consideration of staff actions and behaviours e.g. reduced travel, increased use of virtual engagement and, where feasible, use of electric vehicles. From 2022, all WHSSC policies will have a focus on innovative ways of working including digital and remote clinics to support reducing the carbon footprint.

To deliver the work, WHSSC will

- Assess savings on carbon footprint as a result of reduced office working
- Assess impact of reduced travel costs
- Assess reduced carbon footprint as a result of increase in remote meetings
- Issue direction through the inclusion of a policy statement in all of our policies on decarbonisation
- Encourage use of electric cars

Health and Social Care in Wales COVID-19: Looking Forward

WHSSC is committed to supporting achievement of the ambitious objectives outlined in Welsh Government's "Health and Social Care in Wales COVID-19: Looking Forward" guidance, and adopt a realistic approach to supporting building back our health and care system in Wales, in a way that places fairness and equity at its heart.

To deliver the work, WHSSC will:

- Use the principles developed by Joint Committee to deliver equity in its approach to reset and recovery
- Where possible seek alternative pathways for patients
- Work with English and Welsh providers to continually assess demand, capacity and risk assessment.

Value based healthcare - WHSSC remains committed to ensuring that specialist services provision in Wales is provided to the highest standard for the most prudent use of resources, and evaluated through the lens of both clinicians and patients, with an aspiration to increase use of measures (proms) and patients experience measures (prems). In particular the appointment of a medicines optimisation pharmacist and the use of Blueteq, and embedding this across our systems will throughout the period of this plan realise a series of outcomes that will support our move towards value based commissioning.

To deliver the work, WHSSC will:

- Include within WHSSC policies and contractual frameworks the need for commissioned services to collect PROMs and PREMs and report these through existing contract monitoring mechanisms
- Advertise a post to develop the WHSSC outcomes framework and associated processes
- Work with providers to embed this approach for specialist services provision

Specialised Services supporting the Foundational Economy - Through working in partnership with providers and Welsh Government, over the last decade WHSSC has supported significant investment into moving care closer to home and creating services based in Wales, it is estimated that the £45m revenue investment outlined below has created over 750 high quality and stable employment jobs within NHS Wales, whilst also moving services out of the main specialist centres into more local settings in West and North Wales.

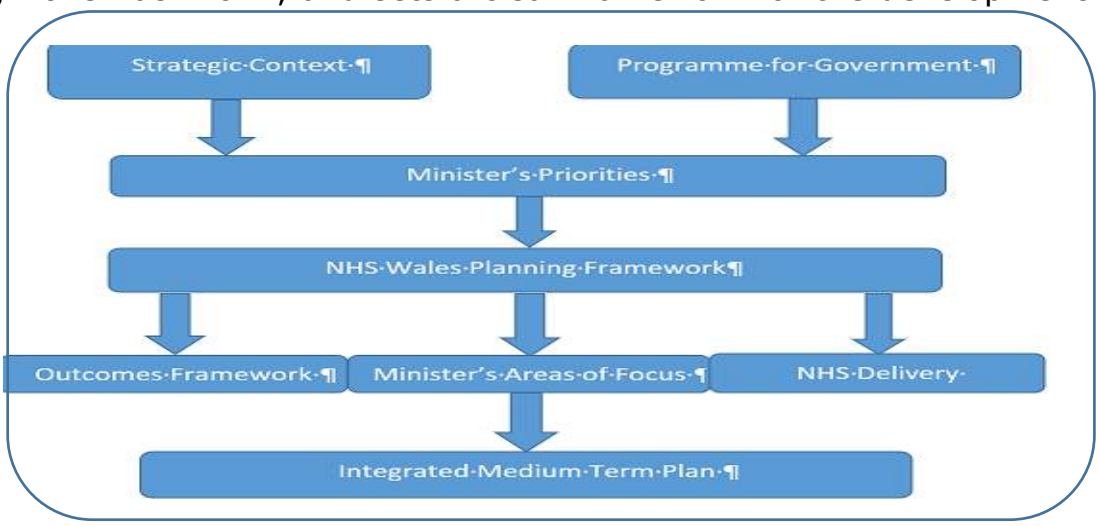
WHSSC's ambition is to continue developing services closer to home by creating new services within Wales and repatriating activity from the private sector providers and NHS England where it is appropriate to do so.

To deliver the work, WHSSC will:

- Review contracts with a view to delivering within Wales where it is safe and effective to do this
- Through appropriate engagement and consultation develop implementation plans to deliver services as close to home as possible
- Work in partnership with providers external to Wales to deliver more services within Wales where it is not appropriate or possible to deliver wholly in Wales

Welsh Government Planning Framework Requirements

The Welsh Government NHS Planning Framework for 2022-2025 was issued during November 2021, and sets a clear framework for the development of this ICP:



This ICP also includes the priorities for specialist services outlined in the Welsh Government correspondence received in October 2021 related to planned and unscheduled care sustainability for 2022-2023, the priority areas are outlined below:

- Implementation of the recommendations of the National Endoscopy Programme

- Regional Cataract services
- Regional plans for aspects of Orthopaedic services
- Strengthened diagnostic and imaging services
- Implementation of the Critical Care Plan
- Stroke Pathway
- Cancer Pathway

The WHSS team will continue to work closely with HBs, and other NHS organisations (e.g. Health Education Improvement Wales (HEIW), the NHS Collaborative, Welsh Ambulance Services Trust (WAST), National Clinical Commissioning Unit (NCCU) to support the specialised services element of these pathways, and inform and influence considerations earlier in the pathway by representation on these National programme Boards and working groups as appropriate.

4.2 Context within which the ICP 2022-2025 has been developed

The 2021-2022 ICP was developed during pandemic conditions, and as such, focussed on restoring access to the specialised services that had reduced during the early phases of the pandemic; and ensuring that strategically important fragile services remained viable. It also aimed to work closely with providers in both NHS England and NHS Wales to ensure full recovery of specialist services where possible.

Whilst COVID-19 remains a sustained pressure upon the population, and within and across our Health and care services, the system is learning to work differently as a result. It has enabled a number of new and innovative ways of working and has made us plan differently in order to ensure the high quality provision of services whilst taking account reduced staffing, limited operational capacity and the heightened focus on the management of infection prevention and control measures.

This is an important consideration for the provision of specialist services. It is clear that there have been differences in the ability of specialist providers to recover pre-pandemic levels of activity across England and Wales.

This potentially creates additional inequity for the Welsh population and is an area that the WHSS Team are working closely with providers to address. The areas of concern in this regard are outlined in more detail in the recovery section of this plan, and Appendix B. The position does however also offer opportunity to consider potential alternate treatment pathways, for example, including outsourcing, redistribution of patient lists and the commissioning of additional short term capacity, which are all considerations within the ICP.

The WHSST team will continue to work with providers across the UK to ensure the best treatment is available for Welsh residents. It will not however make financial provision for recovery within the ICP this year, in recognition that recovery allocations and associated performance are being managed directly with

providers by Welsh Government. There is also a confirmed position that recovery by English providers of services to Welsh residents will be supported from within Welsh Government, through contribution to the English Recovery Fund (ERF).

4.3 Collaborative working across Wales and with NHS England

Throughout the implementation of this plan, and within the context of the National Clinical Framework, WHSSC will continue to work with HBs to plan and commission services for the Welsh population, contributing to National programmes and regional solutions presenting across the NHS in Wales. In formulating this plan, the WHSS Team have worked closely with other national organisations i.e. HEIW, NHS Collaborative and Welsh Ambulance service to ensure alignment between priorities, and plans to ensure it plays an active role not only in the commissioning of specialist services, but also in the entirety of the pathway which could contribute to individuals requiring specialist service provision.

Of specific note are those considerations around workforce as a key enabler to the implementation of Integrated Medium Term Plans.

From a specialist services perspective, staff numbers in teams already tend to be relatively small and any impact has a significant effect. WHSSC colleagues have been working to comment on and inform the HEIW commissioning process to ensure no detrimental effect on specialist services. Some key areas of focus in the period of this plan are:

- ***Finding alternate roles to provide traditional services*** – e.g. a shift from appointing psychologists, to enabling psychological intervention across a variety of roles
- ***Responding to gaps in professional roles***, e.g. Psychiatry provision for people with a learning disability
- ***Working to secure alternative/networked arrangements*** where there are limits to the amount of specialist staff coming through the training i.e. Networked arrangements with NHS England for Inherited Metabolic Disorder

4.4 Policy Development

The development of policies enable WHSSC to achieve its strategic objectives, and deliver high standards of care. There are three kinds of policies: (i) commissioning policies, (ii) policy position statements and (iii) service specifications.

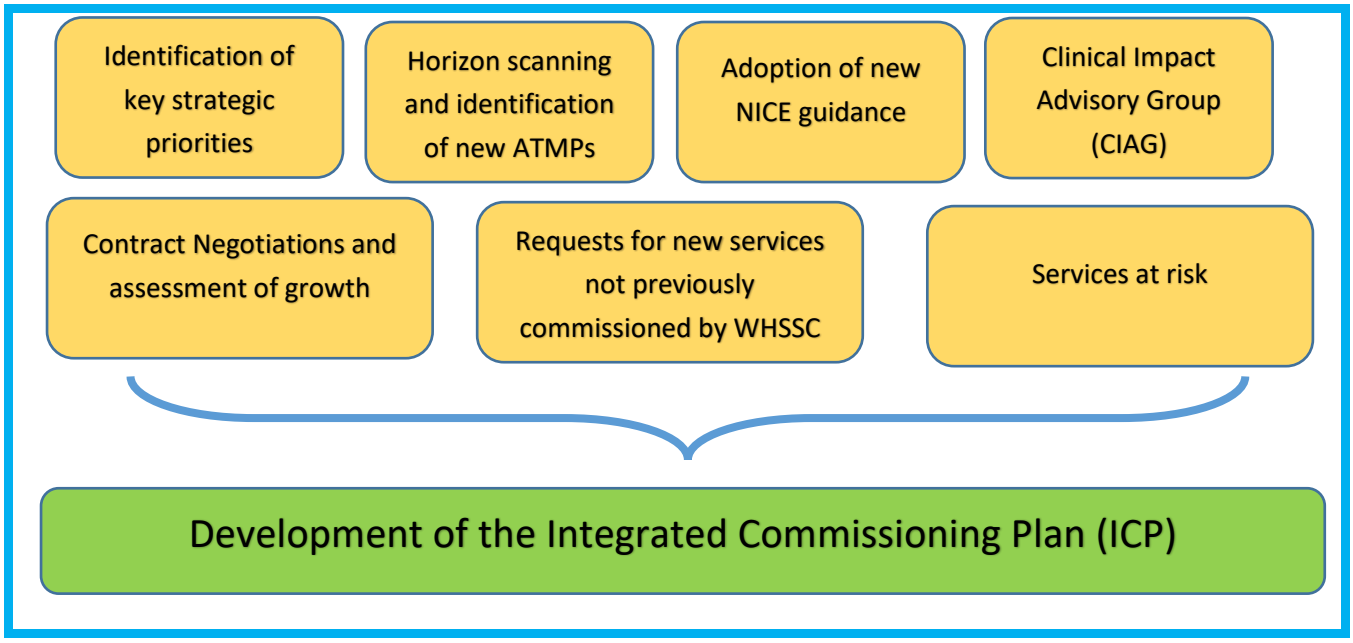
Governance of policy development is overseen by the WHSSC Policy Group who meet bi-monthly. The Group agrees the priorities for WHSSC policy development and ensures all policies are developed according to the published WHSSC methodology and within agreed timelines. The Group also ensures that all policies are based on the best available evidence of clinical and cost effectiveness, where available.

As of November 2021 WHSSC has 106 extant policies published on its website[1] with a further 47 in development or planned. WHSSC continues to publish a high number of new or revised policies each year.

5.0 DEVELOPING THE ICP 2022-2025

Each year, the ICP is formulated through a number of processes that are enabled through the well-established WHSSC annual planning cycle, as outlined below. The process and outcomes of each of these activities is outlined below, and collectively comprise the components of the ICP 2022-2025. These are processes which will run through the consecutive years of the ICP also. Each of the processes have strong clinical and HB representation. A plan on a page of all WHSSC proposed developments for 2022-2023 is presented at Appendix C.

[1] http://www.whssc.wales.nhs.uk/about-whssc-polices).



The ICP ***does not*** include provision or detail on those services that are not currently WHSSC designated services, and which HBs are working together to identify and implement with regard collective commissioning activities.

5.1 WHSSC Strategic Priorities 2022-2025

A number of areas have been identified as Strategic priorities in this year's plan. A summary and the rationale leading to the identification of these can be found in the sections below:

5.1.1 A Specialist Services Strategy for Wales

Whilst the development of the ICP takes place in accordance with the NHS Wales planning cycle, through discussions with Joint Committee, WHSSC have committed to developing an overarching Strategy for Specialised Services in Wales. This was originally an intention in the 2021-2022 plan however this was delayed due to the refocussed activities of WHSSC business and personnel during the COVID-19 pandemic. It will therefore be developed within the context of the National Clinical Framework for consideration by the Joint Committee within the first year of this plan.

5.1.2 Mental Health Strategy

WHSSC is responsible for commissioning specialised Mental Health services on behalf of the seven HBs for Wales. Services are delivered by HBs across various NHS sites in Wales, and by a range of NHS providers in England. The independent sector is also used extensively for Mental Health provision across both England and Wales.

A number of drivers have led to the Mental Health Strategy being identified as a strategic priority, including:

External

- A number of Committee Inquiries and external reviews
- Changes to the commissioning landscape in NHS England
- Transforming Care Strategy for Learning Disabilities (NHS England), which signalled a 20% reduction in medium secure beds and a 50% reduction in low secure beds
- New Models of Care, mental health pilot schemes in NHS England
- The establishment of mental health provider collaboratives in NHS England

Internal

- Workforce recruitment issues particularly affecting CAMHS services
- The Welsh Framework Agreements for accessing non NHS Wales beds
- Recent reviews of inpatient CAMHs services identifying the lack of Psychiatric Intensive Care/Assessment beds, resulting in unnecessary out of area placements
- A complex commissioning model for Forensic Adolescent Consultation Treatment Service (FACTS)
- A lack of national services for women and patients within Learning Disability in Wales
- The development of a new Mother and Baby Unit for South Wales, and considerations in respect of the North Wales population

Work commenced within the previous ICP period to initiate the programme of activity and establish the programme structure for the development and implementation of the strategy which has the following service areas within scope:

- High secure (adult)
- Medium secure (adult)
- Forensic Learning Disability services
- Reference to HB commissioned low secure services
- Specialist CAMHS including the Forensic Adolescent Consultation Treatment Service (FACTS)
- Specialist Eating Disorder Services
- Specialist Perinatal provision
- Specialist Mental Health provision for Women

The aspiration of the strategy is to:

- Provide more care closer to home wherever safe and practicable to do so; primarily in the Welsh NHS but where necessary, and appropriate, with third sector or private sector partners.
- Develop commissioning models which add value and strengthen the whole pathway approach to service delivery supporting the transforming health care agenda within Wales.
- Address the challenge of improving outcomes and transitions between different parts of pathway and commissioning organisational boundaries
- Prioritise investment in areas with demand and capacity constraints and areas with extended waiting times and/or gaps in service.

5.1.3 All Wales Specialist Paediatrics Services Strategy

Tertiary paediatric services are commissioned by WHSSC from a number of providers across the UK. WHSSC commissioned Paediatric services range from, highly specialised bone marrow transplants, and high cost drugs for rare diseases, which are funded on an Individual Patient basis, through to emergency services including Paediatric Intensive Care and Paediatric Surgery and specialities providing ongoing care for long term conditions, such as Paediatric Rheumatology and Paediatric Endocrinology. The main WHSSC contracts for Paediatric services in Wales and England are over £89 million.

Commitment was given to developing a strategy within the 2021-2022 ICP as a number of risks have been identified over recent years with small services proving to be fragile by nature. Reactive investment has been provided in recent years however to ensure sustainability of this investment and the ongoing sustainability of services a strategic approach has been agreed as a mitigation. Programme 'set up' work has taken place within the last quarter of the year, with the strategy and associated delivery plan scheduled to conclude within the first year of this ICP, and associated implementation over the full three years and beyond.

The scope of the strategy will include:

- Establishing a baseline of services across all Wales for Paediatric Services
- An assessment of the current status of all Specialised Paediatric Services
- An assessment of services not currently commissioned
- An assessment of health needs for all Wales – Health needs assessment including predicted demand for specialised Paediatric services over the next 10 years for the Paediatric population for Wales
- Assessment of current and future workforce requirements

5.1.4 Major Trauma

The South and mid Wales Major Trauma Network went live in September 2020. WHSSC have the responsibility for commissioning the Operational Delivery Network (ODN), Major Trauma Centre (MTC) and the specialised service elements of major trauma treatment provided by Swansea Bay University Health Board (SBUHB). A Delivery Assurance Group (DAG) has been established, reporting to the WHSSC Joint Committee to provide commissioner assurance including performance monitoring and to provide recommendations to the Joint Committee on future commissioning developments for the Network.

In the first 12 months of operation activity across the Major Trauma Network has exceeded the planning figures within the Programme Business Case. Growth in activity has been assessed and is addressed within the finance section of this plan. Further developments of the Major Trauma Network will be assessed following the Peer Review process that is planned for March 2022, with any identified priorities being included within the 2022-2023 specialist services prioritisation process.

5.1.5 Intestinal Failure Review

Intestinal Failure services have not been reviewed for many years, there are clearly different pathways in place for Welsh residents, and a number of improvements and efficiencies identified within the service that require address. Commitment was therefore given for a review of Intestinal Failure services. This is in order to better understand intestinal failure pathways and access across Wales with an aspiration to develop a policy and a service specification. The review will also include the potential to develop an NHS solution to the private provision that is currently secured for the provision of Home Parenteral Nutrition (HPN) for patients with intestinal failure.

5.1.6 Neonatal Cot Review

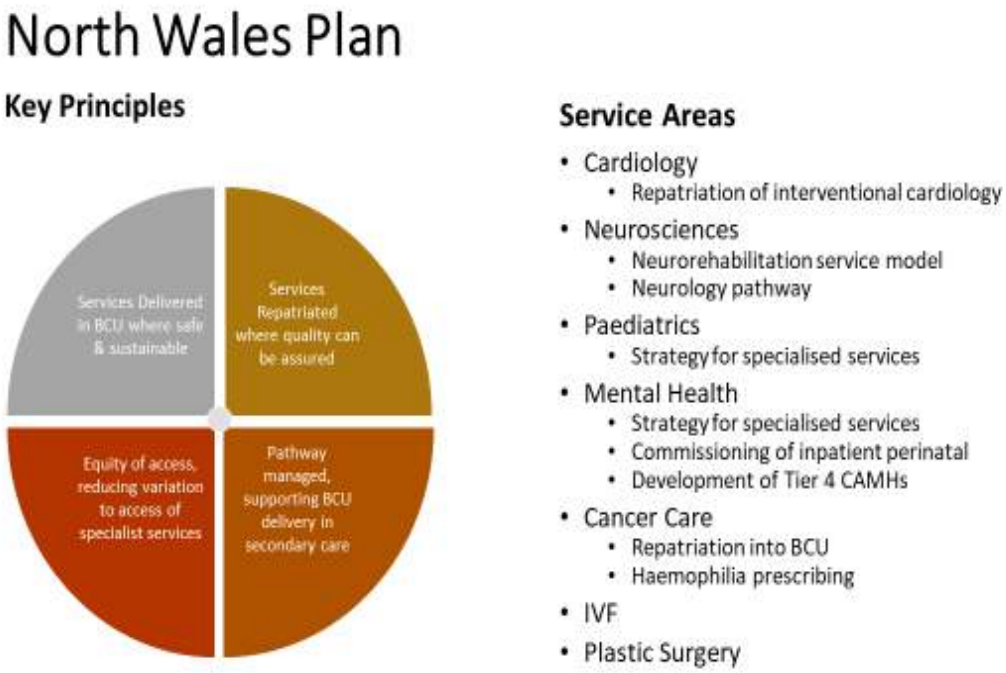
As a result of the Dr Grenville Fox review of the Neonatal transport service, a series of recommendations were made which included a review of neonatal cot configuration across South and West Wales. This was due to the high volume of capacity transfers undertaken by the South Wales Transport service. The Joint Committee supported the recommendations in March 2020 and agreed that improved configuration would reduce the need for capacity transfers. Providers have also submitted proposals over recent years for increased investment, citing that the existing tariff is insufficient to support the units to National Standards. Demand and capacity modelling has been undertaken during 2021-2022, with recommendations on a proposed configuration and tariff for Wales to be made to Joint Committee in the first year of this plan.

5.1.7 Mesothelioma

There is growing evidence regarding the adverse impact of the pandemic on cancer pathways. This has been identified as a particular issues in services where there is already a high degree of variability in equity of access and the Cancer Quality Statement (2021) specifically identifies the need for more specialist cancer services that are fragile or cannot meet vital standards to reconfigure into more resilient regional, super-regional or national services. This may have implications for the requirement of a national Mesothelioma MDT.

5.1.8 Commissioning Specialised Services for North Wales Residents

Developing Tertiary Services in North Wales is an important and key strategic priority within WHSSC. Throughout 2021-2022, WHSSC has strengthened the North Wales liaison team in order to address a number of Specialist Services developments including a desire from Betsi Cadwaladr University Health Board (BCUHB) to repatriate a number of services from England into Wales. Service areas that will be the initial focus of consideration are:



A detailed work programme has been developed jointly with BCUHB to progress this agenda which is reported through existing WHSSC mechanisms.

5.1.9 Ensuring Equity for Powys Residents

The population in Powys is older compared to the rest of Wales and the working age adult population is smaller compared to Wales. It is predicted that there will be an 8% decline in population by 2039, and the number of young people and those under 65 will decrease while older adults will increase.

Powys has some unique challenges in terms of demography and geography and the interrelationship between these factors. It is an entirely rural county with no major urban conurbations and no acute general hospitals. People in Powys have to travel outside the county for many services, including healthcare, higher education, employment and leisure.

Pathways to and from specialised services are extremely complex in Powys. As Powys Teaching Health Board (PTHB) has no District General Hospital (DGH), the majority of secondary care consultants referring Powys patients into specialised services are from hospitals within England. The main patient flows are into the North and West Midlands via hospitals in Shrewsbury, Telford and Hereford. Patients in South Powys and North West Powys are generally referred to services in Cardiff and Swansea via hospitals in Abergavenny, Swansea and Aberystwyth. There are also small flows into North Wales. Powys residents also use specialised services further afield in Bristol and London. It is proposed that a workshop to better understand these flows and the challenges and opportunities that they present is jointly led with Powys Teaching during Q2 of the first year of this plan.

5.1.10 All Wales Positron Emission Tomography (PET) Programme

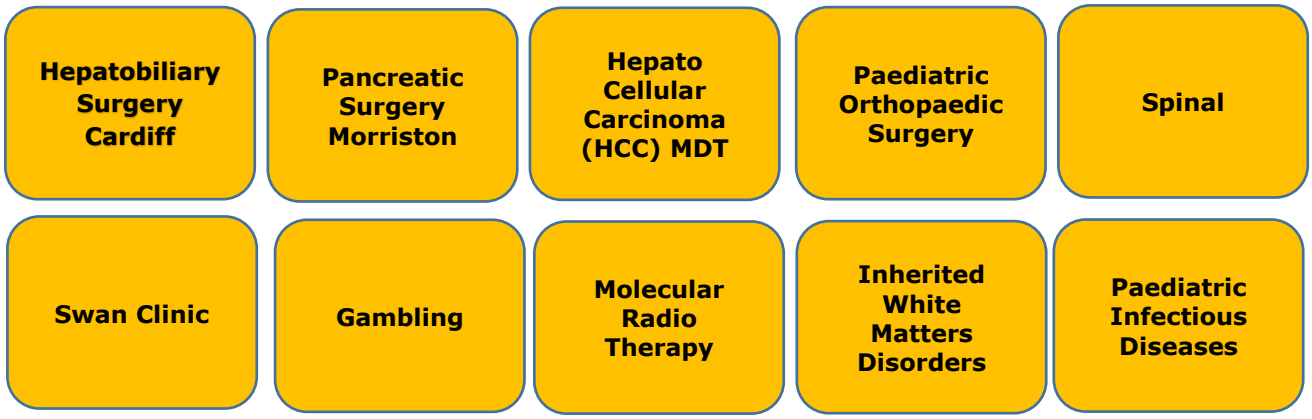
Positron Emission Tomography (PET) has become a central diagnostic tool in the management of cancer, and increasingly in many non-cancer conditions. There is an increasing body of high-quality evidence outlining the contribution of PET to improved patient outcomes. Demand for PET-CT is growing, however the Welsh PET service provision does not compare favourably in comparison to other devolved nations and beyond.

A Programme Board was established, and a Programme Business Case developed. Following Welsh Government scrutiny and receipt of support from all HBs, ministerial endorsement of the £25 million All Wales PET Programme was confirmed on 25 August 2021. Further mandate was given to WHSSC to take on Programme implementation during October 2021. The programme includes the replacement of the fixed site scanner at the University Hospital of Wales, replacement of mobile scanners in SBUHB and BCUHB with fixed site scanners and the establishment of the 4th fixed site scanner at a location yet to be determined.

WHSSC have submitted an additional Business Justification Case to Welsh Government for financial support for a small PET Programme Management Office, which will aid robust programme planning arrangements for the programme and increasing the likelihood of programme success in enabling significant benefits to patient services and treatment outcomes.

5.2 Potential New WHSSC Services 2022-2023

During recent months, WHSSC have been approached to consider taking on responsibilities for a number of new service areas. A summary of these are outlined below *(please note that timescales and key actions for these are included in the commissioning team's priority section)*:



5.2.1 Hepatobiliary Surgery (South Wales)

Currently the commissioning arrangements for Hepato-Pancreato-Biliary (HPB) surgery in South Wales are split between HBs and WHSSC. WHSSC commissions liver cancer surgery service at the University Hospital of Wales (UHW), Cardiff.

All other services, including other Hepatobiliary surgery or staging procedures, and Pancreatic surgery are funded by HBs.

Over the last year, the Collaborative Executive Group (CEG) commissioned the Wales Cancer Network to develop a model service specification to inform the future commissioning of these services. The model service specification is clear that there needs to be much closer integration between the two services. As a result, it was felt that a single commissioner would be more effective and following a request by CEG, the Joint Committee has agreed that WHSSC will become the commissioner for the whole of Hepato-Pancreato-Biliary surgery, with HBs formally agreeing this at their Board meetings during September/October 2021.

5.2.2 Pancreatic Surgery Morriston

As outlined in the previous section, Pancreatic Surgery is delivered at Morriston Hospital Swansea. There is a need to consider the optimum configuration of this service alongside others within the first year of this plan.

5.2.3 Hepato Cellular Carcinoma (HCC) MDT

During a recent review of Hepatobiliary services, the fragility of the Hepato Cellular Carcinoma (HCC) MDT at Cardiff and Vale University Health Board (CVUHB) was identified. As there is an established interdependency with Hepatobiliary surgery, it has been suggested that this service would also benefit from being commissioned through WHSSC for the Welsh population.

5.2.4 Specialised Paediatric Orthopaedic Surgery

At the May meeting of the NHS Wales Health Collaborative Executive Group (CEG), members received a paper, from the Regional and Specialised Services Provider Planning Partnership (RSSPPP), on the current sustainability issues within Paediatric Orthopaedic Surgery services in South and West Wales. Following discussion, it was agreed that service specifications were needed in order to inform the commissioning of these services.

As these services provide a mixture of specialised and non-specialised procedures, it is necessary to develop service specifications that span the entire range of procedures. Therefore, the CEG agreed to commission two complementary service specifications:

- Non specialised – commissioned by HBs
- Specialised – currently commissioned by HBs, but included in the WHSSC signal of commissioning intent for the ICP 2022-2023

5.2.5 Spinal Surgery

Spinal surgery is a high-risk specialty, provided by Orthopaedic surgeons and Neurosurgeons. To ensure that patients have the best possible experiences and outcomes, services need to be appropriately resourced, allowing seamless access to non-surgical management but with effective care pathways to facilitate

admission to the appropriate surgical centre, within an appropriate timeframe when necessary.

A Spinal Surgery Project was launched in October 2020, with the aim of developing recommendations for a safe, effective sustainable multi-disciplinary model for spinal surgery in South and West Wales.

The final report was presented to the Collaborative Executive Group (CEG) on 06 April 2021, and included a range of recommendations, including; HBs needing to formalise their commissioning arrangements for spinal surgery; the establishment of an Operational Delivery Network (ODN) and that immediate action should be taken to formalise a shadow network within existing resources. It was agreed that a Business Case should be developed across affected HBs, and that WHSSC would commission the ODN.

5.2.6 Syndrome without a name (SWAN) Clinic

Rare diseases are a significant health problem, often associated with poor outcomes. A rare disease is one that affects 1:2000 or fewer patients with ultra-rare conditions being those that affect 1:50000 or fewer (NICE). There may be over 8000 diseases that qualify for the definition of a rare disease. This leads to the estimate that 150,000 people in Wales are affected by a rare disease (5% of the Welsh Population). 80% of these conditions are estimated to have a genetic component, and children are disproportionally represented and impacted upon with 50% of rare diseases affecting them. 30% of those affected will sadly die before the age of five years.

The Rare Diseases Implementation Group was established in 2015 to oversee the delivery of the Welsh Rare Diseases Implementation Plan. The Group identified three key actions:

1. Identify and improve the pathway for patients with unknown or delayed diagnosis - "The Diagnostic Odyssey"
2. Ensure better use of patient feedback, best practice and evidence to improve pathways for primary, secondary and specialist services.
3. Improve reporting of rare disease information including epidemiology, significant event analysis and shared learning.

Challenges remain around improvements in delayed diagnosis and improved pathways of care which the establishment of a Syndrome without a name (SWAN) Clinic will aim to address. Due to a lack of evidence in the form of outcome data for the impact of such a service, Welsh Government have provided funding for a 2 year pilot. This, with agreed evaluation criteria, would inform a longer term commissioning proposal to be considered via the WHSSC Integrated Commissioning Planning processes.

5.2.7 Specialist Gambling Addiction Service

WHSSC has been asked to work with Welsh Government and Public Health Wales to scope the development of a specialist Gambling Addiction Service in Wales. The Welsh problem gambling survey 2016 for the Gambling Commission reported the proportion of the Welsh population vulnerable to gambling-related harm is 3·8%, with the greatest risk evident among people aged 16–24 years. Furthermore, Public Health Wales (PHW) has estimated that the most deprived communities of Wales are increasingly vulnerable to gambling-related harms. WHSSC are working with Welsh Government to review the available evidence and agree next steps.

5.2.8 Molecular Radiotherapy

Molecular Radiotherapy Treatment (MRT) involves the administration of a radioactive drug that targets cancer cells with radiation. MRT is currently a treatment option for several tumour sites including Thyroid, Non-Hodgkin Lymphoma, Bone Metastases and Neuroendocrine tumours. NICE is currently undertaking a technology appraisal of MRT in the treatment of prostate cancer. If a positive recommendation is made, this is likely to require a step change in MRT capacity (staff and infrastructure) to deliver the service. It is proposed that WHSSC leads an all Wales strategic programme for the future development of MRT to meet the needs of the population of Wales. A scoping document is being developed by the clinical oncology sub-committee on behalf of Welsh Government to inform future commissioning arrangements.

5.2.9 Inherited White Matters Disorder

NHS England have confirmed their intention to commission a specialised diagnostic and management service for inherited white matter disorders, for both children and adults. Based on the available evidence, and the emerging four nation's position on this, it is proposed that Wales also formalises its commissioning intent for this patient cohort. It is anticipated that numbers of patients will be low, and as such suggested management for funding will be via the Individual Patient Funding Request process.

5.2.10 Paediatric Infectious Diseases

Currently there is no commissioned or funded Tertiary Paediatric Infectious Disease service for South and West Wales. The Joint Committee have agreed that this will be absorbed by WHSSC, however further work is needed to establish a needs assessment and a gap analysis. The transfer of service in to WHSSC will take place throughout 2022-2023 and will inform the ICP 2023-2026. The service will be responsible for the assessment, diagnosis and management of children with complex infectious diseases such as Kawasaki Disease and Hepatitis. The service will provide advice to secondary care centres and provide out-patient care for specialised conditions.

5.3 Clinical Impact Assessment Group (CIAG) Prioritisation Process

Discussions regarding the process for the development of the ICP 2022-2023 commenced early last year, with Management Group having received a timeline

for development at its meeting on 25 March 2021. Subsequently each Management Group meeting has received a verbal update/presentation on the timeline for completion and submission of the ICP as follows:

Reflections Workshop	12 April 2021
Horizon scanning	21 July 2021
CIAG prioritisation day	03 August 2021
Development of plan	August/September 2021
Draft plan to CDGB	November 2021
Draft plan to Management Group	December 2021
Draft plan to Joint Committee	January 2022
Final plan submitted to Welsh Government	February 2022

5.3.1 Reflections Workshop on the 2021-2022 Process

A workshop was arranged for Management Group members on 12 April 2021, in order to reflect on previous year's processes and make any improvements that were necessary. There was positive engagement during and following the session, where members expressed general satisfaction with the process, with some small changes being recommended, including strengthening the involvement of primary care colleagues in the prioritisation process, and strengthening the balance between commissioner led and provider informed commissioning priorities. As such commissioning intentions were shared by WHSSC colleagues during June which invited specific schemes to come forward against known priority areas.

5.3.2 CIAG Prioritisation Process

The CIAG prioritisation process took place on 03 August 2021. 50 schemes were submitted for consideration with the breakdown being:

Cardiff and Vale University Health Board (CVUHB)	21
Betsi Cadwaladr University Health Board (BCUHB)	11
Swansea Bay University Health Board (SBUHB)	16
Velindre NHS Trust (VNHST)	1
WHSSC direct	1
TOTAL	**50**

Included within the submissions this year, were also, schemes from the Major Trauma Network, the Wales Renal Clinical Network (WRCN), and some joint work on-going between HBs for WHSSC non-commissioned services.

An initial sift of the schemes was carried out in order to assess whether CIAG was the most appropriate route for consideration of the scheme, or whether there were other routes available for them to progress, (for example existing contract arrangements, strategic work on-going, repatriation issues, existing underspends in service areas). As a result of this process, 30 schemes were identified as more

appropriately being addressed via an alternate route, and 20 schemes were taken forward into the CIAG process:

Proposals from the Cardiac Commissioning Team
• Increasing access for patients with Inherited Cardiac conditions
Proposals from the Cancer and Blood Commissioning Team
• Clinical Immunology
• Mesothelioma MDT
• Thoracic Surgery
• Psychological Support in the Paediatric Plastic Surgery Regional Service
Proposals from the Neurosciences Commissioning Team
• ALAC Psychology support SBUHB and BCUHB
• ALAS Development of a Welsh Artificial Eye service
• ALAS North Wales Specialist Seating Service
• Neuropsychiatry
• Neurosurgery Sustainability and Standards
• North and Mid Wales Prosthetic Service Sustainability and Resilience
• Prolonged Disorders of Consciousness (PDOC)- Phase 2
Proposals from the Children's Commissioning Team
• Development of a Paediatric Infectious Diseases Service
• Neonatal Surgical Nurse Specialist
• Paediatric Endocrinology Nursing Support
• Paediatric Pathology
• Specialised Paediatric Orthopaedic Surgery
• Specialist Children's Gastroenterology Outreach
• Paediatric Spinal Surgery
• Paediatric Health Psychology

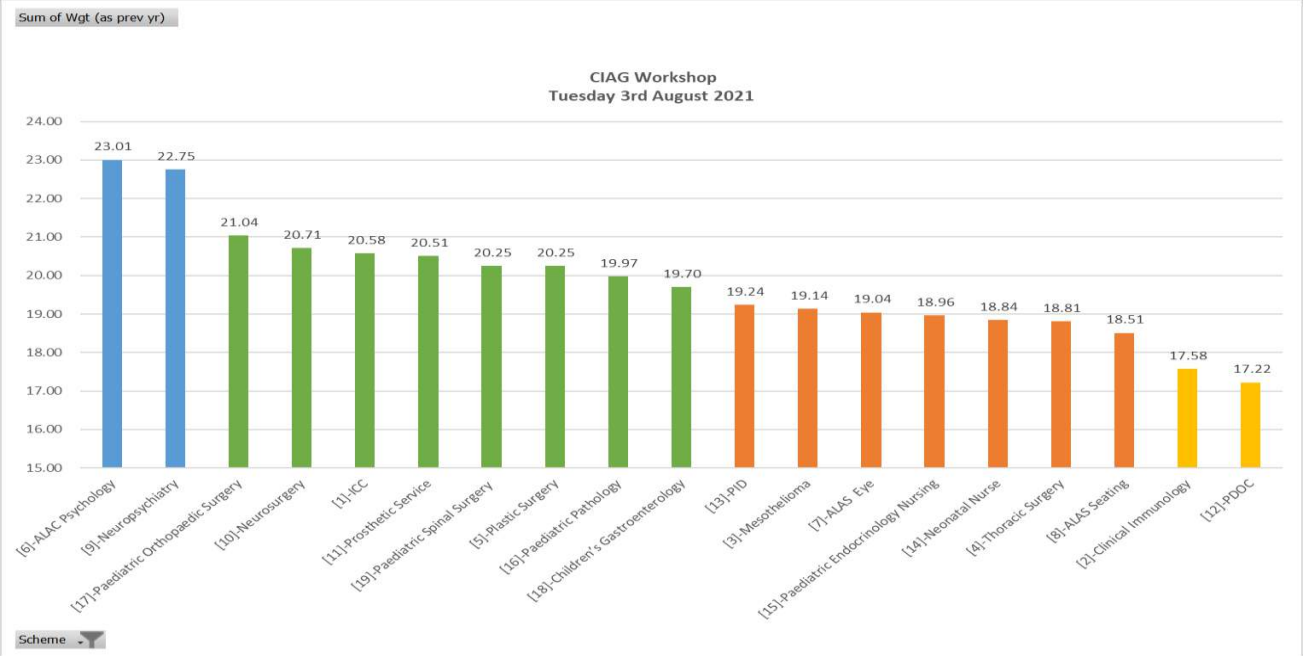
All of these schemes were shared with colleagues who are part of the All Wales Assistant Medical Directors for primary care network, in a workshop that took place on 21 July 2021, attendees shared thoughts and suggestions regarding the entire pathway.

5.3.3 Scoring of CIAG schemes – Criteria for Prioritisation

A simplified scoring protocol for prioritisation was introduced for 2020, utilising the following three criteria:

- Patient benefit (clinical impact)
- Burden of disease – population impact
- Potential for improving/reducing inequalities of access.

The approach was well received, and was therefore maintained for the 2021-2022 process. The session took place as a virtual event with Microsoft forms being utilised to collect the scoring, and offer real time outcomes of the overall event. The outcome from the voting on the day was as follows:

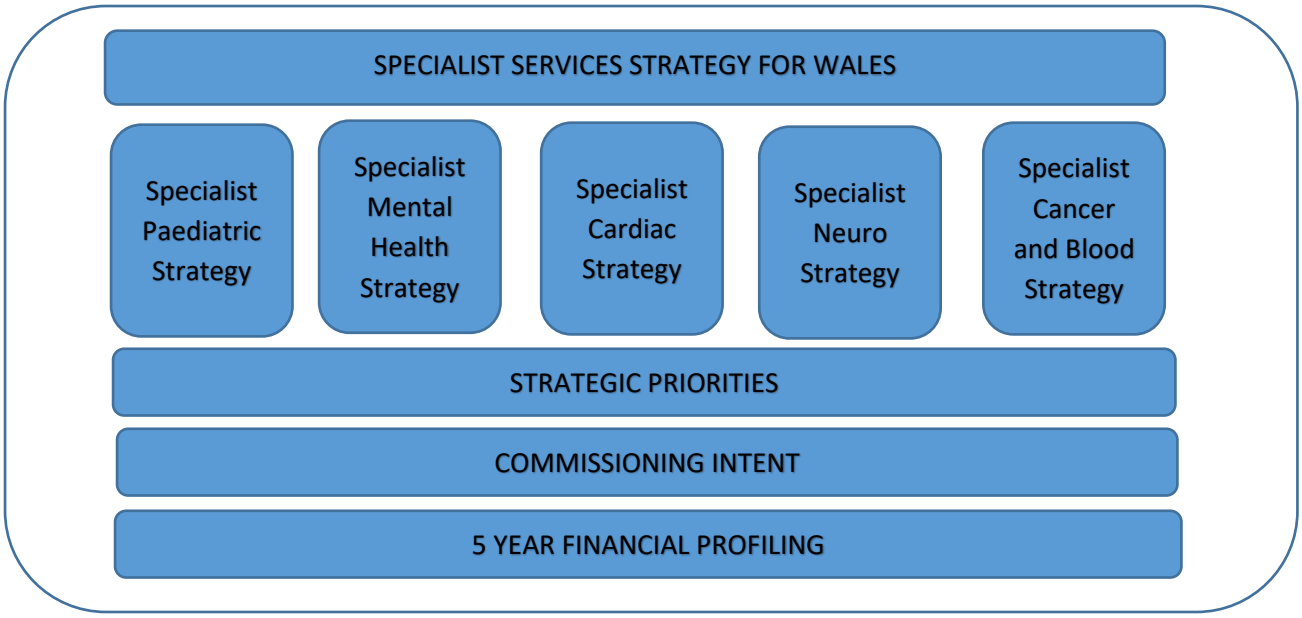


The total investment value of all schemes considered at CIAG was approximately £2.8m. The proposal is that the 10 schemes that scored the highest are funded. This investment profile is at circa £2.1m, with a part year effect being £927k. In comparison with previous years, this years requested investment is relatively low. The schemes are listed overleaf.

Highest	High	Mid	Low
ALAC Psychology	Paediatric Orthopaedic surgery	PID	Clinical Immunology
Neuropsychiatry	Neurosurgery	Mesothelioma	PDOC
	Inherited Cardiac Conditions	ALAS Eye	
	Prosthetic service	Paediatric Endocrinology Nursing	
	Paediatric Spinal Surgery	Neonatal Nurse	
	Plastic Surgery	Thoracic Surgery	
	Paediatric Pathology	Alas Seating	
	Children's Gastroenterology	PID	

During the last ICP period, WHSSC signalled its intention to strengthen the balance between a commissioner-led and provider informed process. The process to inform this plan therefore included the publishing of commissioning intentions for each commissioning portfolio. The process also seeks to understand where

possible what information is collected related to patient experience. WHSSC will incrementally move towards a Strategy led approach to commissioning, and has commenced two strategic pieces (Paediatrics and Mental Health) within the past few months. Once this approach is embedded, the CIAG process should become less prominent in the ICP development process. The process will work as set out below:



The CIAG process can then be utilised for any unforeseen issues that may have emerged in year and would cause risk if not receiving consideration for investment prior to renewal of the strategies.

5.4 Horizon Scanning and Prioritisation

Whereas the CIAG process focuses predominantly on service development, the WHSSC Prioritisation Panel are tasked with assessing new treatments and interventions. To achieve this WHSSC has developed a process that enables it to compare competing proposals for new investment so that these can be prioritised and subsequently implemented.

The Panel consists of 14 voting members who represent a wide range of disciplines including Medical, Quality and Nursing, Public Health, Equalities, Legal and Ethics, Health Economics, Human Tissue Authority and Lay Members. All HBs and Velindre University NHS Trust are represented on the Panel. Members are selected for their expertise and are appointed as individuals and are not appointed to represent the views of any stakeholder organisation. The Panel meeting is chaired by the WHSSC Medical Director.

5.4.1 Horizon Scanning

Horizon scanning identifies new interventions and emerging, innovative health technologies which may be suitable for funding; and prioritisation allows them to be ranked according to a set of pre-determined criteria, including their clinical and cost effectiveness.

A horizon scanning exercise was carried out between January and June 2021 to inform this process. Information on new technologies was obtained from a range of established published resources and a total of seven technologies were identified for consideration by the Panel.

5.4.2 Prioritisation

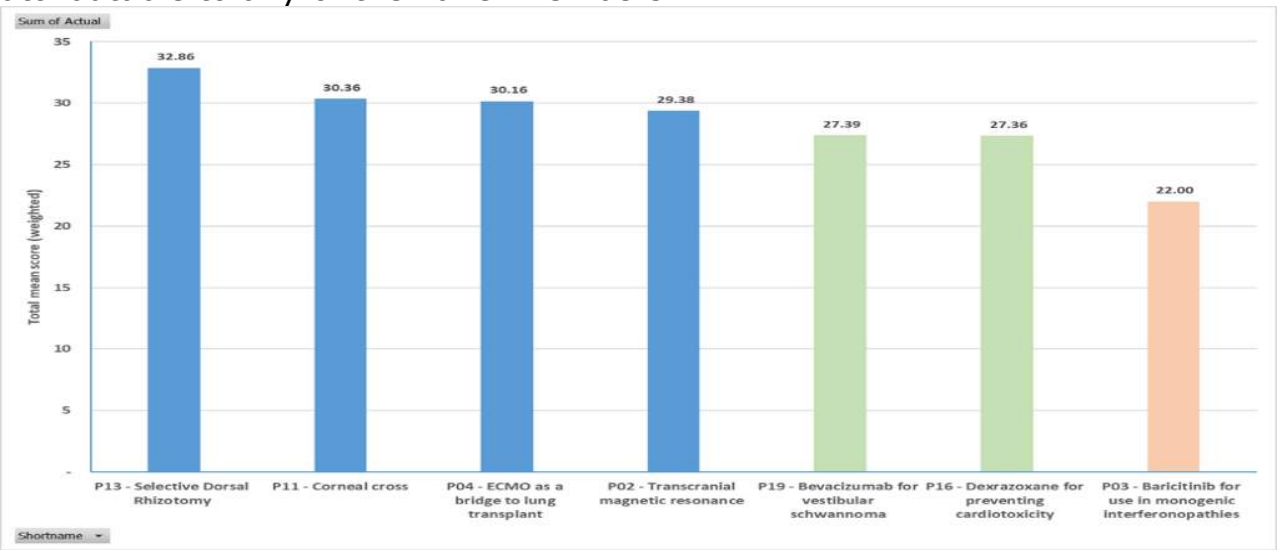
The scoring and ranking of interventions by the WHSSC Prioritisation Panel is carried out based on an agreed methodology and presents a fair and transparent process to ensure that evidence-based healthcare gain and value for money is maximised. Each intervention presented to the Panel was supported by a comprehensive evidence review. Panel members are asked to score each intervention (1 - 10) against each of the five criteria listed below. A high score indicates consistency with each of the criteria.

- Quality and strength of the evidence of clinical effectiveness
- Patient benefit (clinical impact/outcomes)
- Economic assessment
- Burden of disease (population impact)
- Potential for improving/reducing inequalities of access.

Once the Prioritisation Panel has considered all the interventions the results are tabulated and presented back to the Panel at the end of the meeting. Members are then asked to split the final prioritised list into 'high', 'medium', 'low' and 'no routine commissioning' based on their overall score.

5.4.3 Results

The highest possible score for each intervention is 50. All 14 members voted using an online MS Forms system. All of the results were anonymised and are un-attributable to any of the Panel members:



At the close of the meeting the Panel discussed and recommended each intervention a priority status for each intervention for funding in the ICP as either high, medium or low, with the resulting outcome:

Intervention	Priority for Funding
Selective Dorsal Rhizotomy (SDR) for the treatment of spasticity in Cerebral Palsy (children aged 3 – 9 years)	**HIGH**
Corneal cross-linking to treat Keratoconus (children)	
Extracorporeal Membrane Oxygenation (ECMO) as a bridge to lung transplant (all ages)	
Transcranial Magnetic Resonance guided focused ultrasound Thalamotomy for the treatment of medication-refractory essential tremor (adults)	
Bevacizumab (Avastin) for the treatment of Vestibular Schwannoma in Neurofibromatosis type 2 (all ages)	**MEDIUM**
Dexrazoxane for preventing Cardiotoxicity in children and young people (<25 years) receiving high-dose Anthracyclines or related drugs for the treatment of cancer	
Baricitinib for use in monogenic interferonopathies (adults and children 2 years and over)	**LOW** **(not for routine commissioning - IPFR)**

5.5 Advanced Therapeutic Medicinal Products (ATMPs)

WHSSC is working closely with the national Advanced Therapies Programme Board arrangements to commission the new services that are emerging from the strategy. WHSSC's role in this includes ongoing horizon scanning of new therapies; working with providers to deliver as much of these therapies as possible within Wales; developing the appropriate service specifications and policies to commission and then to procure the services from the appropriate providers. This involves working with NHS England designated providers where appropriate for ATMPs for rare diseases.

The number of approved ATMPs is steadily growing and is expected to accelerate as new indications are considered by the NICE process. The pandemic has had some impact on the pace of new ATMPs being considered including backlogs in submission and prioritisation but this is expected to return to normal over the remainder of 2021-2022 and into 2022-2023.

New ATMPs implemented in 2021-2022 include new treatments for spinal muscular atrophy and inherited vision loss. Both these services have been commissioned from a very small number of designated centres in England owing to rarity and low case numbers requiring an appropriate critical mass. Anticipated volumes in total in these new indications are estimated to be between 5-10 over 2021-2022 and 2022-2023.

One of the commissioning challenges is to be able to accurately predict the volumes of cases and type that will be approved in a given year as in practice numbers will be driven by the final company submissions to NICE. Indications for treatment will be influenced by incidence, position in treatment pathway, prevalence of treatable patients and the relative evidence of effect from trial data. A number of NICE technology appraisals of new ATMPs for cancer patients are expected to be published towards the end of 2021-2022 and into 2022-2023. These include in particular new CAR-T treatments for patients with Haematological Cancers. In order to be able to implement any positive recommendations, WHSSC is working with providers and Welsh Government in relation to the commissioning arrangements and service capacity plans to provide access for patients in Wales to these new therapies. The potential expansion in demand for CAR-T treatments could be material and hence WHSSC is working closely with local providers to plan how best to implement. This is likely to need to push beyond current physical capacity requiring a clear strategic approach linked to the constraints and opportunities of major site redevelopment.

6.0 SPECIALIST SERVICES RECOVERY PROFILE

WHSSC commissions services from a wide range of providers across England and Wales. Recovery positions have been shared by all providers to varying levels of granularity. A summary of the position is shared here with detailed performance information attached at Appendix B.

6.1 Cardiology

6.1.1 Complex Devices

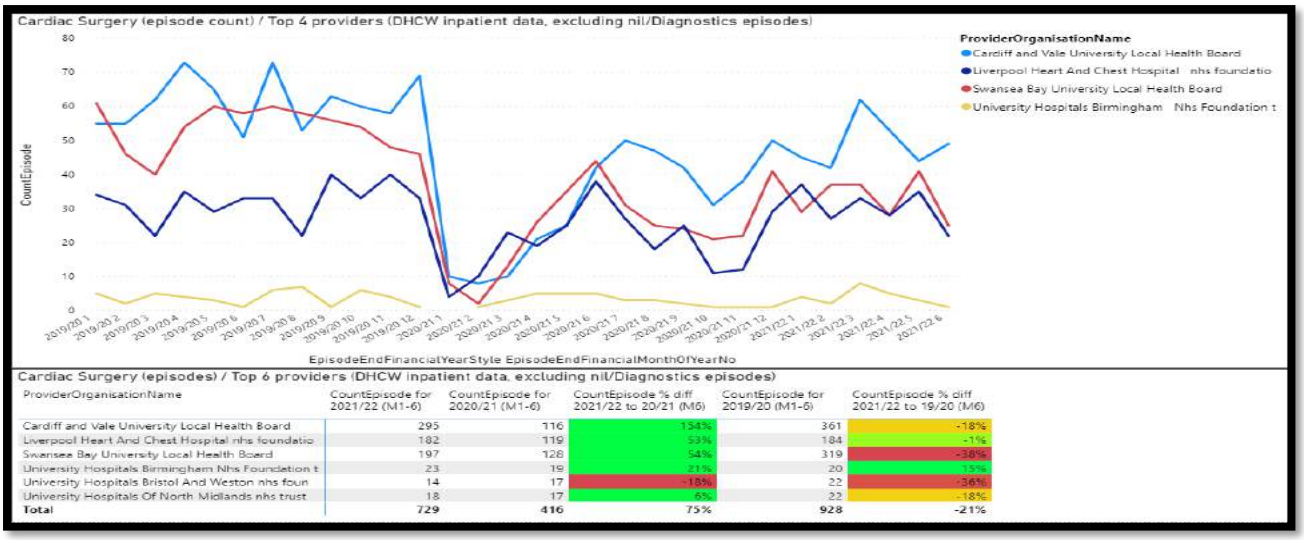
There are no current issues regarding complex devices with either Liverpool Heart and Chest or BCUHB. SBUHB have a number of patients waiting over 36 weeks however a recovery plan is in place with expectations of delivery to LTA levels by the end of Q4. Positions will continue to be monitored via established risk, recovery and assurance meetings.

6.1.2 Primary Percutaneous Coronary Intervention (PCI)

Not specifically associated with recovery as a result of COVID-19, however there remain significant delays in the South East with regard patients being able to access primary PCI. Discussions remain ongoing with WAST.

6.1.3 Cardiac Surgery

The table below highlights the variance in Cardiac Surgery inpatient recovery across the main specialist providers, with Liverpool Heart and Chest Hospital showing the highest and quickest recovery. The main three providers show the expected inverse relationship to the COVID-19 waves across the UK, with activity increasing again.

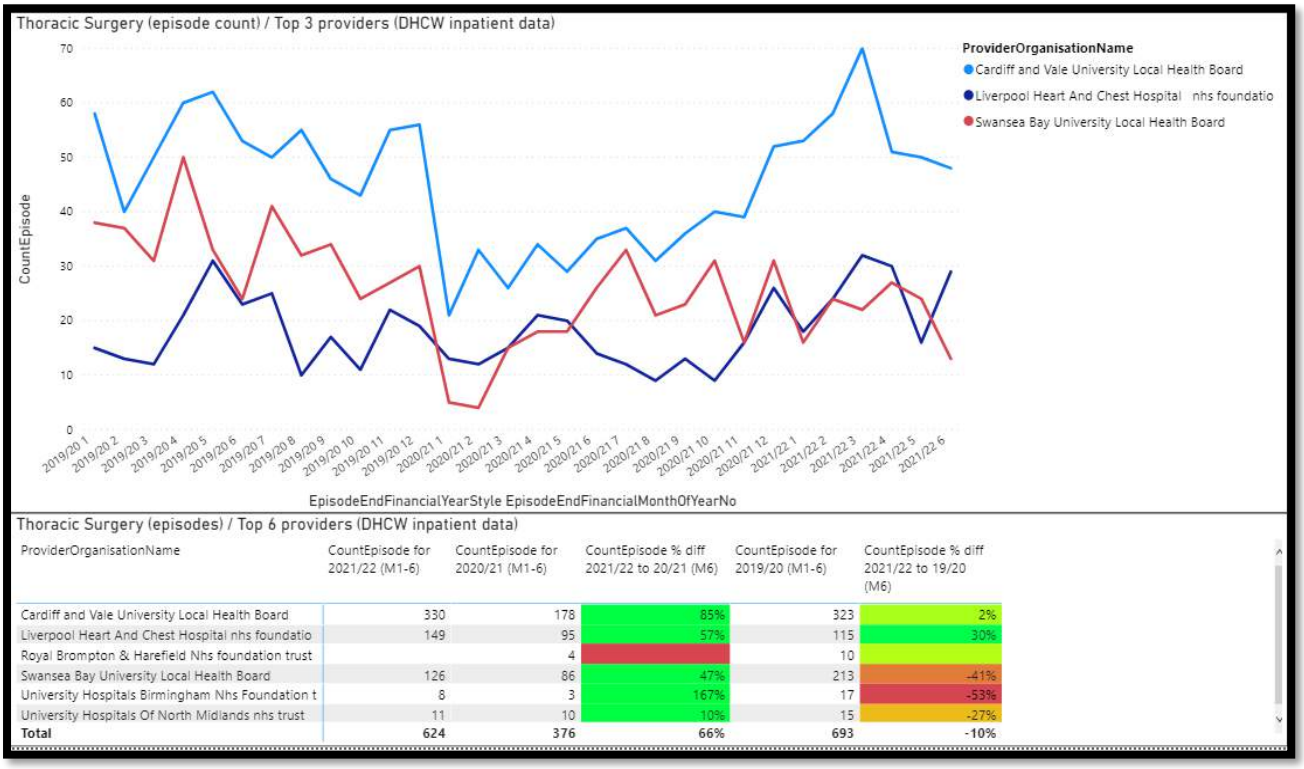


ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Cardiff and Vale University Local Health Board	295	116	154%	361	-18%
Liverpool Heart And Chest Hospital nhs foundatio	182	119	53%	184	-1%
Swansea Bay University Local Health Board	197	128	54%	319	-38%
University Hospitals Birmingham Nhs Foundation t	23	19	21%	20	15%
University Hospitals Bristol And Weston nhs foun	14	17	-18%	22	-36%
University Hospitals Of North Midlands nhs trust	18	17	6%	22	-18%
Total	729	416	75%	928	-21%

Data source: DHCW central data warehouse; all inpatient activity excl. non-procedure/diagnostic episodes

There was a concerning drop in the volume of Cardiac inpatient activity reported during the COVID-19 period, which is recovering but stood at 48% less activity overall in 2020-2021 compared to 2019-2020. Using activity to date this year 2021-2022 (Month 6), activity is already 75% more than last year, but is 21% lower than to the same month in 2019-2020. Historically, Cardiac surgery is seen as an urgent elective specialty with high levels of emergency and inter hospital referrals and lower levels of elective referrals. The decrease is therefore of concern and indicative of a significant risk of harm during the highest COVID-19 periods. The risk of COVID-19 infection in cardiac patients was a real risk identified at the outset of the period and outcomes for positive patients were poor. However, given the seriousness of the impact of non-intervention it is essential that activity levels and the associated referral pathways are reinstated as soon as possible. There has been some proactive switching into TAVI for selected sub groups of patients but numbers are not material.

6.2 Thoracic Surgery
Activity and Access Rate Summary



ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Cardiff and Vale University Local Health Board	330	178	85%	323	2%
Liverpool Heart And Chest Hospital nhs foundatio	149	95	57%	115	30%
Royal Brompton & Harefield Nhs foundation trust		4		10	
Swansea Bay University Local Health Board	126	86	47%	213	-41%
University Hospitals Birmingham Nhs Foundation t	8	3	167%	17	-53%
University Hospitals Of North Midlands nhs trust	11	10	10%	15	-27%
Total	**624**	**376**	**66%**	**693**	**-10%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Thoracic Surgery inpatient recovery across the main specialist providers, with Liverpool Heart and Chest Hospital showing the highest and quickest recovery to activity actually 30% higher to date than 2019-2020. CVUHB is also showing 2% higher activity than 2019-2020 to the same month. However, SBUHB is showing a 41% drop in activity to date compared to 2019-2020, although this is still 47% more than what was able to be delivered to this point in 2020-2021.

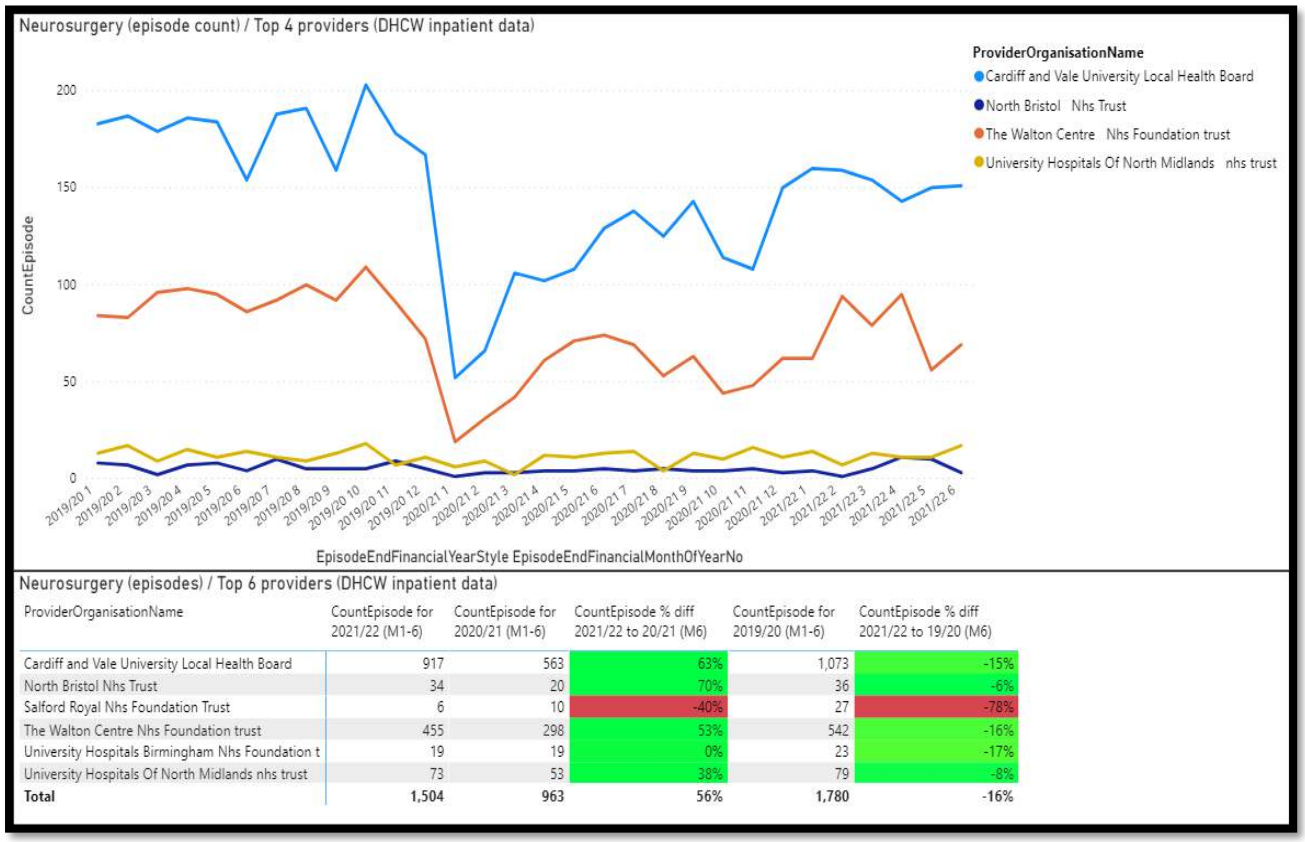
The drop in the volume of Thoracic inpatient activity reported over the COVID-19 period stood at 35% less activity overall in 2020-2021 compared to 2019-2020. Using activity to date this year 2021-2022 (Month 6), activity is 10% less than 2019-2020, but is 66% higher in total than to the same month last year.

Access rates across the HBs varied across the past two years, which is to be expected given the relatively low activity numbers (about 73/month), but should still be monitored.

It is important to note that over the last 12 months, collaborative arrangements have been in place between the two South Wales thoracic surgery services to use the joint capacity across the 2 services to ensure equitable access. This ensures that if the usual centre capacity is constrained due to the impact of the pandemic (or potentially other factors) and there is available capacity at the other south

Wales service, patients can be cross referred and access treatment on the basis of clinical need. This means that activity at a particular centre does not directly translate into access for residents of HBs for which it is the usual provider.

6.3 Neurosurgery
Activity and Access Rate Summary



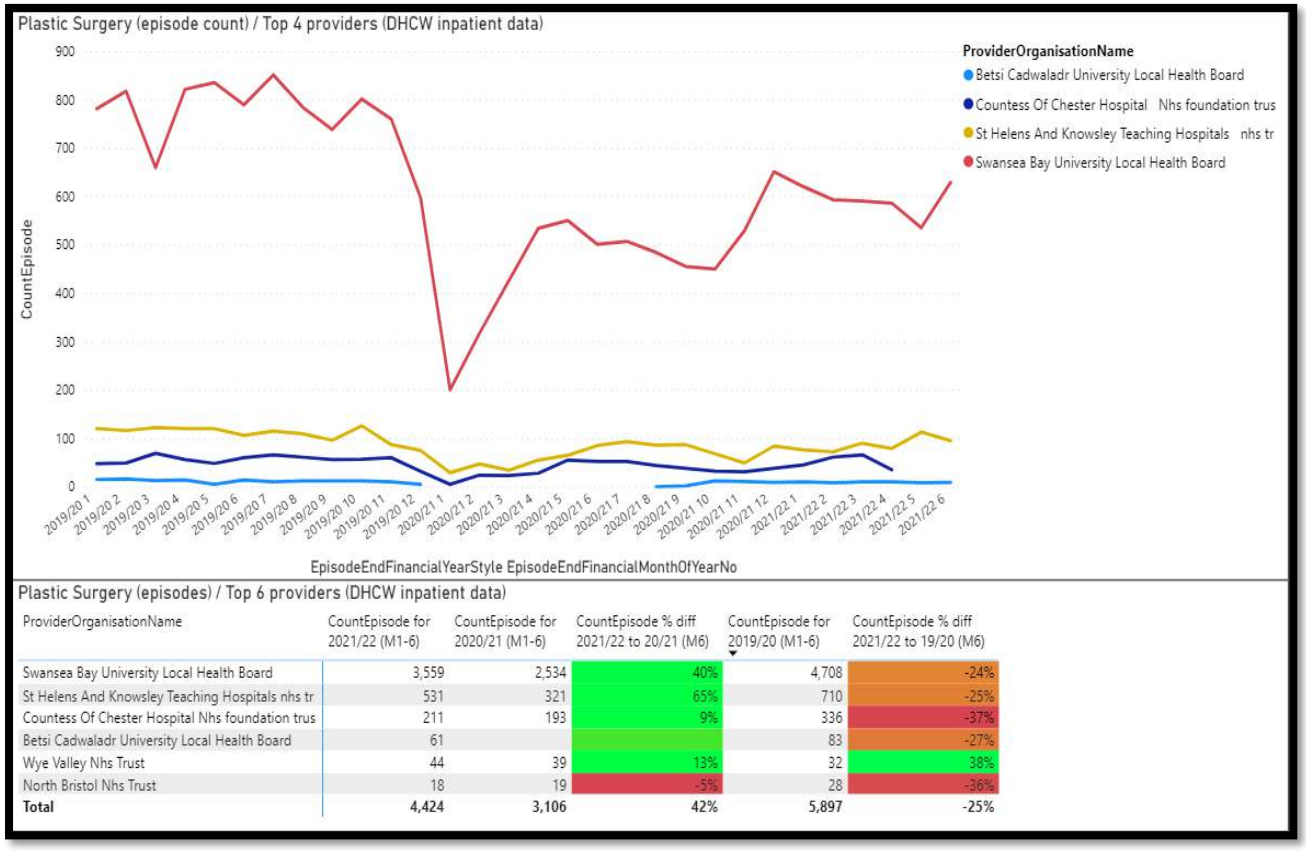
Neurosurgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Cardiff and Vale University Local Health Board	917	563	63%	1,073	-15%
North Bristol Nhs Trust	34	20	70%	36	-6%
Salford Royal Nhs Foundation Trust	6	10	-40%	27	-78%
The Walton Centre Nhs Foundation trust	455	298	53%	542	-16%
University Hospitals Birmingham Nhs Foundation t	19	19	0%	23	-17%
University Hospitals Of North Midlands nhs trust	73	53	38%	79	-8%
Total	**1,504**	**963**	**56%**	**1,780**	**-16%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Neurosurgery inpatient recovery across the main specialist providers, with Cardiff and the Walton Centre showing similar recoveries with reductions of 15% and 16% this year compared to the same point in 2019-2020. Overall activity was 39% less in 2020-2021 than in 2019-2020, with the equivalent figure being 16% less so far in 2021-2022. Please note the University Hospital North Midlands activity above primarily relates to North Wales residents, which is paid for through a local contract and not via WHSSC.

6.4 Plastic Surgery Plastic Surgery (excl. Burns) Activity and Access Rate Summary



Plastic Surgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Swansea Bay University Local Health Board	3,559	2,534	40%	4,708	-24%
St Helens And Knowsley Teaching Hospitals nhs tr	531	321	65%	710	-25%
Countess Of Chester Hospital Nhs foundation trus	211	193	9%	336	-37%
Betsi Cadwaladr University Local Health Board	61			83	-27%
Wye Valley Nhs Trust	44	39	13%	32	38%
North Bristol Nhs Trust	18	19	-5%	28	-36%
Total	**4,424**	**3,106**	**42%**	**5,897**	**-25%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Plastic Surgery inpatient recovery across the main specialist providers, with an overall reduction of 25% so far this year compared to 2019-2020. The total reduction was 39% across the full year of 2020-2021. They all show the expected inverse relationship to the COVID-19 waves across the UK, with activity increasing again after the first few months.

Note that the Countess of Chester Hospital activity above primarily relates to North Wales residents, which is paid for through a local contract and not via WHSSC. Wye Valley patients are primarily Powys residents through the WHSSC contract.

6.5 Bariatric Surgery

There has been limited operating activity for bariatric surgery throughout the past year, however there are plans to recommence activity in SBUHB by the end of the year. There is an anticipated residual gap which could be managed through alternate patient pathways.

6.6 Cleft Lip and Palate

6.6.1 Paediatrics

Good recovery has been made within
SBUHB and there are no anticipated problems moving forward. There are no current issues of concern within BCUHB. Both English providers (Alder Hey Children's Hospital (ACH) and Royal Manchester Children's Hospital (RMCH)) are expected to deliver against pre-COVID-19 levels.

6.6.2 Adults

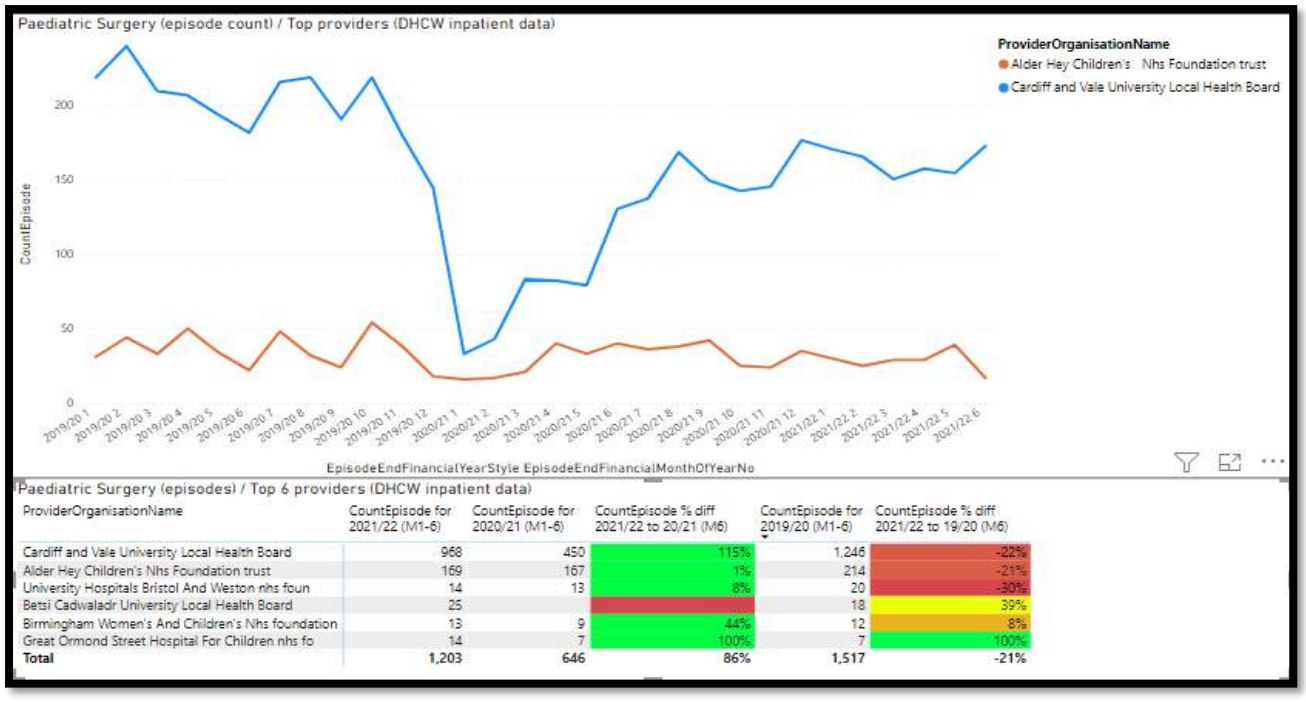
There remains a challenging position in respect of adult services for cleft lip and palate with exploration of alternate pathways being undertaken by the main South East Wales provider.

6.7 IVF

Activity is below contracted levels in the Welsh Fertility Centre, with alternate pathways being explored. Both English providers (The Hewitt Centre at the Liverpool Women's Hospital and Shropshire and Mid Wales Fertility Centre) have recovered and are expected to deliver above contracted activity.

6.8 Paediatric Surgery

Activity and Access Rate Summary



Paediatric Surgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Cardiff and Vale University Local Health Board	968	450	115%	1,246	-22%
Alder Hey Children's Nhs Foundation trust	169	167	1%	214	-21%
University Hospitals Bristol And Weston nhs foun	14	13	8%	20	-30%
Betsi Cadwaladr University Local Health Board	25			18	39%
Birmingham Women's And Children's Nhs foundation	13	9	44%	12	8%
Great Ormond Street Hospital For Children nhs fo	14	7	100%	7	100%
Total	**1,203**	**646**	**86%**	**1,517**	**-21%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Paediatric Surgery inpatient recovery across the main specialist providers, with ACH initially showing the highest and quicker recovery. The main 2 providers show the expected inverse relationship to the COVID-19 waves across the UK, with activity increasing again.

There was a drop in the volume of Paediatric Surgery inpatient activity reported during the period, which is recovering but was 38% less activity overall in 2020-2021 compared to 2019-2020.

Activity so far in 2021-2022 shows an 86% increase compared to last year at this point, and 21% less than 2019-2020, with the 2 main providers being roughly the same.

Access rates across the HBs varied as the pandemic initially hit, but have now stabilised to roughly the same split as last year. The highest age group having inpatient episodes are by far the 0-4 age group.

However, inpatient episodes per 100k population varies significantly overall across the HB areas, from 21 to 97, with Cardiff being by far the highest.

ACH had previously reported to WHSSC through their recovery plans that activity was currently higher than pre-COVID-19 levels and a robust plan is in place to manage the small number of patients waiting over 52 weeks. The provider has confirmed that all patients waiting over 52 weeks will be treated before the end of March 2022.

Cardiff and Vale are reporting a significant number of patients waiting over 52 weeks. In dialogue with the provider, there are a number of contributing factors to the waiting list including nurse capacity, bed capacity and theatre availability. The HB are refining the recovery plan for paediatrics to detail the trajectory for managing the patient cohort. WHSSC have sought assurance on the clinical review and communication with patients on the waiting list. There are 50 newly qualified nurses due to start within the Children's hospital over the coming months, which will work towards alleviating the nursing and bed pressures.

6.9 BMT and CAR-T

There are capacity issues within CVUHB for the provision of BMT with discussions on-going as to whether more patients can be seen at SBUHB. There are currently no issues with NHS England providers.

There are also capacity issues within CVUHB for the provision of CAR-T. This is not just a recovery issue and there will need to be a strong plan for the provision of CAR-T within Wales moving forward. There are no issues with providers from within NHS England.

6.10 Summary of Recovery Position

In summary of the recovery position:

- Providers in England have been able to recover faster and to a higher level of activity than those within NHS Wales

- The main challenges are in South Wales, and areas of particular concern are:
  - Bariatric Surgery
  - Cardiac Surgery
  - Plastic Surgery
  - Neurosurgery
  - Paediatric Surgery
- There is work to be undertaken to project residual gap
- There is work to be done to understand latent demand for specialist services which could occur as a result of investment in the secondary care part of patient pathways
- There is a need to develop a plan for outsourcing/cross patient lists etc.
- Assurance is needed that the plans for recovery are achievable, with robust monitoring arrangements in place to report on further deterioration or emerging risks

A set of principles have been developed by WHSSC through discussions with Joint Committee in respect of recovery as follows:

- A focus on equity – recovery position should be to that of the best
- Patients regardless of where they live should be treated in priority order, as quickly as possible, as close to home as possible
- Patients will be moved between providers should clinical priorities be unable to be met or waiting times are significantly longer
- Alternate pathways options should be considered

WHSSC will continue to work with provider HBs to understand the position, performance manage against recovery profile, and offer commissioner support as necessary. Regular reports will be made to Joint Committee in respect of the position.

7.0 COMMISSIONING TEAM PRIORITIES FOR THE ICP PERIOD

This section of the ICP outlines the priorities within each of the WHSSC commissioning teams for the period of the ICP.

7.1 Cancer and Blood Commissioning Team

7.1.1 Specialist Radiotherapy Molecular Radiotherapy (MRT)

It is currently being proposed that WHSSC leads an all Wales strategic programme for the future development of MRT to meet the needs of the population of Wales. The evidence base for MRT is rapidly developing with the potential for new treatments becoming available in the near future. NICE is currently appraising the evidence for MRT in the treatment of prostate cancer which, if positive, would require a step change in capacity. The Cancer and Blood commissioning team will:

Scheme	Actions	Implementation Timeline
MRT	Work to commission MRT in alignment with the all Wales strategic programme.	Q4

7.1.2 SABR provision for North Wales

BCUHB has indicated its interest in becoming a commissioned provider of SABR for the population of North Wales. Currently patients travel to Liverpool for SABR treatment. Building on work conducted in 2021-2022 to commission a second provider of SABR in South Wales, WHSSC will scope and take forward a designation process for commissioning a SABR service within North Wales.

Scheme	Actions	Implementation Timeline
SABR	Scope and take forward a designation process for commissioning a SABR service within North Wales.	Q4

7.1.3 Thoracic Surgery

WHSSC will continue to provide commissioner support to the implementation project board for the future single Thoracic Surgery Service for South West, Mid and South East Wales based at Morriston Hospital, Swansea. This will include input and support as required to business case development for capital and revenue implications to deliver the service model.

7.1.4 Genomics

WHSSC will continue to work closely with the All Wales Genomics Service to support the continued strategic development of genetic testing for Wales including the test directory, new pharmacogenetic tests, repatriation and infrastructure development.

7.1.5 Extracorporeal Membrane Oxygenation (ECMO)

ECMO has been identified as a potential area for service repatriation at an appropriate time further to the completed implementation of existing plans to increase critical care capacity in Wales. WHSSC will work with the Critical Care Network to explore at the appropriate time the potential for developing an ECMO service within Wales provided it can be delivered safely and sustainably. This work will be taken forward in accordance with the WHSSC designation framework.

Scheme	Actions	Implementation Timeline
Extracorporeal Membrane Oxygenation (ECMO) as a bridge to lung transplant (all ages)	To develop the commissioning policy for ECMO as a bridge to transplant.	Q2

7.1.6 Specialised Haematology and Immunology

WHSSC is commissioning a piece of work to provide clinical advice in relation to the boundary between specialised and non-specialised commissioning in haematology and immunology. In particular, the work will focus on the BMT pathway, new services such as Thrombotic Thrombocytopenic Purpura, and secondary immunodeficiency. Depending on the outcome of this work, there may be actions within the work programme 2022-2023 required to implement any changes that may be agreed to commissioning arrangements for these services.

Scheme	Actions	Implementation Timeline
Haematology/immunology	To commission a review of the scope of specialised commissioning of haematology and immunology	Q1

7.1.7 CIAG Schemes

The following scheme was prioritised for inclusion in the WHSSC ICP through the Clinical Impact Advisory Group process:

Scheme	Actions	Implementation Timeline
Psychology support for Paediatric Plastic Surgery	To work with stakeholders to develop and implement models for the provision of psychology support	Q3

7.2 Cardiac Commissioning Team

7.2.1 Improving Access to Pulmonary Hypertension (PH) Services

The Cardiac Commissioning team intend to continue the work started in 2021, which scoped the feasibility of providing a more local PH service to reduce delays in the patient pathway, avoid duplication of diagnostics and improve the overall patient experience. Whilst the future model is yet to be agreed, early indications are that the preferred clinical model would be the development of a satellite clinic supported from one of the main NHS England specialist providers.

Scheme	Action	Implementation Timeline
Improving access to Pulmonary Hypertension (PH) services	Continue engagement with NHSE and local HB to implement the agreed clinical model.	Q2

7.2.2 Cardiac Surgery

The Cardiac Commissioning Team has committed to work with both South Wales providers to scope out the future provision of Cardiac surgery for the South Wales population. The overall aim is to review the demand and capacity requirements, taking account of future sustainability and access and the growth in interventional cardiology procedures in order to inform the development of a strategy for the ongoing delivery of the service.

Scheme	Action	Implementation Timeline
Strategy for future provision of cardiac surgery services for South Wales	Review demand and capacity requirements. Continue to engage with stakeholders with regards to the future delivery of service. Develop and implement a service specification for cardiac surgery.	Q2 dependant on further intelligence around current cardiology backlogs and HB recovery plans Q2

7.2.3 Inherited Cardiac Conditions

The Commissioning Team intend to continue the work commenced during 2021 to develop the full service model (Phase 2) for the delivery of Inherited Cardiac Conditions.

Scheme	Action	Implementation Timeline
Developing a full service model for the delivery of ICC services	Implementation of a service specification for ICC. Continued engagement with clinical working group. Develop a proposal for full service model to link with the Phase 1 investment.	Q2 Q2 Q2

The following service have been supported for additional investment during 2022-2023:

Scheme	Actions	Implementation Timeline
Improving Access for Patients with or Suspected Inherited Cardiac Conditions (Phase 1)	Commissioning team to develop the funding release paper.	Q2

7.3 Mental Health and Vulnerable Groups Commissioning Team

7.3.1 Mental Health Strategy

Programme governance for the mental Health Strategy will be provided through the WHSSC reporting structure.

There will be seven service work streams:

• CAMHS (including FACTS (Forensic Adolescent Consultation and Treatment Service) • Learning Disabilities • Secure Services (Men) • Eating Disorders	• Women's Services • Perinatal Mental Health • Neuropsychiatry

There will be four enabling work streams to support strategy development:

- Programme Structure and Development
- Finance and Information
- Quality and Governance
- Workforce

An overarching work stream on "Transition" will be considered through the programme team in order to ensure alignment. The stream will consider issues of transition between age groups, services and tiers of mental health support. Alongside the strategy will sit the Implementation Plan for 2022-2025 which will provide the key commissioning priorities for the term of the strategy.

The key priority for the Mental Health Portfolio will be the implementation of the Specialised Services Strategy for Mental Health. The strategy will include the following provisions:

7.3.2 Publication of Strategy for Mental Health Specialised Services

High quality specialised care provided to patients in the least restrictive environment appropriate for their treatment.

Providing more care closer to home wherever safe and practicable to do so; primarily in the Welsh NHS but where necessary, and appropriate, with third sector or private sector partners.

Scheme	**Action**	**Implementation Timeline**
Publication of Strategy for Mental Health Specialised Services	Alignment of draft Mental Health Specialised Services Strategy with Together for Mental Health and sign off	Q1

7.3.3 Implementation of Mental Health Specialised Services Strategy

Developing commissioning models which add value and strengthen the whole pathway approach to service delivery supporting the transforming health care agenda within Wales.

Scheme	**Action**	**Implementation Timeline**
Implementation of Mental Health Specialised Services Strategy	Implementation plan to be followed to ensure actions for 2022-2023 are met and foundations for implementing 2023-2024 actions are in place. Continued engagement with stakeholders and programme board.	Q4 Q4

7.3.4 Policy and Service Specification Development

Addresses the challenge of improving outcomes and transitions between different parts of pathway and commissioning organisational boundaries.

Scheme	Action	Implementation Timeline
Policy and Service Specification Development	Develop and/or revise policies and service specifications to meet the needs of the strategy and subsequent services developments	Q3

7.3.5 Funding Options to Consider Developments as a Result of the Strategy

To prioritise investment in areas with demand and capacity constraints and areas with extended waiting times and/or gaps in service.

Scheme	Action	Implementation Timeline
Funding options to consider developments as a result of the strategy	Funding options sourced and applications made as appropriate to ensure funding available to achieve. implementation plan Identification of potential CIAG schemes	Q2 Q2 Q2

7.4 Neurosciences Commissioning Team

The following offer the priorities for the Neuroscience Commissioning Teams for the first year of the ICP 2022-2025 are as follows:-

7.4.1 Specialised Rehabilitation

A key priority for the Neurosciences and LTC Commissioning Team in 2022-2023 is the development of a Specialised Rehabilitation Strategy for Wales. The strategy will develop a commissioning model which will strengthen the whole pathway approach to service delivery. A gap analysis will be undertaken to address the challenge of meeting national standards to ensure timely access to specialised rehabilitation treatment and improve outcomes for patients across the clinical pathway.

Scheme	Actions	Implementation Timeline
Specialised Rehabilitation Strategy	To provide a sustainable and equitable service model across Wales for Neuro rehabilitation and Spinal Injury Services To work towards achieving national standards. Explore the development of a Rehabilitation network across Wales.	Q4 Q4 Q4

7.4.2 Commissioning of a Tertiary Thrombectomy Centre in South Wales

A business case for the establishment of a tertiary Mechanical Thrombectomy centre in South Wales will be developed within the timescale of this plan. The provision of a local fully funded Mechanical Thrombectomy service in South Wales will enhance the provision and accessibility of this life changing procedure for the south Wales population.

Scheme	Actions	Implementation Timeline
Commissioning of a Tertiary Thrombectomy Centre in South Wales	Address long term commissioning arrangements Ensure sustainability, deliverability and access of the Mechanical Thrombectomy service Improve patient outcomes with the development of a more local regional centre	Q3 Q3 Q3

7.4.3 Sustainability of the South Wales Neurosurgery Service – Cardiff and Vale UHB

This development will address the sustainability of the service and staffing deficits, thereby, enabling an improvement in access and outcomes for patients. This includes investment in theatre capacity, clinical nurse specialist and consultant workforce to address the challenge of meeting national standards.

Scheme	Actions	Implementation Timeline
Sustainability of the South Wales Neurosurgery Service – Cardiff and Vale UHB	Address the sustainability and inequity of the service to meet the Safe Neurosurgery national standards, which is comparable to centres in NHS England	Q3

7.4.4 Phase 2 of the Neuropsychiatry Care Pathway – Cardiff and Vale UHB

This development will address the sustainability of the Welsh Neuropsychiatry Service by enhancing the staffing establishment in line with BSRM standards. This will ensure staff have the specific training, skill and expertise to meet the needs of the existing service and provide an equitable service across Wales for those with an acquired brain injury, who have developed neuropsychiatric sequelae and require specialised services to support their recovery and adjustment. The investment will enable the service to develop and deliver a Liaison model of working; creating stronger relationships with Welsh HBs to provide training and support to teams caring for patients requiring specialist neuropsychiatric rehabilitation.

Scheme	Actions	Implementation Timeline
Phase 2 of the Neuropsychiatry Care Pathway – Cardiff and Vale UHB	To provide a sustainable and equitable service model across Wales for Neuropsychiatry services	Q4

7.4.5 Sustainability and Equity of the North Wales Prosthetic Service and the Provision of an Outreach Service for Rural Communities

This development will see an additional prosthetist to deliver an equitable service to both War Veterans and the civilian population. The investment will ensure resilience in the overall Prosthetic Service and improve waiting times.

Scheme	Actions	Implementation Timeline
Sustainability and equity of the North Wales Prosthetic service and the provision of an outreach service for rural communities	To provide an equitable service to the civilian population and war veteran clients. Address service sustainability to improve service provision to meet clients' needs	Q2 Q2

7.4.6 Joint Proposal from North and South West Wales Prosthetic Service for Psychology Support to Ensure Equity across both Regions

This development will improve access to psychology services in order to provide equity of access to psychological care and in line with the provision at the Cardiff centre.

In addition, with the funding of psychology support will allow the service to address some of the associated mental health elements due to traumatic limb loss, which will have an impact on client outcomes and enable the service to provide an effective pre-habilitation to clients awaiting amputation.

Scheme	Actions	Implementation Timeline
Sustainability and equity of the North Wales Prosthetic service and the provision of an outreach service for rural communities	To provide an equitable service to the civilian population and war veteran clients. Address service sustainability to improve service provision to meet clients' needs	Q2 Q2

7.4.7 Repatriation of Adolescent Paediatric Cochlear Implant Patients from Manchester

The proposal sought to repatriate the children who have cochlear implants at RMCH to be seen locally in North Wales. A decision was made that this process could be managed outside of the CIAG process and the WHSS Team will work with colleagues in BCUHB to take this issue forward.

Scheme	Actions	Implementation Timeline
Repatriation of adolescent Paediatric Cochlear Implant patients from Manchester	To deliver a more local and accessible service for Paediatric Cochlear Implant patients in the North Wales region	Q3

7.5 Women's and Children Commissioning Team

The following offer the priorities for the Women and Children's Commissioning Teams for the first year of the ICP 2022-2025 are as follows:

Scheme	Actions	Implementation Timeline
Paediatric Orthopaedic Surgery	Service specifications are developed for the secondary and tertiary elements of provision, to ensure that the entire pathway is commissioned effectively. Needs assessment and gap analysis to inform future requirements.	Q3 Q3

7.5.1 Specialised Paediatric Spinal Surgery

Paediatric Spinal Surgery is a specialised service. It is proposed that the responsibility for commissioning the service is formally delegated to the Welsh Health Specialised Services Committee, which will be a key priority for the commissioning team during 2022. Initial steps will include the appointment of a Paediatric Spinal Clinical Nurse Practitioner to ensure that patients across South and West Wales have timely access to surgical treatment. A further gap analysis will be undertaken as part of the development of the WHSSC Paediatric Strategy.

Scheme	Actions	Implementation Timeline
Specialised Paediatric Spinal Surgery	A Paediatric Spinal Clinical Nurse Practitioner would ensure that patients across South and West Wales have timely access to surgical treatment A further gap analysis will be undertaken as part of the development of the WHSSC Paediatric Strategy.	Q3 Q3

7.5.2 Paediatric Pathology

The proposal for the Paediatric Pathology Service is to commission a sustainable service 52 weeks of the year. This will ensure that the volume of required work can be met as well as developing a clear succession plan for the service. The work will be undertaken in Q1 of 2022.

Scheme	Actions	Implementation Timeline
Paediatric Pathology	To commission a sustainable service 52 weeks of the year. This will ensure that the volume of required work can be met as well as developing a clear succession plan for the service.	Q1

7.5.3 Paediatric Gastroenterology

The proposal is to establish quarterly outreach clinics in each of the three District General Hospitals within BCUHB. These will be joint clinics with the local paediatric team along with specialist Gastroenterologists from ACH. This will provide care closer to home for the children and families as well as enhanced training and education for paediatricians and nursing staff.

Scheme	Actions	Implementation Timeline
Paediatric Gastroenterology – north Wales	Establish Qly outreach clinics in each of the three DGH's within BCUHB. These will be joint clinics with the local paediatric team along with Specialist Gastroenterologists from AHCH.	Q3
	This will provide care closer to home for the children and families as well as enhanced training and education for paediatricians and nursing staff.	Q3
	This proposal will result in positive earlier intervention, and therefore improve safety and clinical outcomes.	Q3

7.6 Welsh Renal Network

All submissions from the HBs to the WHSSC prioritisation process via the Clinical Impact Assessment Group (CIAG) were returned to the WRCN for consideration. To ensure a fair and transparent process, the WRCN have adapted the CIAG methodology for identifying priorities and it is anticipated that this will be run annually.

The proposals received in this round sought investment in all three HBs that host the regional renal centres and were aligned to the achievement of the WRCN priorities as set out overleaf:

7.6.1 Procurement of a Sustainable High Quality Service in South West Wales

Complete procurement of a sustainable high quality service in South West Wales, including geographical and capacity expansion to include Neath Port Talbot and Bridgend localities by March 2022. Oversee contract mobilisation and delivery process.

Scheme	Actions	Implementation Timeline
Procurement of a sustainable high quality service in South West Wales including geographical and capacity expansion to include Neath Port Talbot and Bridgend localities by March 2022	Oversee contract mobilisation and delivery process.	Q2

7.6.2 Improvements to Access to Home Dialysis and Re-tender the National Home Dialysis Framework

Further improvements to access to home dialysis, utilising the learning gained from the peer review process and by embedding Shared HD Care in all unit dialysis services. To ensure deliver of value for money and ease of access to equipment to facilitate improved uptake of home dialysis.

Scheme	Actions	Implementation Timeline
Improvements to access to home dialysis	Peer review process and embed Shared HD Care in all unit dialysis services. Re-tender the National Home Dialysis Framework to ensure deliver of value for money and ease of access to equipment to facilitate improved uptake of home dialysis.	Q4

7.6.3 Establishment of a Quality Assurance Dashboard that Encompasses Key Metrics

Establishment of a quality assurance dashboard that encompasses key metrics such as nurse to patient ratio's, Datix reports, PREM and PROM outcomes to enable proactive identification of areas requiring service improvement programmes.

Scheme	Actions	Implementation Timeline
Establishment of a quality assurance dashboard that encompasses key metrics	Produce dashboard to include key metrics such as nurse to patient ratio's, Datix reports, PREM and PROM outcomes to enable proactive identification of areas requiring service improvement programmes	Q3

7.6.4 National Quality Improvement Programme

Embed a national quality improvement programme relating to safe cannulation to preserve vascular access.

Scheme	Actions	Implementation Timeline
Safe cannulation to preserve Vascular access.	Embed a national quality improvement programme relating to safe cannulation to preserve vascular access	Q4

7.6.5 Delivery of the Transformation Fund Projects to Digitise Kidney Care in Wales

To realise the benefits and complete the delivery of the Transformation Fund projects to digitise kidney care in Wales. Patient education and training to be linked to the findings of the Dialysis Choices research study to maximise impact.

Scheme	Actions	Implementation Timeline
Delivery of the Transformation Fund projects to digitise kidney care in Wales	To realise the benefits and complete the delivery of the Transformation Fund projects to digitise kidney care in Wales. To link patient education and training to the findings of the Dialysis Choices research study to maximise impact.	Q4

7.6.6 Supporting Patients to Manage the Wider Aspects of Health

To work proactivity with Local Authority, Charity and third sector partners to provide a structured approach to supporting patients to manage the wider aspects of health i.e. Mental Health, Hardship and Housing.

Scheme	Actions	Implementation Timeline
Supporting patients to manage the wider aspects of health i.e. Mental Health, Hardship and Housing.	To work proactively with Local Authority, Charity and third sector partners to provide a structured approach to support patients to manage the wider aspects of health	Q1
Paediatric Gastroenterology – north Wales	Establish quarterly outreach clinics in each of the three DGH's within BCUHB. These will be joint clinics with the local paediatric team along with Specialist Gastroenterologists from AHCH.	Q3

8.0 SERVICES PRESENTING AS IN YEAR RISKS

8.1 Welsh Artificial Eye Service Risk and Solution

The Welsh Artificial Eye Service currently has 1,985 patients and accepts approximately 80 new patents per year. This is a lifelong service as patients are never discharged and will continue to require follow up care.

A number of risks have been identified within the service:

- There are currently only three Band 6 Orbital Prosthetics providing the service across Wales.
- The service is now at full capacity with no contingency plan for long-term absence or retirement.
- Basic training take 2 years with advanced training required for complex cases.
- The workforce required to safely and sustainably deliver the service is not readily available, as there is no surplus of clinicians, active succession planning is required to ensure continuation of the service to patients.

In order to address the above, the establishment needs to be uplifted by one WTE Band 6. In house training will be provided. Without funding this issue is likely to present as an in-year risk.

9.0 REALIGNMENT OF COMMISSIONING

During the period of this plan, WHSSC will work with commissioner HBs to determine any services which could more appropriately be provided within an acute setting as they are no longer of a specialist nature and more routinely picked up within a DGH setting. Examples of services which this could apply to are some elements of plastics and Percutaneous Coronary Intervention (PCI).

10.0 GOVERNANCE, ASSURANCE AND RISK MANAGEMENT

10.1 Quality and Patient Safety

The quality of care and experience that patients and their families receive, is central to the commissioning of specialised services. Quality is everyone's business and all of our staff strive to ensure that quality and patient centred services are at the heart of commissioning.

An overarching goal of WHSSC is to improve outcomes for people, whoever they are and wherever they live, by providing them with access to high-quality specialised services. To achieve this aspiration of having a quality-led commissioned service, we need to operate within an effective quality management system. The WHSSC Quality Framework first developed in July 2014 has been revised during the past year, and re-launched as the Commissioning Assurance Framework. This framework provides an overview of what quality looks like, highlights the key principles that underpin it and the arrangements that need to be in place to be assured of high quality services at all times.

The aim of the Commissioning Assurance Framework (CAF) is to move beyond the basic infrastructure to the next stage of driving quality assurance, and more importantly improvement in the services we commission. The fundamental principles underpinning the CAF are to develop open and transparent relationships with our providers, to engage and involve the clinical teams and work in partnership with stakeholders when planning and commissioning services.

The Commissioning Assurance Framework (CAF) is supported by a suite of documents namely the Performance Assurance Framework, Escalation Process, Risk Assurance Framework, and Patient Engagement and Experience Framework which were endorsed by the Quality and Patient Safety Committee in August 2021 and the Joint committee on 07 September 2021. They were designed to support the overarching ambition in order to:

- Gaining assurance regarding the quality of commissioned services
- Identifying and addressing variation in access and outcomes for populations
- Ensuring services are sustainable and there is continuous service improvement.

10.2 Once for Wales Concerns Management System

The reporting and investigation of incidents play an important role in terms of changing culture, transparency and shared learning from when harm occurs. The Once for Wales Concerns Management System (OfWCMS) is a new approach to how NHS organisations in Wales consistently report, record, learn and monitor improvements following incidents, complaints, claims and other adverse events that occur in healthcare. WHSSC is working closely with HBs in ensuring that the platform is utilised to bring vital data together to improve patient safety as well as patient experience.

10.3 Quality Surveillance Information System (QSIS)

NHS England and NHS Improvement monitors the quality of all specialised commissioned in England. The Quality and Nursing Team (QNT) plays a crucial part in assessing the quality of those services and has developed a QNT Framework to discharge these responsibilities. The QNT framework uses defined metrics to collect information from each provider on an annual basis through a self-report process, with the option to follow this up with a peer review process. The report is based on quality indicators and reflect the particular service specification. The self-report process allows QNT to obtain relevant data through an established Quality Surveillance Information System (QSIS) where categories are populated by service responses, then collated centrally and analysed by regional hubs.

10.4 Approach to Risk Management

Risk management (for risks other than health and safety) is embedded in the activities of WHSSC through the WHSSC Risk Management Framework and associated operating procedures. The Corporate Risk and Assurance Framework (CRAF) forms part of WHSSC's approach to the identification and management of strategic and other top level risks. The framework is subject to continuous review by the Executive Director lead for each risk, the Corporate Directors Group Board (CDGB), the joint sub-committees and the Joint Committee.

The CRAF is informed by risks identified by both Directorates and Commissioning Teams which are considered by a monthly risk scrutiny panel that reports to CDGB. Each risk is allocated to an appropriate sub-committee for assurance and monitoring purposes. The CRAF is received by the sub-committees as a standing agenda item, and the Joint Committee receives the CRAF at least twice yearly.

A revised Risk Management Strategy was approved by the Joint Committee in May 2021 and is based on the Risk Management Strategy agreed by CTMUHB (WHSSC's host organisation) so that there is alignment of approach.

The CRAF is an integral part of the system of internal control and defines the extreme potential risks listed on the Corporate Risk Register (scored 15 or above) which may impact upon the delivery of strategic objectives. It also summarises the controls and assurances that are in place or plans to mitigate them. The CRAF

aims to align principal risks, key controls and assurances on controls alongside each of WHSSC's strategic objectives.

Since May 2021, the commissioning teams have been busy reviewing their risks through a peer review process. A risk management workshop has also been held with the Corporate Directors Group during September to review the risks, review the risk scoring in light of COVID-19 and to horizon scan for new risks. The outcomes included: each directorate developing their own directorate specific risk register, the creation of a risk scrutiny group who meet monthly, to scrutinise directorate risks and offer a critical friend process for challenging risk narrative and scoring; and they consider those risks scoring 15 and above which should be escalated to the CRAF in accordance with the risk strategy.

The updated CRAF was approved by the Joint Committee on 09 November 2021. The following risks were identified as posing the greatest risk (20 and above) to the delivery of the WHSSC's commissioning objectives during 2021-2022 (as at Dec 2021):

Ref	Risk Description	Risk Score
27 (P/21/15)	Neonatal service cots - There is a risk that the Neonatal service in Cardiff & Vale are unable to open the commissioned number of cots due to staffing shortages, and as a consequence babies will need to be transferred to other units in Wales or transferred to NHS England	20
18 (CT046)	Waiting Times Cardiac Surgery There is a risk that people waiting for Cardiac Surgery will have their treatment delayed due to long waiting times with a consequence of deteriorating condition and disease progression	20
23 (MH/21/08)	Access to Care Adults with a LD There is a risk that adults with a learning disability will not have access to appropriate care and treatment due to the lack of secure MH beds in Wales and a reduction in access to beds in England.	20
26 (NCC046)	Waiting Times Neuropsychiatry Patients There is a risk that neuropsychiatry patients will not be able to be treated in a timely manner with the appropriate therapy support, due to staffing issues.	20

Finally, a further risk management workshop to be held in February 2022 to review how the RSG process is working, to consider risk appetite and tolerance levels and to discuss developing a Joint Assurance Framework (JAF).

10.5 WHSSC Committee Governance Arrangements

The Auditor General for Wales is CTMUHB's statutory external auditor and the Audit Wales undertakes audits of WHSSC as part of the hosting arrangement.

The Audit Wales review into Committee Governance arrangements at WHSSC was undertaken between March and June 2020, however as a result of the COVID-19 pandemic, aspects of the review were paused, and re-commenced in July. A survey was issued to all HBs and the fieldwork was concluded in October 2020.

The scope of the work included interviews with officers and independent members at WHSSC, observations from attending Joint Committee and sub-committee meetings, feedback from questionnaires issued to HB Chief Executive Officers and Chairs and a review of corporate documents.

The findings were published in May 2021 in the Audit Wales Committee Governance Arrangements at WHSSC report. The report outlined four recommendations for WHSSC and the three recommendations for Welsh Government as outlined below:

Audit Wales Recommendations
WHSSC
R1 Increase the focus on quality at the Joint Committee. This should ensure effective focus and discussion on the pace of improvement for those services in escalation and driving quality and outcome improvements for patients.
R2 Implement clear programme management arrangements for the introduction of new commissioned services. This should include clear and explicit milestones which are set from concept through to completion (i.e. early in the development through to post implementation benefits analysis). Progress reporting against those milestones should then form part of reporting into the Joint Committee.
R3 In the short to medium term, the impact of COVID-19 presents a number of challenges. WHSSC should undertake a review and report analysis on: a. the backlog of waits for specialised services, how these will be managed whilst reducing patient harm. b. potential impact and cost of managing hidden demand. That being patients that did not present to primary or secondary care during the pandemic, with conditions potentially worsening. the financial consequences of services that were commissioned and under-delivered as a result of COVID-19, including the under-delivery of services commissioned from England. This should be used to inform contract negotiation.

R4 The current specialised services strategy was approved in 2012. WHSSC should develop and approve a new strategy during 2021. This should: a. embrace new therapeutic and technological innovations, drive value, consider best practice commissioning models in place elsewhere, and drive a short, medium, and long-term approach for post pandemic recovery. b. be informed by a review of the extent of the wider services already commissioned by WHSSC, by developing a value-based service assessment to better inform commissioning intent and options for driving value and where necessary decommissioning. The review should assess services: • which do not demonstrate clinical efficacy or patient outcome (stop); • which should no longer be considered specialised and therefore could transfer to become core services of HBs (transfer); • where alternative interventions provide better outcome for the investment (change); currently commissioned, which should continue.
Progress against the WHSSC actions outlined within the management response are monitored through the Integrated Governance Committee (IGC) and the Joint Committee (JC).
Welsh Government
R5 Review the options to recruit and retain WHSSC independent members. This should include considering measures to expand the range of NHS bodies that WHSSC members can be drawn from, and remuneration for undertaking the role
R6 This is linked to Recommendation 2 made to WHSSC in this report. When new regional or sub-regional specialised services are planned which are not the sole responsibility of WHSSC, ensure that effective multi- partner programme management arrangements are in place from concept through to completion (i.e. early in the development through to post-implementation benefits analysis).
R7 A Healthier Wales included a commitment to review the WHSSC arrangements along with other national hosted and specialist advisory functions. COVID-19 has contributed to delays in taking forward that action. It is recommended that the Welsh Government set a revised timescale for the action and use the findings of this report to inform any further work looking at governance and accountability arrangements for commissioning specialised services as part of a wider consolidation of current national activity.
Progress against the WG management responses is monitored through discussions between the Chair, the WHSSC Managing Director and the Director General Health & Social Services/ NHS Wales Chief executive.

Once the progress made against the tracker has been considered and approved by the Joint Committee on 18 January 2022 the tracking report will be shared with the NHS Wales Board Secretaries in HBs for inclusion on HB Audit Committee agendas in February/March 2022 to ensure that all NHS bodies are able to

maintain a line of sight on the progress being made, noting WHSSC's status as a Joint Committee of each HB in Wales.

10.6 Governance for Plan Approval

The ICP requires approval through both WHSSC and HB governance structures. As such it will be considered by:

Management Group	December 2021
Joint Committee	January 2022
Welsh Government Submission	February 2022

10.7 Growing Capacity and Capability within WHSSC

The WHSST team have long worked in a structured way to ensure effective commissioning of specialised services. As previously mentioned, the portfolios within WHSSC have grown considerably over recent years, and continues to do so. Within the period of this plan therefore, the WHSST team seeks to grow both in capacity and capability. Of note is the strengthening of programme and project methodologies within the organisation. Investment within the direct running costs of the organisation will offer the ability to:

- Strengthen our information function to deliver real time activity data and meet the recommendation of the WAO report.
- Strengthening our policy development function
- Invest in capability to deliver outcome measurement and support the Value Based Commissioning Agenda
- Embed the use of Blueteq and our new Medicines Management expertise to support the VBC Agenda
- Investing in our capability to deliver needs analysis
- Further investment in our IT infrastructure to support homeworking and reducing our carbon footprint

11.0 FUNDING THE ICP 2022-2023

11.1 Key Assumptions for 2022-2023

The financial planning outlook and planning assumptions for 2022-2023 are summarised as follows:

- **Risk sharing** – There is no risk sharing utilisation adjustment for 2020-2021 activity during COVID-19, the current commissioner shares are based on two year utilisation for the 2018-2019 and 2019-2020 financial years. The only exception is a commissioner adjustment for neonatal utilisation as part of the cot configuration review, neonatal baselines have not updated since the initial rebasing was implemented aside of the Bridgend boundary transfer and a recognition of some flows to the University Hospital of Wales from the Royal Glamorgan unit closure.

- **Contracting framework –** It is assumed that English providers will move to an aligned payment and incentive system approach. It should however be noted that this represents substantial changes to the NHSE framework for contracting and funds flow with the introduction of the Integrated Care Board. Whilst full details are as yet unknown, it is anticipated that there will be a transition towards more of a block contracting environment informed by historic and planned volumes. The role of tariff in this new framework is not fully defined. For Welsh providers, this plan assumes a return to the cost and volume framework with marginal rates for performance variation but acknowledges there is currently an all wales financial flows sub group developing a framework proposal.

- **Budgets** - Budgets will be re-set to 2021-2022 baselines as a key principle, although a detailed baseline assessment has been undertaken to review if any recurrent performance adjustments are required for sustained over or under performance (not COVID-19 related).

- **Progress against 2021-2022 plan** - The majority of planned developments in service stabilisation did proceed in 2021-2022 with some non-recurring slippage but the recurrent funding originally approved will be required as planned for 2022-2023. The full year effect of previous year developments is assessed at a maximum of £4.152m. For context the 2021-2022 ICP full year effect uplift was £4.3m

- **Growth and inflation**- A number of growth provisions incorporated into the 2020-2021 plan and rolled into 2021-2022 plan are sufficient to cover forecast growth in 2022-2023 - e.g. historic high value areas such as renal dialysis and immunology products. New growth provisions for existing high cost drugs, further PET activity and the renal independent sector provider's inflation will be required for 2022-2023. Provider inflation is planned at 2.8% in line with the central core allocation uplift for 2022-2023, this includes an assumption that the increase in provider employer's national insurance will be funded by commissioners from this uplift. NHS wales provider wage awards will be will be fully dealt with as an in-year allocation during 2022-2023. Cross border inflation is also planned for at 2.8%, the current NHSE national tariff consultation document is proposing a net 2022-2023 uplift of 1.7% (2.8% inflation – 1.1% efficiency factor). However the prudent assumption of 2.8% provider inflation includes an assumption that in year English provider wage uplifts will exceed 2% and it is expected these will be funded from within the 2.8% core uplift. ***Note that Powys HB have requested their ICP contribution for NHSE provider inflation is held at 2.0% until the wage award uplift is finalised.***

- **New medicines and technologies -** NICE / new medicines forecast is expected to exceed the baseline £2.4m provision, with an estimated additional provision of £2m required. New medicines will be approved via NICE at the same or higher rate as historic levels and expenditure on cancer

medicines and high unit cost packages will return to normal. This is subject to the current backlog and the pace of clearance. ATMPs will continue to be considered by NICE, probably at an increased rate. The expected quantum will be as initially expected for 2021-2022 at circa £20m. The allocation for this is held by WG and drawn down as incurred.

- **Strategic resource** Investment will be required for a number of key strategic priorities including the major trauma network and specialised paediatric services. As part of the neonatal cot configuration review there will be a requirement to invest in both cot capacity and a catch-up in tariff rates in line with recently published NHS England benchmarking.

- **Value based commissioning schemes** There are a number of value work streams included in the ICP, these are described as follows:
  - ***Neonatal Transfers*** - (£0.25m) is anticipated from reducing capacity transfers for neonatal babies to English providers, this will be achieved by commissioning the appropriate level of provision at the appropriate geographical unit through the neonatal cot capacity review.
  - ***Medicines Management*** – (£0.35m) is expected to be secured from new Patient Access Scheme (PAS) and Managed Access Schemes (MAS) commercial discounts and rebates that will be made available to Welsh commissioners. Whilst no explicit savings target has been set in this plan it is anticipated that the roll out of the Blueteq prior approval system will also deliver efficiencies against the high cost drug and NICE prescribing provisions.
  - ***Cystic Fibrosis*** – (£0.5m) a review of inpatient and home IV service activity since the WG/Vertex rebate agreement in December 2019 has identified that the vastly increased access of the new Vertex triple therapies will deliver significant savings against the current baselines from existing cystic fibrosis contracting mechanisms.

11.2 Recovery

The 2021-2022 ICP recovery provision of £4m is returned to HBs on the basis that in year recovery funding was routed directly from Welsh Government to Welsh providers and via WHSSC or HB commissioners to English providers where activity triggered over performance under the English Recovery Fund (ERF) rules.

During October 2021 Welsh Government made recurrent an allocation of £170m for **'Planned and Unscheduled Care Sustainability for 2022-2023'** on a commissioner basis. This allocation is equivalent to a further 2.8% above the core allocation uplift of 2.8% and is to cover the full range of HB responsibilities for planned and urgent care, including specialised services commissioned by WHSSC on their behalf and includes funding for English recovery activity.

In the interests of IMTP alignment WHSSC has agreed with commissioning HBs to include a provision upfront in the 2022-2023 ICP to route this funding to NHSE providers for forecast recovery activity and Welsh trusts such as Velindre Cancer

Centre which require COVID-19 sustainability funding flows to be routed through commissioners in line with their IMTP requirements. This provision totals £6.699m and is made up of the following four recovery pressures:

Planned and Unsheduled Care Sustainability Commissioner Allocation Routed Through WHSSC for 2022/23	Total £
English Recovery Forecast	2,737,495
Velindre COVID Drug recovery	422,000
Velindre COVID Sustainability	1,380,781
WBS COVID Sustainability (4th Collection)	2,159,016
Total Sustainability Funding through WHSSC	**6,699,292**

Further work is on-going with Welsh HB providers to establish if additional sustainability allocation will need to flow through WHSSC to fund recovery activity or this can be managed against the full contract baselines established as the starting assumption for 2022-2023. England & Wales recovery will probably continue at different rates with English providers recovering fully earlier but the gap is expected to close if Welsh providers deliver their plans for the second half of 2021-2022. ***Note that Powys HB have opted to retain their share (£0.263m) of the forecast NHSE ERF over performance provision and will direct to providers through WHSSC when the activity materialises.***

11.3 Residual Risks and Uncertainties

The impact of COVID-19 on specialised services delivery remains subject to uncertainty with significant differences between services:

- **Contracting frameworks** – at this point no decision has been taken on whether contracting frameworks will return to their previous structures or at what point any return may happen. A continuation of block contracting would result in decreased value for money and would not provide the right incentive for delivery. Whilst provider HB plans for the second half of 2021-2022 mostly predict a return to contract levels this will take significant improvements in performance to achieve and sustain.

- **Rate of recovery** – the timing of recovery to full operating activity levels is uncertain at this point. Whilst it is reasonable to assume that this will happen during 2022-2023 the pace of return may vary by provider and specialty. Specialised services with high elective components are currently lagging behind and some services remain lower in the clinical priority order despite excess waiting times – examples include paediatric surgery and plastic surgery.

- **Operating efficiency** – the post-COVID-19 operating environment will have had some longer term impact on efficiency and throughput. It is unclear the extent of this impact and whether it will impact on contract prices.

- **System capacity** – an additional risk for 2022-2023 will be the risk of a further backlog or service interruption caused by severe winter pressures on top of an already high level of system pressure going into the winter.

- **Demand backlog** – there is uncertainty as to the scale of the demand backlog and at what pace demand will present at historic levels. Detailed monitoring of the waiting list position indicates that new demand has not yet returned to pre-COVID-19 levels in a number of key specialties but is increasing. It is likely that waiting lists will continue to fluctuate being sensitive to both delivery changes and referral volatility.

- **New medicines backlog** – there continues to be uncertainty regarding the rate at which the medicines approval backlog will clear through the system and how approvals will be prioritised by regulators. This will have an impact on specialised services for AMTPs, high cost medicines cancer therapies and additional genetic testing.

- **Innovation pace** – the pace of innovation in specialised services both in therapeutics and services will continue at a higher rate than general services. However, the ability of the delivery system to be able to prioritise these new and emerging service will continue to be limited by recovery pressures.

- **Collective commissioning services** – during 2021-2022 HBs have identified a range of existing services they would like WHSSC to commission. These are summarised in the 'potential new services' section of the ICP. They include Paediatric Orthopaedics and Spinal Surgery. The rationale to ask WHSSC to commission includes the need to agree necessary investment and stabilisation of these services. HBs will need to be clear on their respective priorities for these services and allocate appropriate investment resources to address the underlying issues.

- **NHSE provider wage award** – if the final net NHS England tariff settlement agreed including the 2022-2023 provider wage award is above 2.8% then it is expected that commissioners will fund from the core allocation uplift with no further central funding. This risk is pertinent to BCU and Powys due to the commissioned flows to English providers.

- **ISP inflationary pressures** – the economic system is currently experiencing a range of pressures including staffing shortages, energy and transporting which is translating into higher inflation indices. There is a risk that inflation provisions will not be adequate to deal with changes in the indices unless the system starts to stabilise. Prices pressures of up to 5% may become more realistic in some areas.

11.4 Financial Planning Summary 2022-2023

The financial planning forecast for 2022-2023 is detailed in the table below:

WHSSC 2022-23 ICP Financial Summary

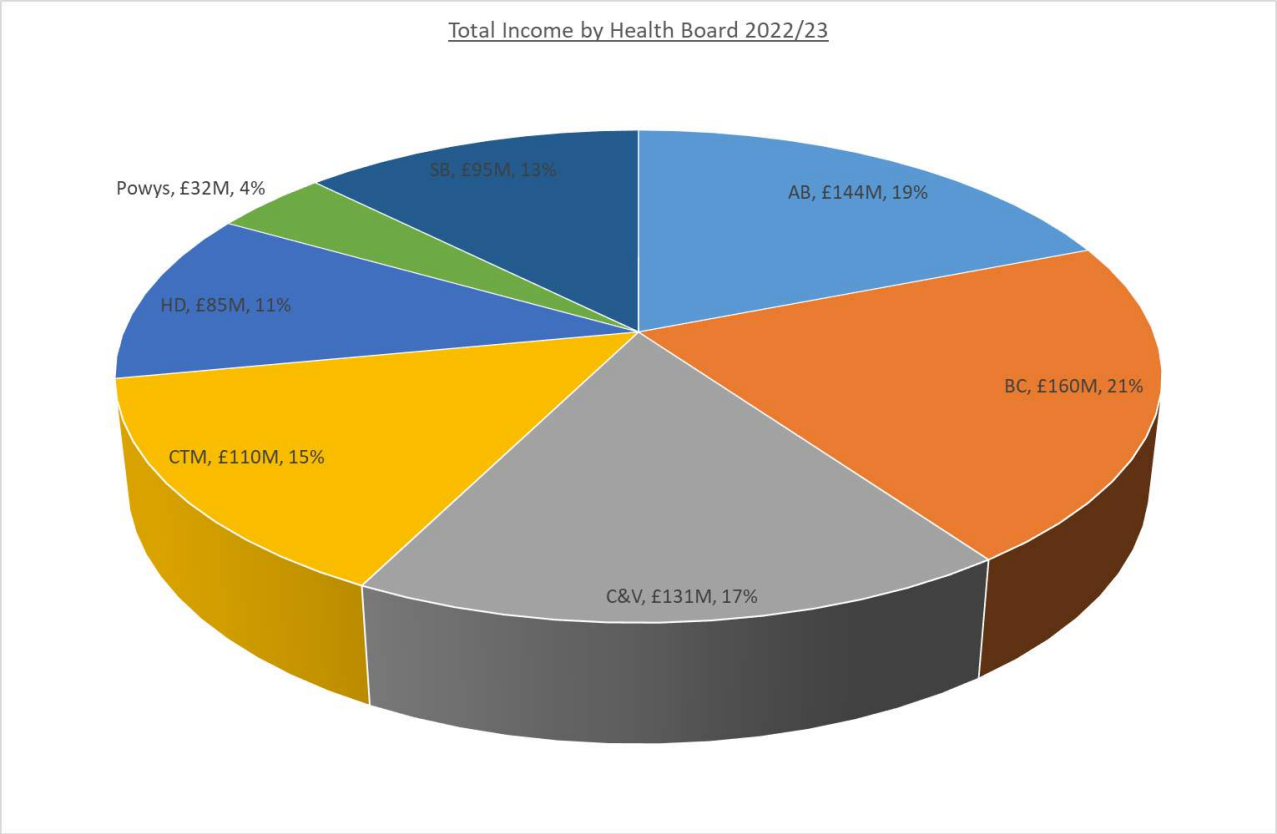
	Aneurin Bevan UHB £m	Betsi Cadwaladr UHB £m	Cardiff & Vale UHB £m	Cwm Taf Morgannwg UHB £m	Hywel Dda UHB £m	Powys THB £m	Swansea Bay UHB £m	2022/23 WHSSC Requirement £m
2021/22 Closing Income	136.045	149.083	122.980	104.236	81.251	29.942	90.359	713.897
Hand back 21/22 NR Recovery Provision	(0.750)	(0.892)	(0.633)	(0.568)	(0.491)	(0.168)	(0.497)	(4.000)
2022/23 Opening Income	135.295	148.192	122.347	103.668	80.760	29.773	89.862	**709.897**
Neonatal Rebasing (2019 - 2021 average)	(0.408)	0.000	0.548	(0.304)	(0.272)	(0.129)	(0.344)	(0.909)
21/22 Utilisation Adjusted Income Baseline	134.887	148.192	122.895	103.364	80.488	29.645	89.518	**708.989**
Recurrent Adjustments	0.264	0.134	0.153	0.106	0.119	0.122	0.077	0.975
Re-stated Rollover Requirement	(0.144)	0.134	0.701	(0.198)	(0.153)	(0.007)	(0.267)	0.066
Full Year Effect of Prior Approved Commitments	0.905	0.399	1.051	0.740	0.463	0.129	0.464	4.152
Unavoidable Growth & Cost Pressures	0.782	0.851	0.656	0.592	0.499	0.165	0.505	4.050
New VBC Workstreams	(0.251)	(0.080)	(0.223)	(0.201)	(0.148)	(0.039)	(0.158)	(1.100)
Underlying Rollover & Growth	1.293	1.304	2.185	0.933	0.662	0.248	0.543	7.168
CIAG & Prioritisation Schemes	0.263	0.191	0.240	0.196	0.143	0.044	0.164	**1.240**
Strategic Specialist Priorities	0.902	0.000	0.619	0.646	0.564	0.150	0.555	**3.436**
NHS England Provider Inflation	0.546	2.161	0.385	0.374	0.307	0.205	0.329	4.306
NHS Wales Provider Inflation	2.557	1.553	2.436	2.033	1.638	0.375	1.830	12.423
ICP Investment 2022/23	5.561	5.209	5.865	4.182	3.314	1.022	3.420	28.573
Total WHSSC Funding 2022/23	140.856	153.401	128.212	107.851	84.074	30.795	93.282	738.471
% Core Uplift Required	**4.11%**	**3.52%**	**4.79%**	**4.03%**	**4.10%**	**3.43%**	**3.81%**	**4.02%**
COVID Recovery & Sustainability Allocation	1.208	2.852	0.912	0.865	0.377	0.146	0.340	6.699
% Recovery & Sustainability Uplift Required	**0.89%**	**1.92%**	**0.75%**	**0.83%**	**0.47%**	**0.49%**	**0.38%**	**0.94%**
Total Funding Requirement	**6.769**	**8.061**	**6.776**	**5.048**	**3.691**	**1.168**	**3.761**	**35.272**
% Total Uplift Required	**5.00%**	**5.44%**	**5.54%**	**4.87%**	**4.57%**	**3.92%**	**4.18%**	**4.97%**

The core components are described as:

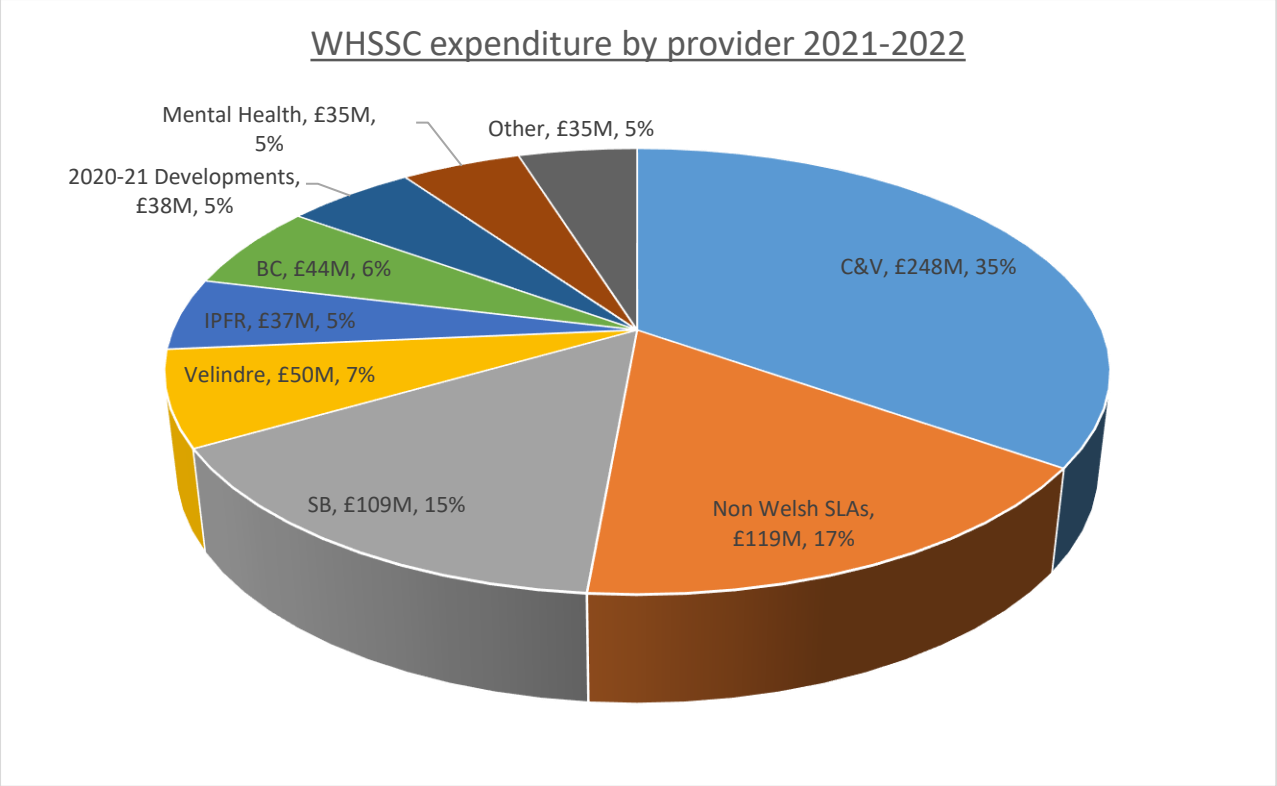
- Opening baseline – the starting point for the budget is the opening agreed budget for 2021-2022 of £713.897m
- The Non-Recurrent COVID-19 recovery provision of £4m from the 2021-2022 plan is released back to commissioners
- Neonatal Rebasing – the reduction in neonatal activity between the current baselines based on a three year average to 2014/15 and the proposed baseline from 2019-2020 and 2020-2021 average activity initially reduces the requirement by £0.909m
- Recurrent adjustments – recurrent performance adjustments to the baseline totalling £3.227m are required. This includes an increase on TAVI baselines to 2021-2022 forecast performance levels and an uplift in the Gender activity baseline at NHS England providers. A revised under performance provision of £2.25m has been included to net the total adjustment down to £0.975m
- Full year effect of prior year commitments – the impact of these commitments is £4.152m
- Unavoidable growth and cost pressures – the impact assessment totals £4.050m
- New value based work streams – the net cost is offset by value-based schemes totalling £1.1m. This excludes provider efficiency requirements

- CIAG and prioritisation requirements – the cost of CIAG and prioritisation schemes is £1.544m comprised of £0.927m high priority CIAG schemes and £0.617m prioritisation schemes
- Strategic provision for the Paediatric Services Strategy, Major Trauma and Neonatal cot configuration is made, with a first year provision totalling £3.436m
- Provider inflation provision – provisional provider inflation has been provided for in line with the core allocation uplift of 2.8%, totalling £4.306m for English providers and £12.423m for Welsh providers
- The Planned and Unscheduled Care Sustainability routed through WHSSC for 2022-2023 amounts to £6.699m.

The additional £35.272m investment by each HB is shown in the ICP summary above. The contribution by HB towards the total plan is shown below. BCUHB make the biggest contribution (21%) and Powys the smallest (4%) in line with utilisation and population.



WHSSC's expenditure by provider is shown in the table below. Cardiff provides 35% of specialised services with 17% being provided outside Wales. SBUHB is second largest Welsh provider.



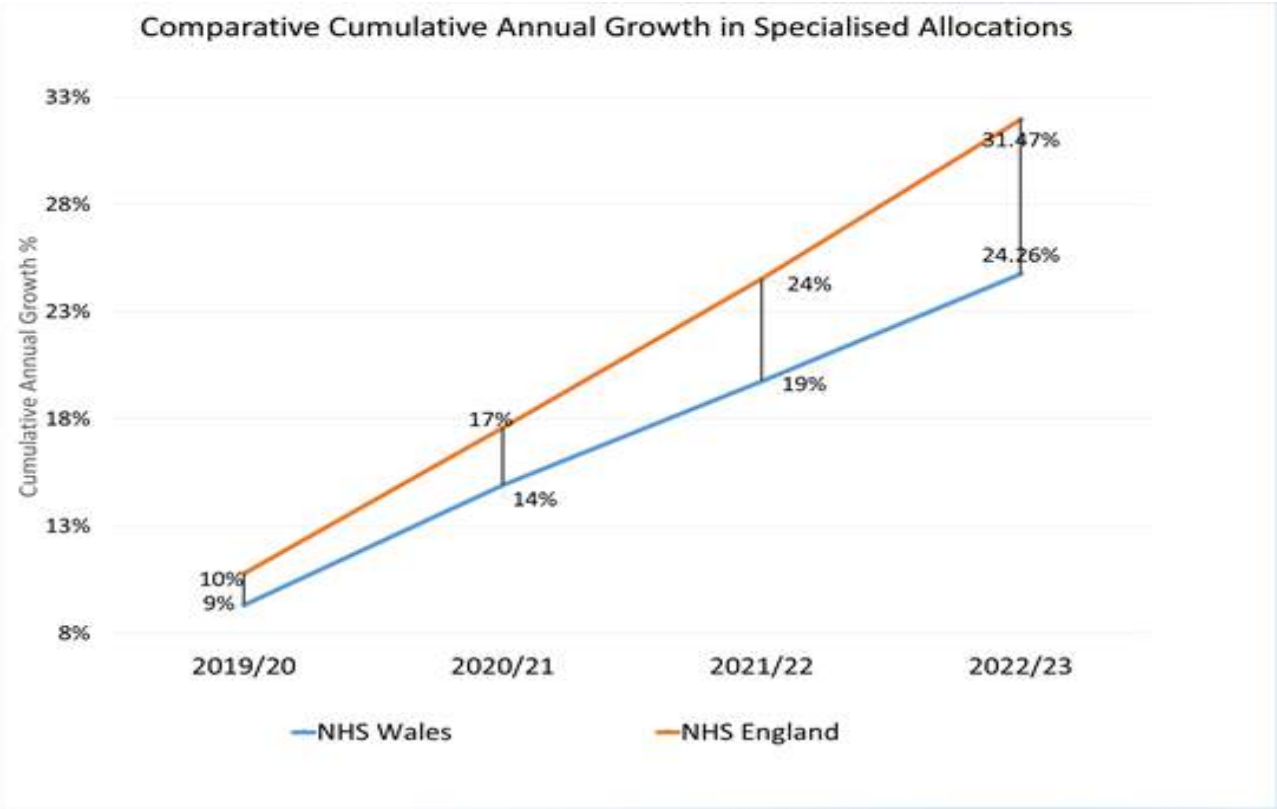
A detailed Financial Plan is attached in Appendix D

11.5 Specialised Services Allocation Context

Over recent years the ICP has tracked Welsh Specialised Services allocation growth against the published NHS England clinical commissioning group planned specialised allocations.

This analysis identified that the NHS Wales Specialised allocation growth lagged behind NHS England by > 8% over the five year period, which is equivalent to a recurrent funding gap of approx. £50million if Wales was on parity with England. A number of reforms to the English payment by results system, the 2018 pay deal and subsequent cross border central funding settlements have improved the historic growth differential by £15 million for 2019-2020 allocations levels.

Revisiting this analysis from a starting point of the finalised 2019-2020 allocations, which includes recurrent uplifts for HRG4+ and the wage award. This illustrates that if the current 2022-2023 requested ICP uplift of 5% is approved, then the cumulative Welsh specialised growth over the last four years still lags the current NHS England published allocation growth by more than 7%.



The Welsh comparator figures includes significant top sliced investments in the genetic test directory, genomic precision medicine strategy and the 2020-2021 commissioner investments in Mechanical Thrombectomies and Advanced Therapeutical Medicinal Products baselines.

	Finalised Growth			Published Planned Growth	
	2019/20	2020/21	2021/22	2022/23	2023/24
NHS Wales Specialised Services	8.81%	5.60%	4.85%	5.00%	TBC
NHS England Specialised Services	10.29%	6.79%	6.95%	7.44%	7.68%

The current identified differential in investment could widen further if future years ICP investment does not keep pace with NHS England planned growth levels for 2023-2024 of above 7.5%.

12.0 CONCLUSION

This three year ICP presents the WHSSC ambition for its duration. It reflects a strong commitment to continuing to work with and behalf of the seven HBs to plan, commission and ensure delivery of Specialist Services for the Welsh population through the implementation of this 2022-2025 plan.

APPENDICES

APPENDIX A – PROGRESS ON DELIVERING THE INTEGRATED COMMISSIONING PLAN FOR SPECIALISED SERVICES FOR WALES 2021 - 2022

Progress on Delivering the Integrated Commissioning Plan for Specialised Services for Wales 2021 - 2022

December 2021

WHSSC

"On behalf of Health Boards, to ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."

GIG CYMRU NHS WALES
Tîm Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Team

PARCH · RESPECT

PARTNERIAETH · PARTNERSHIP

GWELLA AC ARLOESI · IMPROVEMENT & INNOVATION

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1.0 WHSSC PRIORITIES 2021-2022

The Principles and Priorities for WHSSC for 2021-2022 were discussed and agreed by Joint Committee at its meeting in November 2020 prior to the Integrated Commissioning Plan (ICP) being approved and submitted.

This progress report updates against each of the priorities and actions agreed within the ICP at December 2021.

2.0 MINISTERIAL PRIORITIES

The ICP 2021-2022 identified a response to the Ministerial priorities as appropriate to WHSSC. Progess specifically on those most applicable is detailed below:

- Mental Health has been identified as a key strategic priority further progress on developing the mental health strategy for WHSSC is provided at section 9
- Planning for recovery update is provided at section 7 and
- Decarbonisation – WHSSC continues to operate a hybrid model of working and the majority of meetings remain remotely significantly reducing the need for travel.

3.0 STRATEGIC PRIORITIES

A number of strategic priorities are highlighted within the WHSSC ICP 2021-2022 and a progress report is provided in each of the relevant sections of this report.

- Continued implementation of ATMPs
- Planning for Recovery
- Mental Health services in particular services for women and CAMHS
- Paediatric Specialist Services

4.0 WORKFORCE PRIORITIES 2021-2022

Supporting and developing the WHSS Team remained key priorities within the ICP in particular.

Action	Progress
Staff development and well-being support.	Staff have access to a range of well-being support via CTM. The senior management team have undertaken specific training in recognition and supporting staff experiencing mental health and well-being difficulties. The organisation has a number of mental health first aiders that staff can contact.
Future involvement in talent management succession planning	The Managing Director is a member of the Talent Board. PDR continues and opportunities for training and learning continue to offer. Many of the learning events are offered on Teams and this has made it easier for staff to engage and in larger numbers.
Restructuring to meet changing organisational needs	WHSSC commissioning approach continues to be flexible to ensure that the request are proportionate to business needs recognising pressures on operational services. Joint Committee has supported additional resources into the running costs budget in recognition of the additional services that WHSSC is being asked to commission.
WHSSC will also continue supporting the wider NHS during remainder of pandemic and will redeploy staff to support operational needs as appropriate	Some staff remain on secondment to support organisations

5.0 PRIORITISATION PROCESS FOR THE 2021-2022 ICP

A number of schemes were included in the ICP for additional funding during 2021-2022 as part of the CIAG process. Funding against these schemes is only released on the submission of a business case by the provider and following scrutiny by Management Group. A progress report on the release of funding against these schemes is provided in section 12, Commissioning Team update.

6.0 HORIZON SCANNING AND PRIORITISATION

A number of schemes were included in the ICP for additional funding during 2021-2022 as part of the horizon scanning and prioritisation process. A progress report on the implementation of these new treatments is prvided in section 12, Commissioning Team update.

7.0 ADVANCED THERAPEUTIC MEDICINAL PRODUCTS (ATMPS)

All ATMPs approved by NICE have been made available to Welsh residents during the year.

8.0 PLANNING FOR RECOVERY

Considerable work with provider organisations in both England and Wales continues and is reported regularly to Joint Committee.

Detailed activity reports are provided monthly to Management Group and bi-monthly to Joint Committee.

An Equity Workshop was held with Joint Committee in May 2021. This provided the WHSS Team with a mandate to work with providers to consider alternate pathways where required.

Recovery positions have been received from the main providers within Wales. These are monitored through the regular service level agreement (SLA) meetings. Discussions are on-going regarding sourcing additional activity to reduce waiting times to a minimum.

9.0 COMMISSIONING TEAM PRIORITIES 2021-2022

9.1 Mental Health & Vulnerable Groups

9.1.1 Gender Services for Adults CIAG Scheme

Scheme Title	Impact of Scheme	Progress
Welsh Gender Service (Adult - non surgical)	Management and reduction of waiting list.	A three phased investment was agreed through CIAG. Phase 1 funding release has been completed. Phase 2 April 2022 and phase 3 in April 2023.

Action	Progress
Evaluation of Peer Support Programme A 12 month evaluation of the peer support and information service to be submitted by June 2021.	Partial evaluation has been submitted by the service. Cardiff & Vale University Health Board (CVUHB) to tighten procurement going forward so activity/information deadlines are met.
Waiting List - Opportunities to increase activity to address the waiting list backlog whilst mindful of the capacity within local gender teams and delays to gender re-assignment surgery.	Submission of Paper to MG for CIAG funding 2021-2022 completed and supported (focus on waiting list, repatriation from the London GIC, retention of skills and North Wales development). Phase 1 funding release complete for 2021-2022. Supported proposal/paper to Chief Executives Management Team for a Managed Clinical Network (outside of WHSSC) to oversee whole pathway.

9.1.2 Gender Identity Development Service (GIDS) for Children and Young People

Action	Progress
Independent Review of GIDs Develop action plan arising from the Independent Review with NHS England	The recommendations have yet to be published. They are likely to impact on the way GIDS is commissioned in NHS England which will impact on Welsh patients. Once known the work required will be scoped and work plan updated.

9.1.3 Traumatic Stress Wales

Action	
Full implementation of the TSW programme All posts fully recruited Launch website	Information Analyst appointed. Website up and running. Other posts to be recruited in Q3/4.

9.1.4 Forensic Adolescent Consultation Treatment Service (FACTS)

Action	Progress
Stabilisation of the Service WHSSC are working with CTM UHB on an improvement plan to address recruitment and retention issues • Recruitment to key vacant posts including, medical, psychology and nursing • Investment in service management	FACTS was put into level 3 escalation in October 2020 to address key issues including recruitment, retention and access to resources. Draft Service Specification has been completed for core FACTS health element. Agreement with Welsh Government to simplify commissioning arrangements (WHSSC to commission YOTs and potentially prison in reach).
Support to Youth Offending Team Agreement on the offer to YOTs	Pathway developed for FACTS offer to Youth Offending Teams (Enhanced case management). To be transferred into WHSSC service spec in Q4/next year.
FACTS Specification WHSSC are working with CTM UHB and key stakeholders on the development of a draft service specification.	Progress made to the development of a service specification. Will be finalised in quarter 4 and published for consultation

9.1.5 Mental Health Portfolio

Action	Progress
Mental Health Programme Develop a programme initiation document to pull all strands of the portfolio together	Completed programme structure in place and work started

9.1.6 Child & Adolescent Mental Health Services (CAMHS)

Action	Progress
Implementation of Service Specification Confirmation that the service specification remains preferred way forward following NCCU work Gap analysis and work force models Implementation and resourcing plan Agree with Welsh Government and Health Boards (HBs) any further developments to inpatient services	Service Specification published. Ongoing discussions through Strategy to respond to the NCCU report to include gap analysis and workforce models. Service Specification to be further revised following the development of the strategy in 2022-2023.
Access to tier 4 beds in medium secure Work with QAIS to develop plans to improve access to tier 4 beds in NHS England in particular for medium secure	Surge beds purchased
Eating disorder services Work with the Eating Disorders sub group to agree a plan for tier 4 inpatient services	Links to ED subgroup established as part of the strategy.
Bed Management Further refine the bed management panel and actions required around use of age appropriate beds	Bed management panel fully operational and successfully identifying patients requiring tier 4 beds.
Wider pathways issues including community intensive support Work with the DU and QAIS to develop actions arising from the review of community intensive care teams and the implications for tier 4 services	Actions being developed through the strategy to respond to recommendations from the review of community intensive care teams and the implications for tier 4 services.

9.1.7 Secure Services: Learning Disability

Action	Progress
Implementation of the recommendations from the individual patient reviews report	Action Plan being developed to take forward the recommendations from the individual patient reviews report as appropriate to the WHSSC portfolio as part of the strategy
Secure inpatient capacity for patients with Learning Disabilities	Action plan being developed as part of the strategy for access to secure inpatient beds for Welsh Residents with a learning disability

9.1.8 Secure Services: Women

Action	Progress
Develop a commissioning strategy for women's secure services plus a resourcing plan	A commissioning strategy for women's secure services plus a resourcing plan is being developed as part of the strategy.

9.1.9 Perinatal Mental Health Services - Mother and Baby Unit

Action	Progress
Continue to work with SBUHB to ensure implementation of the service specification and opening of the unit in April 2021	MBU continues to deliver well and according to service specification. Monitoring continues on a regular basis.
Continue to work with Welsh Government and SBUHB to progress the business case for the permanent MBU. Indicative resource plan to be agreed to inform the ICP for 2022-2023	12 month review of unit to be conducted in 2022-2023 with the recommendations to progress the business case as part of the strategy.
Working with NHS England, develop an implementation plan for a MBU that provides improved access for women from BCU and north Powys HBs	Ongoing discussions with NHSE to develop a service in Chester with two beds available for women from BCU and North Powys HBs. Agreement reached with project development into 2022-2023.

9.2 Cardiac Commissioning Team

9.2.1 Aortic Stenosis Commissioning Strategy

Action	Progress
Agree a clinical pathway for AS with a maximum waiting time of 18 weeks but with a view to work towards a maximum 12 week wait for treatment Agree the AS Clinical Pathway Development and Implementation Plan	The Aortic Stenosis Clinical Pathway has been developed over the last 12 months through an iterative process involving several workshops with Cardiology, Cardiac Surgery and Radiology representatives. The final draft of the Aortic Stenosis Clinical Pathway was discussed and agreed with the wider group in the workshop on 24 November 2021, prior to finalising through the WHSSC

	processes and Heart Conditions Implementation Group. Implementation will start in quarter 4.

9.2.2 Pulmonary Hypertension

Action	Progress
Consider the options presented in the final project report 'A Pulmonary Hypertension Service for Wales' and develop a plan in conjunction with stakeholders to be able to take this work forward	Work is ongoing. A draft Service specification outlining the requirement for the delivery of a satellite PH service has been developed and is currently being reviewed by key clinicians. Work will continue into quarter 4.

9.2.3 Inherited Cardiac Conditions (ICC)

Actions Required	Progress
Establish a stakeholder working group. To understand the clinical models in place across Wales Develop an outline proposal for how the future ICC services should be delivered across Wales	Completed Completed Options for the service model have been developed a full option appraisal will be taken forward through remainder of year.

9.2.4 Obesity Surgery

Actions Required	Progress
Complete a review of the current Obesity Surgery Policy and Service Specification and undertake Key Stakeholder Consultation Undertake an assessment of any financial impact of the changes to the Commissioning Policy. Review the current arrangements for delivery of obesity surgery	Both documents have been developed and approved for stakeholder consultation. Documents planned to be published in quarter 4 following completion of the stakeholder consultation process. A paper was submitted to Management Group for the meeting on 23 September 2021, seeking support to scope out the potential for an additional designated provider for the Level 4 Obesity Surgery Service. This was supported.

	WHSSC has received formal communication from ABUHB's CEO that they would like to be considered as a service provider. WHSSC has asked the HB to complete a self-assessment against the service specification to underpin an evaluation of their potential to become a provider. Work to continue across quarters 3 and 4.

9.2.5 Cystic Fibrosis

Actions Required	Progress
Work with the provider to determine the exact inpatient capacity requirements. Determine the impact of Kaftrio on capacity requirements.	The demand and capacity modelling and updated business case was received in September 2021. A further meeting will be held with the HB in December 2021. Timeline for completing this work has slipped into quarters 3 and 4, due to the delay in receiving the information required.

9.2.6 CIAG Prioritised Schemes

ICP Scheme	Actions to be taken	
Inherited Cardiac Conditions (SBUHB)	Agree investments priority with SBUHB SBUHB to submit business case for scrutiny by Management Group	Additional funding provided to Swansea Bay University Health Board (SBUHB) to stabilise the service there.
Cardiac MRI for Adults with Congenital Heart Disease	Agree investment priority with C&VUHB	WHSSC are awaiting the business case from C&VUHB. Timeline for this has slipped and work will continue in quarters 3 and 4.

9.3 Women and Children Commissioning Team

Actions Required	Progress
Strategy for Specialised Paediatric Services (strategic priority in plan)	The project has been initiated and the Project Board has met, all working groups have been established.
Paediatric Inherited Metabolic Disease – the service delivered from CVUHB is not sustainable. The Women and Children Commissioning Team are working at pace with providers across the UK to implement a sustainable service from quarter 1 2021-2022	Service agreed to be commissioned from Birmingham. Engagement underway with all Stakeholders over service change.
Neonatal Transport service – An interim 24 hour service commenced in south and mid Wales in January 2021 (north Wales and north Powys already have access to a 24/7 service). Work continues to agree the service model for a permanent service which will be in place by end quarter 1.	Now being progressed by SBUHB with MH as SRO. Approval has been provided to extend interim model until June 2022 to ensure continued 24 hour provision. Support being provided by KM where necessary.

Other Key Priorities

9.3.1 CIAG Schemes

Scheme Title	Impact of Scheme	
Paediatric Neurology	• Increase in workforce to ensure sustainability • Timely access to care • 24/7 access • Video telemetry to improve access to whole pathway	Approved to fund over two phases throughout 2021-2022. Phase 1 has been approved by CDGB and MG, funding release letter issued.
Paediatric Cystic Fibrosis (Pharmacy)	• Manage the needs of people with CF • Ensure safe and cost effective use of new medications for CF	Completed - Funding has been approved by CDGB and MG. Letter has been issued to provider.
Paediatric Clinical Immunology	• Meet demand for immunodeficient paediatric patients	Not Complete – awaiting Business case from provider

Paediatric Radiology	• Collective commissioning • 24/7 cover in the Children's Hospital • Support for all DGHs in hours	Completed- Funding has been approved by CDGB and MG. Letter has been issued to provider.
Paediatric Gastroenterology	• Increase workforce to ensure sustainability • 24/7 cover • Will bring service in line with national standards	Completed – funding has been approved.
Paediatric Rheumatology	• Sustainable MDT • Repatriation of patients from NHS England • Current unmet demand that will be met	Completed Approved by CDGB and Management Group. Funding release issued

9.4 Cancer & Blood Commissioning Team

9.4.1 CIAG Schemes

PET CT - new indications (inc. colorectal cancer, cholangiocarcinoma, dementia, gastrointestinal stromal tumours, lymphoma, prostate cancer).	Complete stakeholder consultation and publish commissioning policy updated with new indications.	Completed
Stereotactic Ablative Body Radiotherapy (SABR) for oligometastatic cancer and hepatocellular carcinoma	Commissioning policies for both oligometastatic cancer and HCC are already developed. Scrutiny of business case via Management Group.	Consultation on commissioning policies completed. Funding release dependent on outcome of VCC contract rebasing and revision. Currently awaiting confirmation from VCC of their requirement for 2021-2022 and case for additional resource.
Tuberous Sclerosis Complex specialist service	Scrutiny of business case via Management Group.	Completed

Sarcoma radiology service	Scrutiny of business case via Management Group.	Completed
Brachytherapy for prostate cancer	Commissioning policy already developed. Scrutiny of business case via Management Group.	Consultation on commissioning policies completed. Policy published. Funding release dependent on outcome of VCC contract rebasing and revision. Currently awaiting confirmation from VCC of their requirement for 2021-2022 and case for additional resource.

In addition, 2 further schemes were included following assessment of the clinical and cost effectiveness evidence by the Prioritisation Panel:

Scheme	Actions	
Allogeneic Haematopoietic Stem Cell Transplantation for adults with sickle cell disease	Complete stakeholder consultation and publish commissioning policy updated with new indication.	Consultation completed. Policy group in Nov for approval.
Autologous Haematopoietic Stem Cell Transplantation for people with previously treated relapsing remitting multiple sclerosis	Complete stakeholder consultation and publish commissioning policy updated with new indication.	Delay to policy. Postponed to Q4.

9.4.2 Thoracic Surgery

WHSSC have continued on the Implementation Programme Board and the Strategic Outline Case for the new unit has been submitted to Welsh Government by SBUHB having been supported by Joint Committee.

9.4.3 Specialist Radiotherapy

Issue	Action	
SABR: designation of additional provider/s	To consider commissioning a second SABR provider in south Wales (in accordance with WHSSC's designation process).	Business case received from SBUHB. Final scrutiny in progress prior to taking to Management Group.

WHSSC will develop a strategy and commissioning intentions for specialised radiotherapy for Wales to ensure patients have equitable access to sustainable, high quality radiotherapy services as locally as possible. These services include Stereotactic Ablative Body Radiotherapy (SABR), Radioligand Therapy, Proton Beam Therapy (PBT), Brachytherapy and Paediatric Radiotherapy. The strategy will set out the key drivers (including population need, the evidence base and horizon scanning) and WHSSC's commissioning intentions across the various areas of service delivery.

Action	Timeline
Strategy for specialised radiotherapy - To develop the strategy for specialised radiotherapy for Wales	A scoping paper has been prepared. Work has commenced
SABR: designation of additional provider/s To consider commissioning a second SABR provider in south Wales (in accordance with WHSSC's designation process). To engage and explore the potential for considering repatriation of SABR to north Wales.	Designation of SBUHB as a provider discussed by Management Group. Work is on-going to bring to a conclusion Work commenced
Radioligand therapy: designation and repatriation To consider commissioning a provider within south Wales to repatriate the service for patients with NETs (in accordance with WHSSC's designation process).	Work has commenced
Paediatric radiotherapy To engage with stakeholders in Wales and NHS England with regard to a sustainable service model for paediatric radiotherapy as locally as possible.	Discussion started with NHS England and Velindre. Joint proposal being considered with NHS England will conclude in quarter 4.

9.4.4 Hepato-Pancreato-Biliary Service

Service specification produced and agreement gained through Joint Committee that WHSSC will commission this service in the future. The WHSS Team continues to input into the programme being led by the partnership between Swansea Bay and Cardiff and the Vale UHBs on the process to agree the new clinical model.

9.4.5 Other Service Developments

- Teenage and Young Adult Cancer Service

Awaiting outcome of the radiotherapy review from NHS England.

- PET-CT Programme Business Case

The All Wales PET-CT Programme Business Case submitted and approved by Welsh Government. Implementation programme now being established.

9.5 Neurosciences and Long Term Conditions Commissioning Team

Title	Scheme Objectives	
Tertiary Thrombectomy Services in south Wales and development of HASUs	• Address long term commissioning arrangements • Ensure sustainability, deliverability and access of the Mechanical Thrombectomy service • Improve patient outcomes with the development of a more local regional centre.	Project Manager in post. Awaiting a business case from C&VUHB to establish a Tertiary Thrombectomy service in South Wales. Business case expected November 2021
Relocation of Rehabilitation services	• To provide a sustainable and equitable model. • To work towards achieving national standards • Review the business case for Prolonged disorders of Consciousness (PDOC) – ICP 2020-2021	Business Case received from the service in September/October 2021. Funding release paper has been submitted to the November 21 Management Group. Completed.
		Business case for Prolonged Disorders of Consciousness (PDOC) service has been received. Funding release paper completed and submitted to

		Management Group in May 21. •completed
Neurosurgery Service Gateway Review	• To provide a sustainable and equitable service model • To work towards achieving national standards • Develop and publish the Adult Neurosurgery Service Specification	

The following schemes have been supported through the Clinical Impact Advisory Group (CIAG) process for additional investment during 2021-2022.

Scheme Title	**Scheme Proposal**	
Prosthetics Service SBUHB	• To stabilise the service • Increase in the workforce to ensure sustainability • Addressing inequity	Completed - Funding Release Paper completed April 2021.
Neuro Oncology	• Addressing inequity • Increase in workforce – consultant and AHP support • To stabilise the service currently single handed consultant • Improve access and outcomes	C&VUHB have submitted the business case to WHSSC in Sept/October 21. The funding release paper has been submitted to the November 21 Management Group. Completed.
Neuro-rehabilitation – SBUHB	• Addressing inequity • Increase in workforce to address the issue of the increase in acuity of patients • Strengthen the model of care • Review of the contracting model	Initial discussions have taken place with the service. WHSSC were expecting to receive a scheme proposal for CIAG prioritisation process to be included in ICP 22-25 but this was not forthcoming. The service have developed an SBAR as part of the SBUHB's recovery plan outlining the workforce constraints, short and long term actions to be taken.

		WHSS have contacted the team to arrange a further meeting
Spinal Injuries Rehabilitation	• Increase in workforce to support patients to use therapy space • Address inequity • Delivering a sustainable model • To bring the service closer to meeting national standards	Business case received.
Relocation of Rehabilitation Services	• Increase in workforce to support patients to use therapy space • Address inequity • Delivering a sustainable model • To bring the service closer to meeting national standards	Business Case received from the service in September/October 2021. Funding release paper has been submitted to the November 21 Management Group. Completed.
Neurosurgery	• Include on the gateway review • Equitable access and sustainability and improve the delivery model • Increase theatre capacity and address workforce gaps • Improve access and outcomes • Review commissioning arrangements of some services	Work commenced. Outcome report to be submitted to Management Group by the end of quarter 4.
Stereotactic Radiosurgery (SRS)	• Review the current contract model	Review complete. Rebased contract agreed with Velindre
Clinical Gait Analysis	• Currently not designated as a WHSSC commissioned service. • Work with service in 2021-22 to understand interdependencies of service with existing WHSSC Prosthetic services	Agreed to remain as a HB commissioned service.

Functional Electrical Services	• Not currently designated as a WHSSC commissioned service. • Work with service in 2021-22 to understand interdependencies of service with existing WHSSC services and supra-regional nature of the service currently.	Agreed to remain as a HB commissioned service.

9.6 Welsh Renal Clinical Network

All actions have been progressed and will complete during the year.

Action	Progress
Further develop unit dialysis facilities Complete North Wales refurbishment and procurement of a sustainable high quality service in South West Wales, including geographical and capacity expansion to include Neath Port Talbot and Bridgend localities.	Wrexham refurbishment completed alongside work around the logistics of temporary changes in location of dialysis to enable the development NPT and Bridgend dialysis off-site locations incorporated into the ongoing tender led by SBUHB to procure dialysis capacity for the whole of South West Wales.
Further development of the Wales transplantation service to include innovative technology such as ANRP (Abdominal Normothermic Regional Profusion) to deliver better usage of organs and improve patient outcomes	NRP programme commenced by the CVUHB transplant retrieval service – important improvement and one of a small number of chosen sites across the UK. The initiative is planned to improve the quality of organs retrieved leading to better long term outcomes for transplanted patients.
Further improvements to access to home therapies utilising the learning gained and the findings from the research (Dialysis Choices) study led by WRCN Clinical Lead.	Peer review of home therapies completed with positive feedback about the benefits of the process. Formal responses from units awaited with a planned follow-up visit due for early 2022 for one unit. New specification in development. Engagement visits being completed as part of new tender for home therapies.
To realise the benefits and complete the delivery of the Transformation Fund projects to digitise kidney care in Wales. Of note this will enhance patient safety by full roll-out of EPMA and make more efficient use of pharmacy resources. Patient education and training to be linked to the findings of the Dialysis Choices study to maximise impact	EPMA has now been rolled out across the whole of Wales following the completion of the roll-out to South East Wales. This is a notable achievement and has been enabled by exceptional support from the SBUHB pharmacy and wider support team spending many hours working away from home during a difficult time across the service

Roll-out across Wales of the digital solution to auditing staff to patient ratio's for both dialysis units and home therapies to gain assurance of patient safety.	The live monitoring system is now up and running. The lead nurse for the WRCN will be working closely with units to use the information gathered to best effect and evaluate the benefits achieved

10.0 COMMISSIONER ASSURANCE

A new Commissioner Assurance Framework has been approved by Joint Committee. This Framework includes a suite of documents:

- Risk Management Framework
- Performance Framework
- Escalation process
- Patient Experience & Engagement Framework

11.0 FINANCIAL PLAN 2021-2022

Comprehensive financial reports are provided monthly to Management Group and Joint Committee.

The ICP remains underspent and regular communication with HBs to ensure that they are clear of the position.

Risks within the ICP are discussed with Management Group, Joint Committee and Welsh Government regularly.

12.0 RISK MANAGEMENT

A new Risk Management Strategy has been approved by Joint Committee.

13.0 CORPORATE RISK ASSURANCE FRAMEWORK (CRAF)

Development of the CRAF continues and is presented to each Integrated Governance Committee, the CTM Audit and Risk Assurance Committee and monthly to Corporate Directors Group (CDG) in line with the Risk Management Strategy.

Additionally:

- a Risk Assurance Group has been established within WHSSC;
- each Directorate has a comprehensive risk register;
- The Commissioning risk are updated monthly and presented to CDG; and

- A risk workshop was held for WHSSC staff in quarter 2 with a further one planned for quarter 4.

14.0 SOCIO ECONOMIC DUTY

Training on the Duty has been undertaken by relevant staff.

APPENDIX B – RECOVERY PROFILE

CARDIOLOGY

Complex Devices

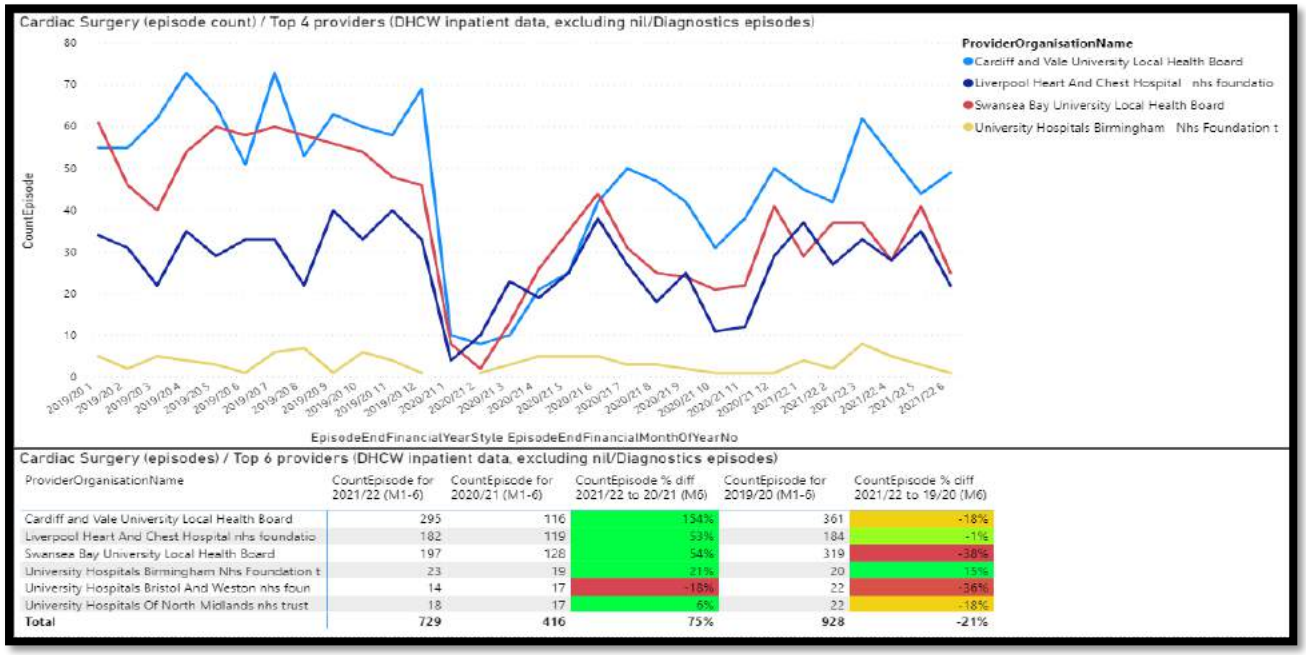
There are no current issues regarding complex devices with either Liverpool Heart and Chest or Betsi Cadwaladr University Health Board (BCUHB). Swansea Bay University Health Board (SBUHB) have a number of patients waiting over 36 weeks however a recovery plan is in place with expectations of delivery to LTA levels by the end of Q4. Positions will continue to be monitored via established risk, recovery and assurance meetings.

Primary Percutaneous Coronary Intervention (PCI)

Not specifically associated with recovery as a result of COVID-19, however there remain significant delays in the South East with regard patients being able to access primary PCI. Discussions remain ongoing with WAST.

Cardiac Surgery

Cardiac Surgery – Activity and Access Rate Summary



Cardiac Surgery (episodes) / Top 6 providers (DHCW inpatient data, excluding nil/Diagnostics episodes)

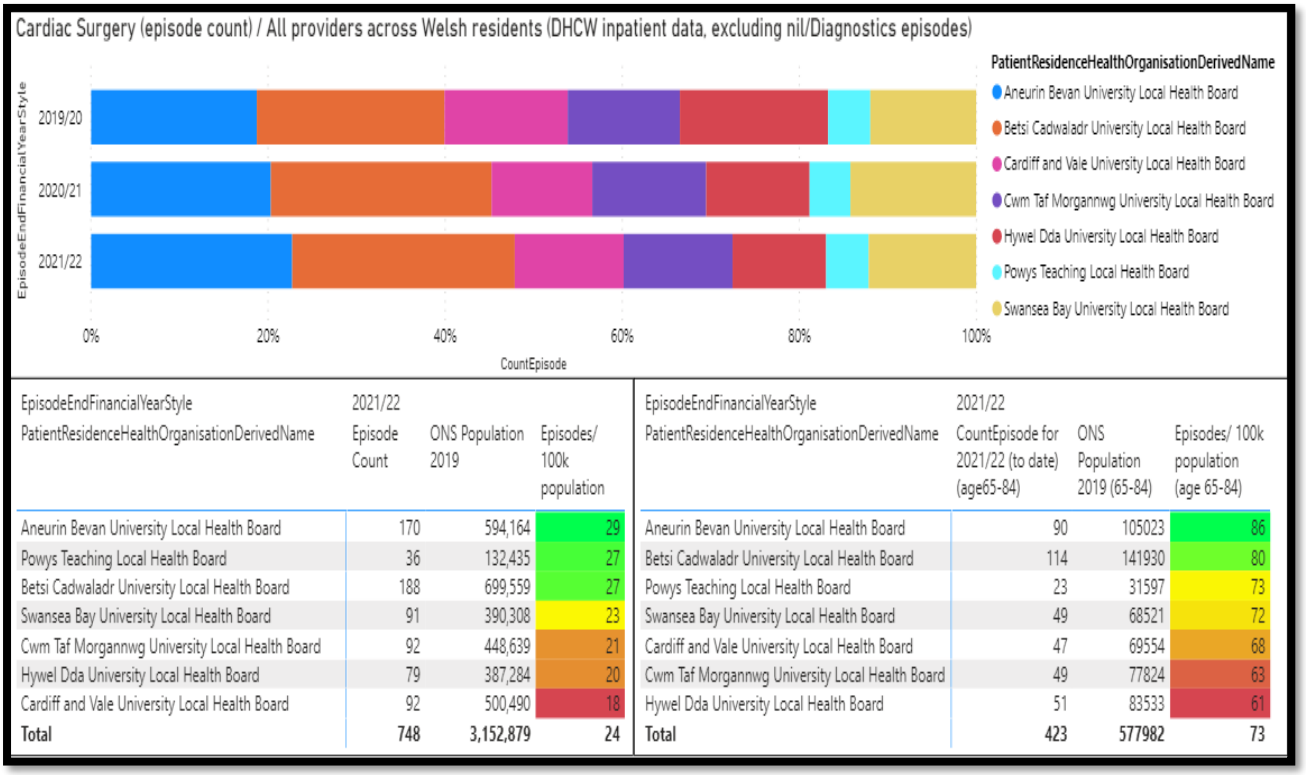
ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Cardiff and Vale University Local Health Board	295	116	154%	361	-18%
Liverpool Heart And Chest Hospital nhs foundatio	182	119	53%	184	-1%
Swansea Bay University Local Health Board	197	128	54%	319	-38%
University Hospitals Birmingham Nhs Foundation t	23	19	21%	20	15%
University Hospitals Bristol And Weston nhs foun	14	17	-18%	22	-36%
University Hospitals Of North Midlands nhs trust	18	17	6%	22	-18%
Total	729	416	75%	928	-21%

Data source: DHCW central data warehouse; all inpatient activity excl. non-procedure/diagnostic episodes

The above table highlights the variance in Cardiac Surgery inpatient recovery across the main specialist providers, with Liverpool Heart and Chest Hospital showing the highest and quickest recovery. The main three providers show the expected inverse relationship to the COVID-19 waves across the UK, with activity increasing again.

There was a concerning drop in the volume of Cardiac inpatient activity reported during the COVID-19 period, which is recovering but stood at 48% less activity overall in 2020-2021 compared to 2019-2020. Using activity to date this year

2021-2022 (Month 6), activity is already 75% more than last year, but is 21% lower than to the same month in 2019-2020. Historically, Cardiac surgery is seen as an urgent elective specialty with high levels of emergency and inter hospital referrals and lower levels of elective referrals. The decrease is therefore of concern and indicative of a significant risk of harm during the highest COVID-19 periods. The risk of COVID-19 infection in cardiac patients was a real risk identified at the outset of the period and outcomes for positive patients were poor. However, given the seriousness of the impact of non-intervention it is essential that activity levels and the associated referral pathways are reinstated as soon as possible. There has been some proactive switching into TAVI for selected sub groups of patients but numbers are not material.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2021/22 Episode Count	ONS Population 2019	Episodes/ 100k population
Aneurin Bevan University Local Health Board	170	594,164	29
Powys Teaching Local Health Board	36	132,435	27
Betsi Cadwaladr University Local Health Board	188	699,559	27
Swansea Bay University Local Health Board	91	390,308	23
Cwm Taf Morgannwg University Local Health Board	92	448,639	21
Hywel Dda University Local Health Board	79	387,284	20
Cardiff and Vale University Local Health Board	92	500,490	18
Total	**748**	**3,152,879**	**24**

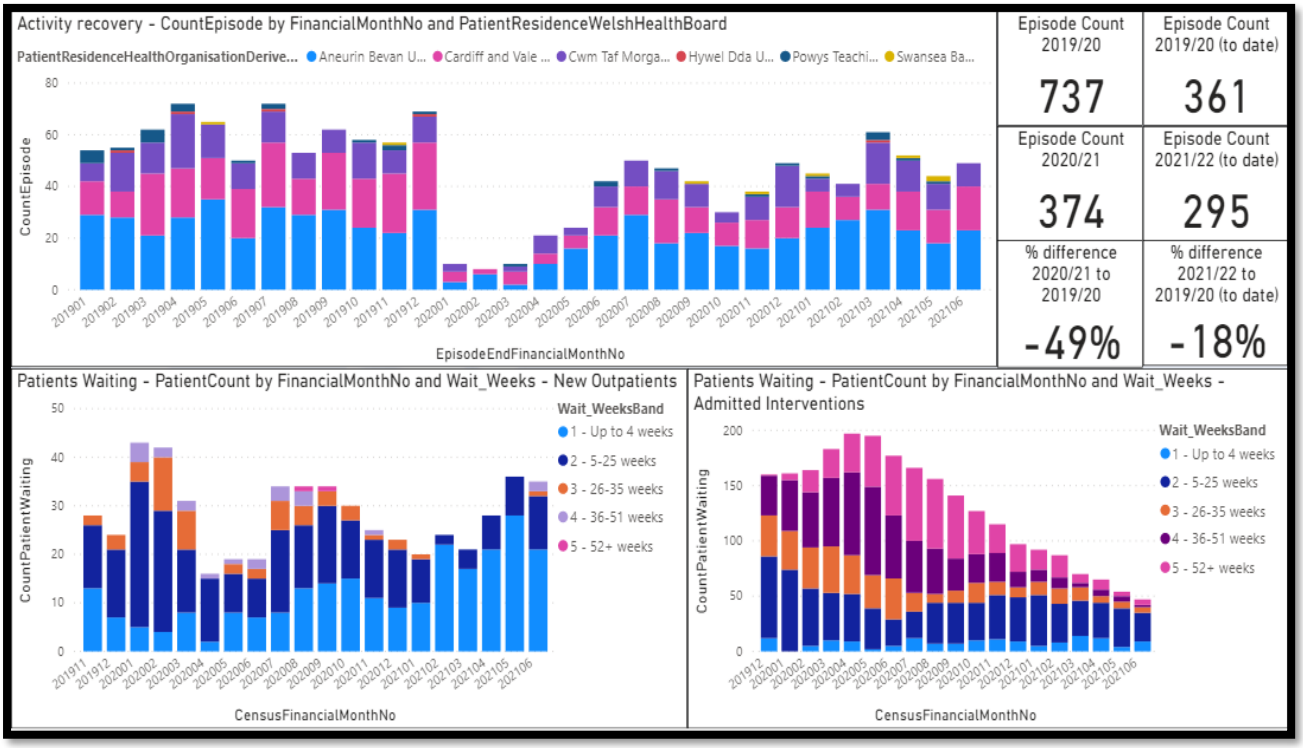
EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2021/22 CountEpisode for 2021/22 (to date) (age65-84)	ONS Population 2019 (65-84)	Episodes/ 100k population (age 65-84)
Aneurin Bevan University Local Health Board	90	105023	86
Betsi Cadwaladr University Local Health Board	114	141930	80
Powys Teaching Local Health Board	23	31597	73
Swansea Bay University Local Health Board	49	68521	72
Cardiff and Vale University Local Health Board	47	69554	68
Cwm Taf Morgannwg University Local Health Board	49	77824	63
Hywel Dda University Local Health Board	51	83533	61
Total	**423**	**577982**	**73**

Data source: DHCW central data warehouse; all inpatient activity excl. non-procedure/diagnostic episodes

Access rates across the HBs varied the most during the initial COVID-19 wave, however have stabilised in recent months to almost the same split of the available activity as 2019-2020. However, SBUHB and Hywel Dda University Health Board (HDUHB) are reflecting a decreased share of the activity, due to SBUHB recovering more slowly than the other providers. BCUHB is showing a higher share, due to the good recovery at Liverpool Heart and Chest Hospital.

Interestingly, inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 18 to 29 so far in 2021-2022 as per the small table above. Analysing the biggest age group user (age 65-84), which represents over half the overall activity, still shows a broad range of 61 to 86 across HBs.

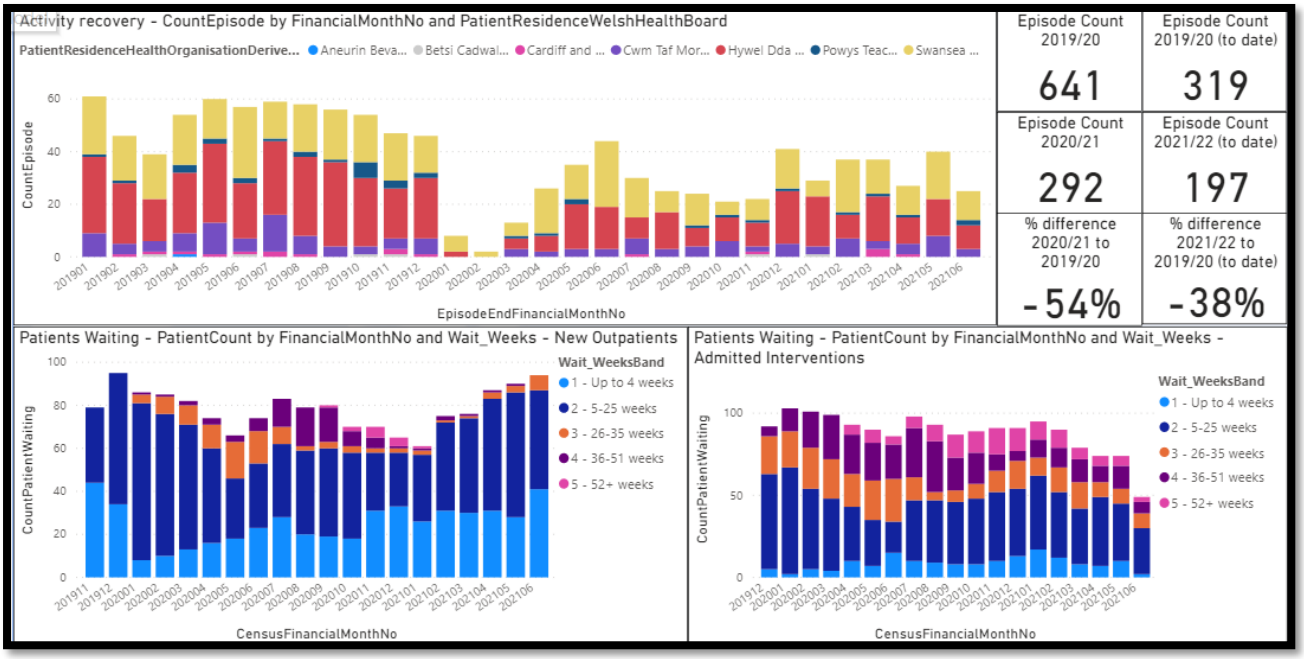
Cardiac Surgery – Recovery and Waiting Lists
Cardiff and Vale University Health Board (CVUHB)



Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at Cardiff and Vale University Health Board (CVUHB) in relation to Cardiac Surgery. Whilst the chart showing new out-patients shows a growing increase in new referrals (those between 0-4 weeks) again, elective activity has kept pace to the point that the waiting list for admissions has reduced to almost a third of pre-COVID-19 demand, with very few patients now waiting over 26 weeks.

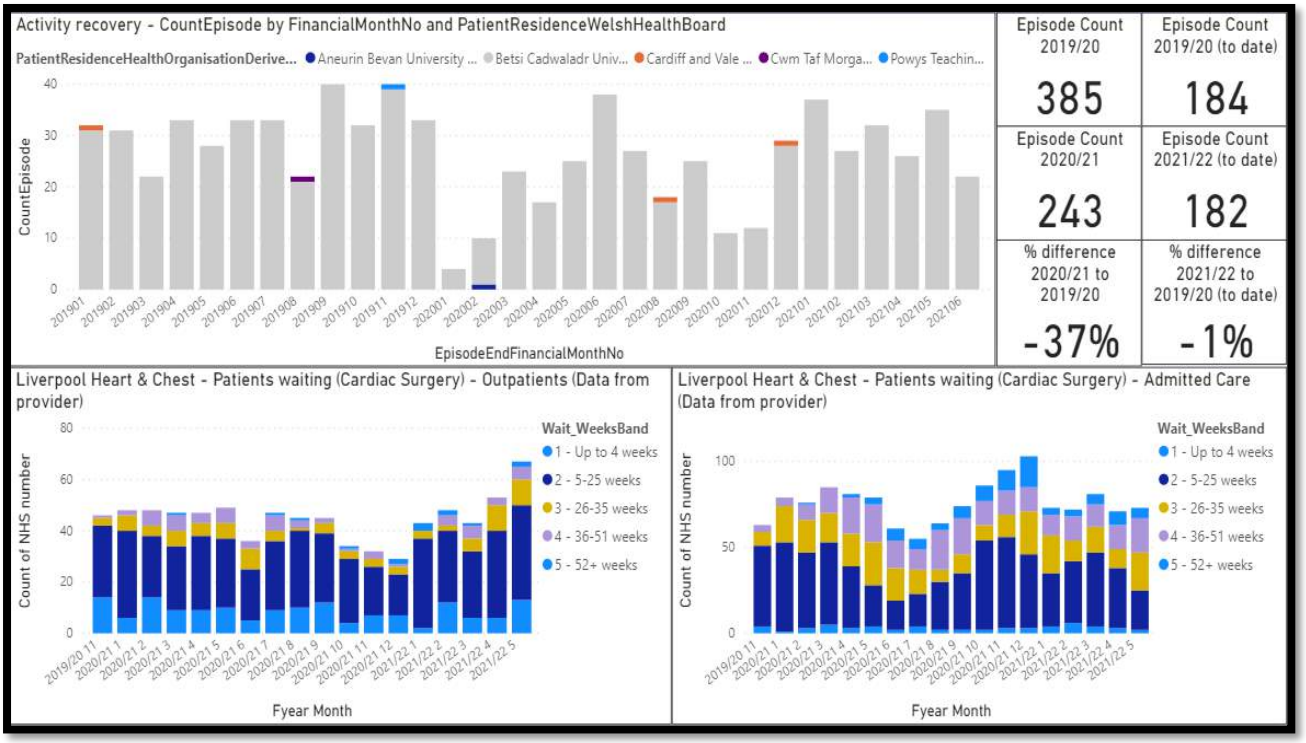
Swansea Bay University Health Board (SBUHB)



Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at SBUHB in relation to Cardiac Surgery. Whilst the chart showing new out-patients shows a growing increase in new referrals (those between 0-4 weeks) again to pre-COVID-19 levels, elective activity has kept pace to the point that the waiting list for admissions has reduced to about half of pre-COVID-19 demand, with about 40% now waiting over 26 weeks.

Liverpool Heart and Chest Hospital

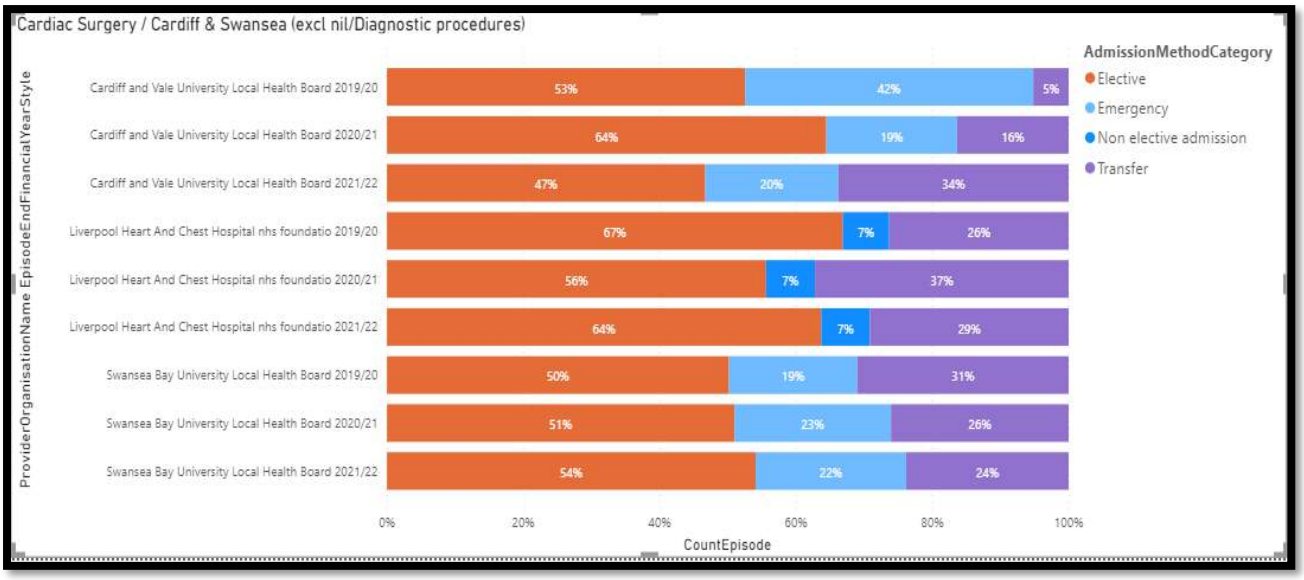


Data source: DHCW central data warehouse; Waiting list data from provider directly

The tables above show a summary of the position at Liverpool Heart and Chest Hospital in relation to Cardiac Surgery. Whilst the chart showing New Outpatients shows a slight decrease in new referrals (those between 0-4 weeks) again to pre-COVID-19 levels, elective activity is back to the same pre-COVID-19 levels. However, the waiting list for admissions has increased slightly, with approximately half now waiting over 26 weeks.

An additional note is that the reported pattern of activity is historically different between Wales and England, with England reporting typically higher proportions of elective/transferred expected overnight stay activity. Welsh centres have reported that the pressure from transfers squeezes capacity available for elective cases with a resulting adverse impact on the waiting list.

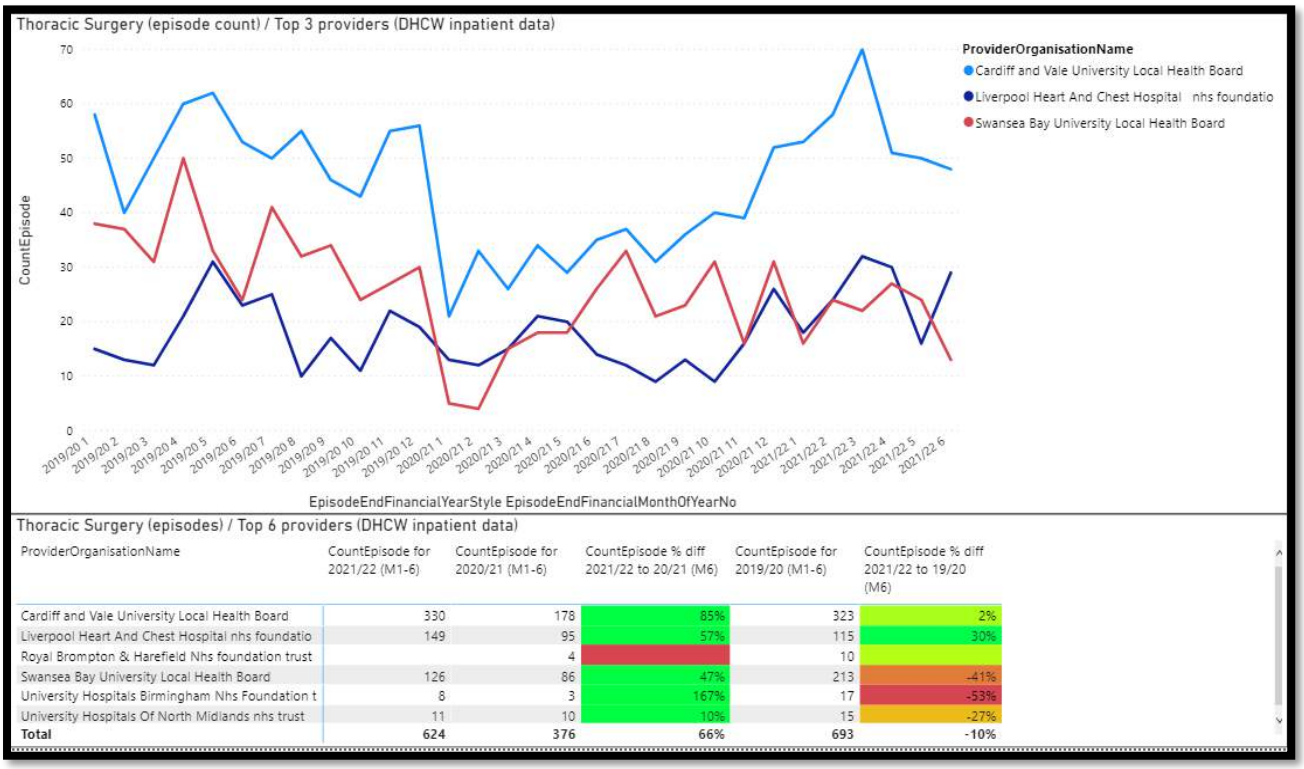
The below chart shows the elective/emergency percentages of the overall inpatient activity. Whilst Liverpool Heart and Chest Hospital appears to be back to 2019-2020 splits, CVUHB has seen a marked increase in transferred activity, while SBUHB has seen a small decrease.



Data source: DHCW central data warehouse; all inpatient activity excl. non procedure/diagnostic episodes

Both South Wales centres have developed improvement plans to drive forward the recommendations from the recent Getting it Right First Time (GRFT) review of Cardiac surgery in South Wales commissioned by WHSSC. Project management arrangements have been put in place. The WHSSC team have received recovery plans from all three main providers and will be monitoring through the Risk, Recovery and Assurance and SLA meetings. Capacity has been increased in all three centres over the last month.

Thoracic Surgery – Activity and Access Rate Summary

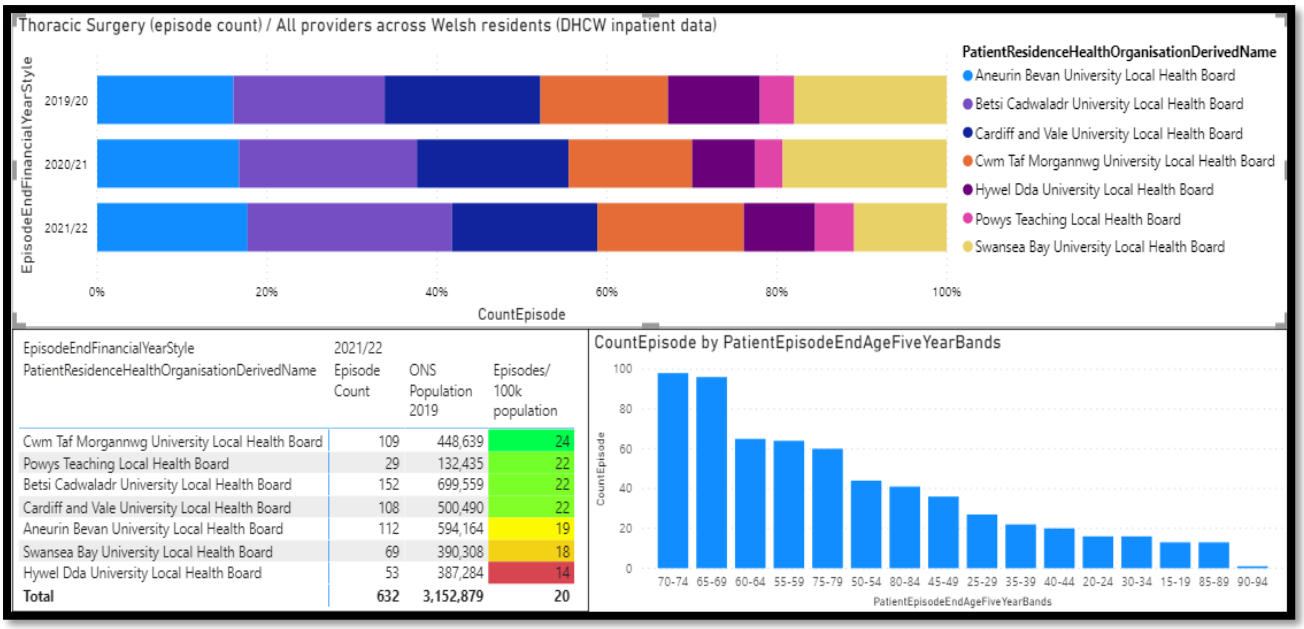


ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Cardiff and Vale University Local Health Board	330	178	85%	323	2%
Liverpool Heart And Chest Hospital nhs foundatio	149	95	57%	115	30%
Royal Brompton & Harefield Nhs foundation trust		4		10	
Swansea Bay University Local Health Board	126	86	47%	213	-41%
University Hospitals Birmingham Nhs Foundation t	8	3	167%	17	-53%
University Hospitals Of North Midlands nhs trust	11	10	10%	15	-27%
Total	**624**	**376**	**66%**	**693**	**-10%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Thoracic Surgery inpatient recovery across the main specialist providers, with Liverpool Heart and Chest Hospital showing the highest and quickest recovery to activity actually 30% higher to date than 2019-2020. CVUHB is also showing 2% higher activity than 2019-2020 to the same month. However, SBUHB is showing a 41% drop in activity to date compared to 2019-2020, although this is still 47% more than what was able to be delivered to this point in 2020-2021.

The drop in the volume of Thoracic inpatient activity reported over the COVID-19 period stood at 35% less activity overall in 2020-2021 compared to 2019-2020. Using activity to date this year 2021-2022 (Month 6), activity is 10% less than 2019-2020, but is 66% higher in total than to the same month last year.



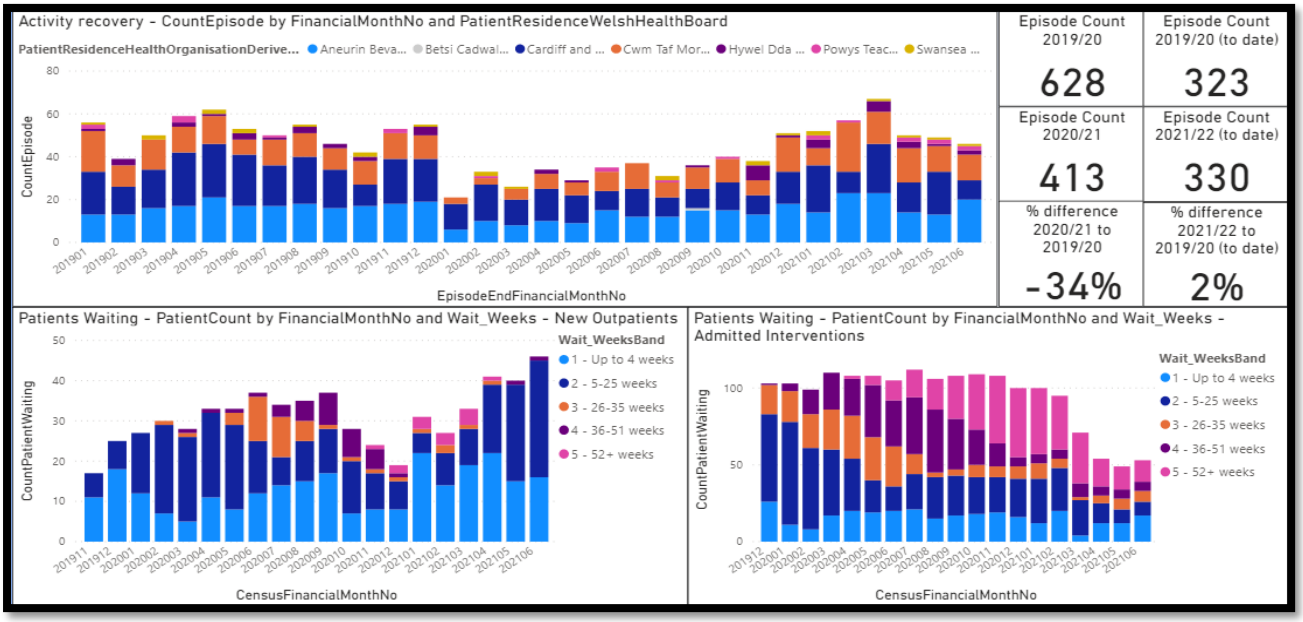
EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2021/22 Episode Count	ONS Population 2019	Episodes/ 100k population
Cwm Taf Morgannwg University Local Health Board	109	448,639	24
Powys Teaching Local Health Board	29	132,435	22
Betsi Cadwaladr University Local Health Board	152	699,559	22
Cardiff and Vale University Local Health Board	108	500,490	22
Aneurin Bevan University Local Health Board	112	594,164	19
Swansea Bay University Local Health Board	69	390,308	18
Hywel Dda University Local Health Board	53	387,284	14
Total	**632**	**3,152,879**	**20**

Data source: DHCW central data warehouse; all inpatient activity

Access rates across the HBs varied across the past two years, which is to be expected given the relatively low activity numbers (about 73/month), but should still be monitored.

Inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 14 to 24 as per the small table above for 2021-2022. Given SBUHB's slower recovery, it is unsurprising to see lower access rates for HDUHB and SBUHB residents. A breakdown of the total activity across 5-year age bands shows a higher access by ages 60-79, which should be taken into account.

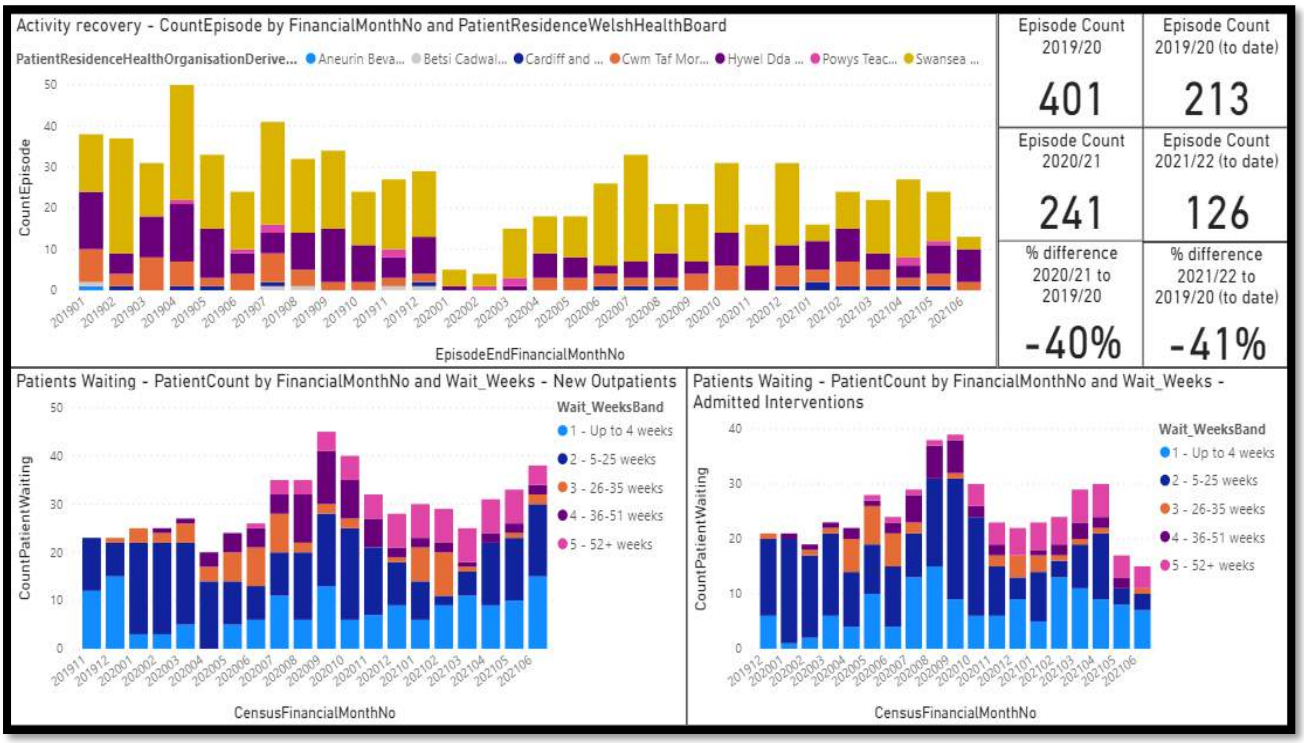
Thoracic Surgery – Recovery and Waiting Lists Cardiff and Vale University Health Board



Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at CVUHB in relation to Thoracic Surgery. Whilst the chart showing New Outpatients shows a growing increase in new referrals (those between 0-4 weeks) again, elective activity has recovered to the same episode counts as 2019-2020. The waiting list for admissions has reduced to almost a half of pre-COVID-19 demand.

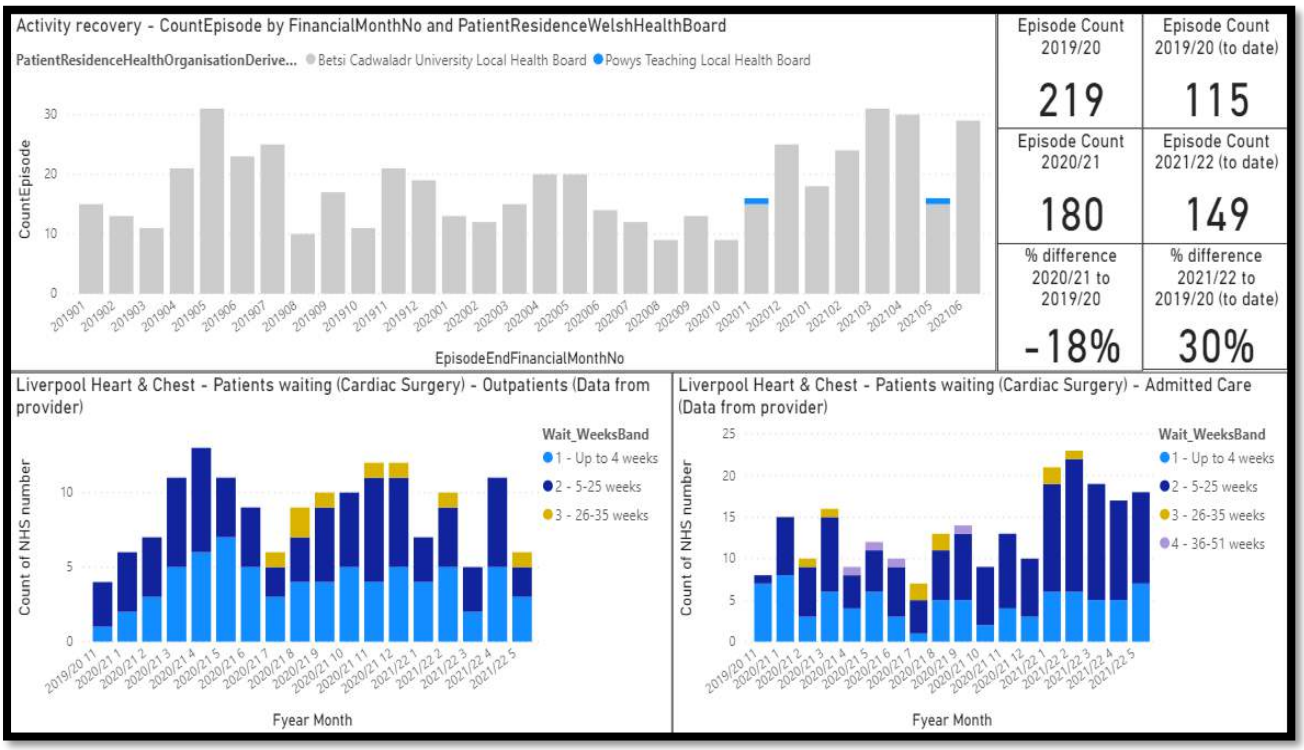
Swansea Bay University Health Board (SBUHB)



Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at SBUHB in relation to Thoracic Surgery. Whilst the chart showing new out-patients shows a growing increase in new referrals (those between 0-4 weeks), elective activity is still 41% lower than in 2019-2020, which demonstrate a similar recovery level as to this point in 2020-2021. However, the overall waiting list for admissions has reduced slightly.

Liverpool Heart and Chest Hospital



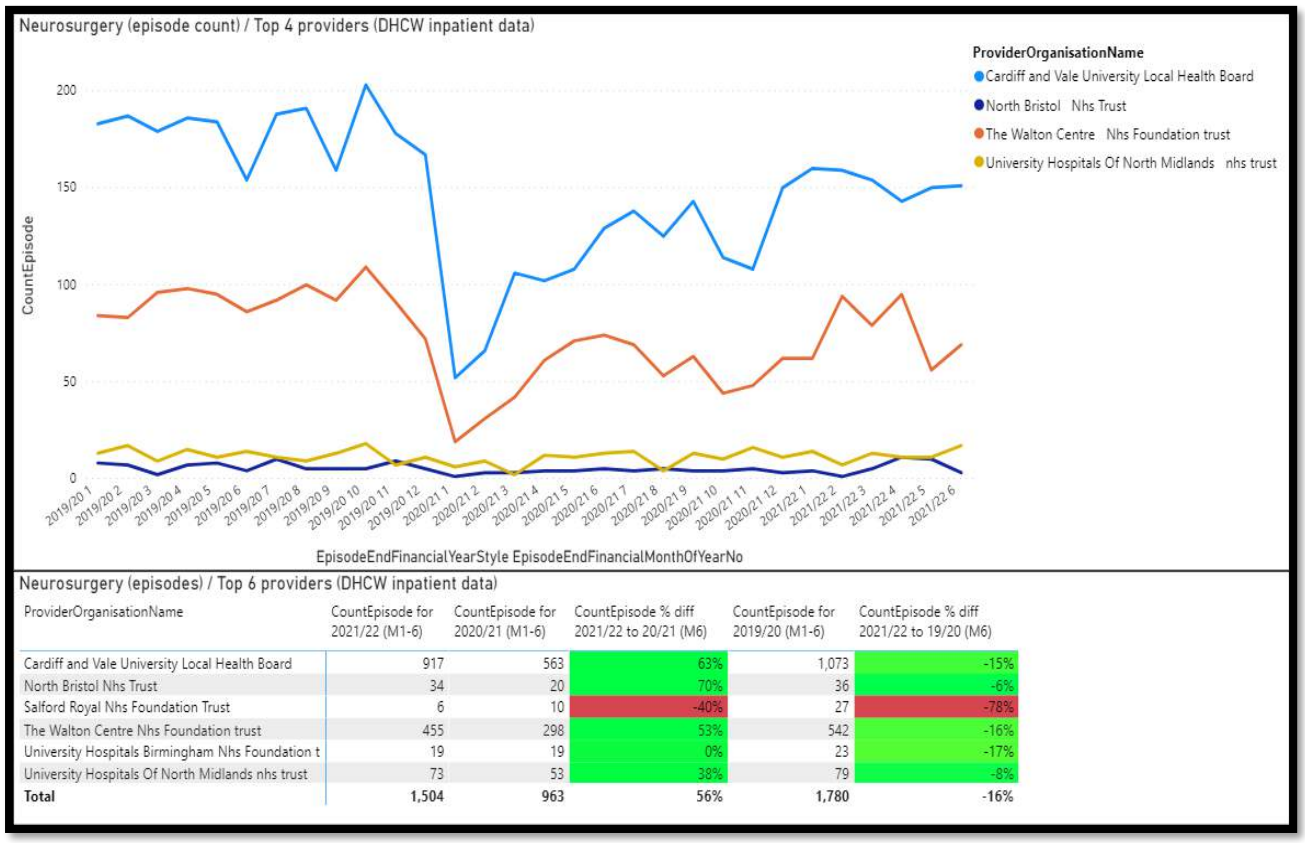
Data source: DHCW central data warehouse; Waiting list data from provider directly

The tables above show a summary of the position at Liverpool Heart and Chest Hospital in relation to Thoracic Surgery. Whilst the chart showing new out-patients shows a quick increase in new referrals (those between 0-4 weeks) after the pandemic started, inpatient activity has increased by 30% compared to 2019-2020. Despite this, the number of patients waiting for admission has still almost doubled, although these are not material numbers.

In interpreting the data above, it is important to note that over the last 12 months, collaborative arrangements have been in place between the two South Wales thoracic surgery services to use the joint capacity across the 2 services to ensure equitable access. This ensures that if the usual centre capacity is constrained due to the impact of the pandemic (or potentially other factors) and there is available capacity at the other south Wales service, patients can be cross referred and access treatment on the basis of clinical need. This means that activity at a particular centre does not directly translate into access for residents of HBs for which it is the usual provider.

It is important also to be aware that the lung cancer Multi-disciplinary Team (MDT in HDUHB has reported that many patients referred to the MDT over the last few months have presented late in their disease which has sadly led directly to lower referrals to surgery since patients with advanced disease are less likely to be suitable for surgical treatment. This is the likely explanation for the particularly low rate of utilisation for HDUHB residents observed to month 5. This also at least partly explains the lower level of activity at SBUHB in comparison to 2019-2020. However recent discussions at the bi-weekly joint thoracic surgical meeting between CVUHB and SBUHB have indicated that late presentation is becoming a more general factor affecting surgical referrals from across the region.

Neurosurgery – Activity and Access Rate Summary



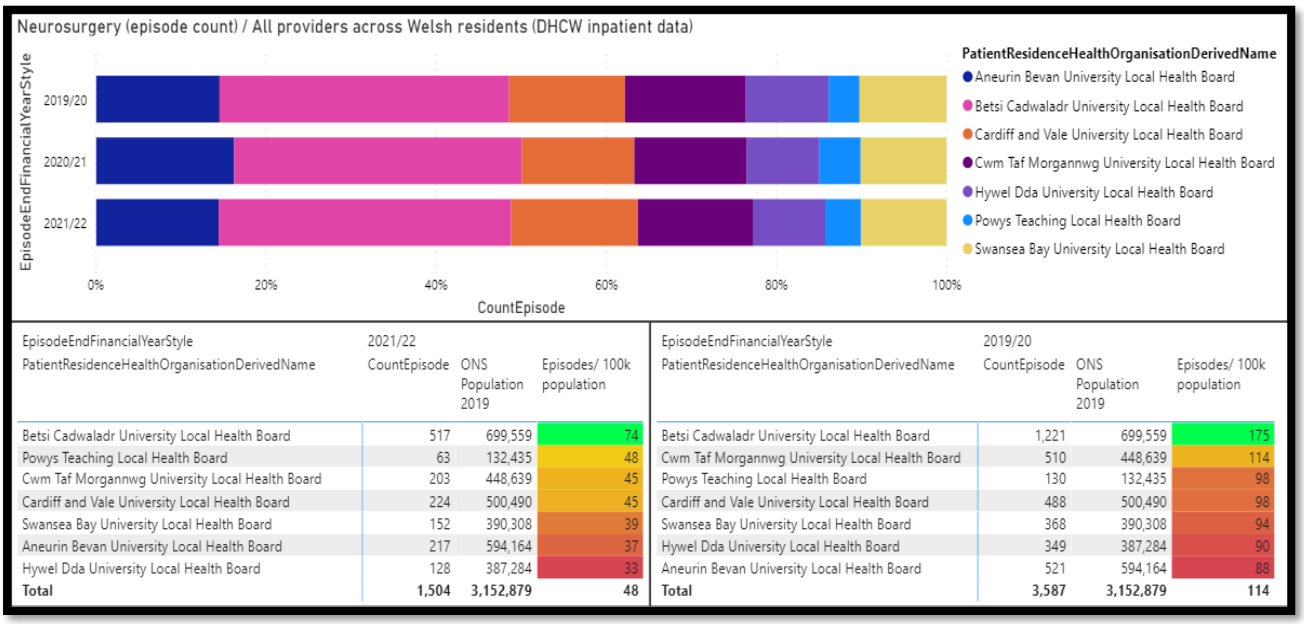
Neurosurgery (episodes) / Top 6 providers (DHCW inpatient data)

ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Cardiff and Vale University Local Health Board	917	563	63%	1,073	-15%
North Bristol Nhs Trust	34	20	70%	36	-6%
Salford Royal Nhs Foundation Trust	6	10	-40%	27	-78%
The Walton Centre Nhs Foundation trust	455	298	53%	542	-16%
University Hospitals Birmingham Nhs Foundation t	19	19	0%	23	-17%
University Hospitals Of North Midlands nhs trust	73	53	38%	79	-8%
Total	**1,504**	**963**	**56%**	**1,780**	**-16%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Neurosurgery inpatient recovery across the main specialist providers, with CVUHB and the Walton Centre showing similar recoveries with reductions of 15% and 16% this year compared to the same point in 2019-2020. Overall activity was 39% less in 2020-2021 than in 2019-2020, with the equivalent figure being 16% less so far in 2021-2022.

Please note the University Hospital North Midlands activity above primarily relates to North Wales residents, which is paid for through a local contract and not via WHSSC.



EpisodeEndFinancialYearStyle	2021/22		
PatientResidenceHealthOrganisationDerivedName	CountEpisode	ONS Population 2019	Episodes/ 100k population
Betsi Cadwaladr University Local Health Board	517	699,559	74
Powys Teaching Local Health Board	63	132,435	48
Cwm Taf Morgannwg University Local Health Board	203	448,639	45
Cardiff and Vale University Local Health Board	224	500,490	45
Swansea Bay University Local Health Board	152	390,308	39
Aneurin Bevan University Local Health Board	217	594,164	37
Hywel Dda University Local Health Board	128	387,284	33
Total	**1,504**	**3,152,879**	**48**

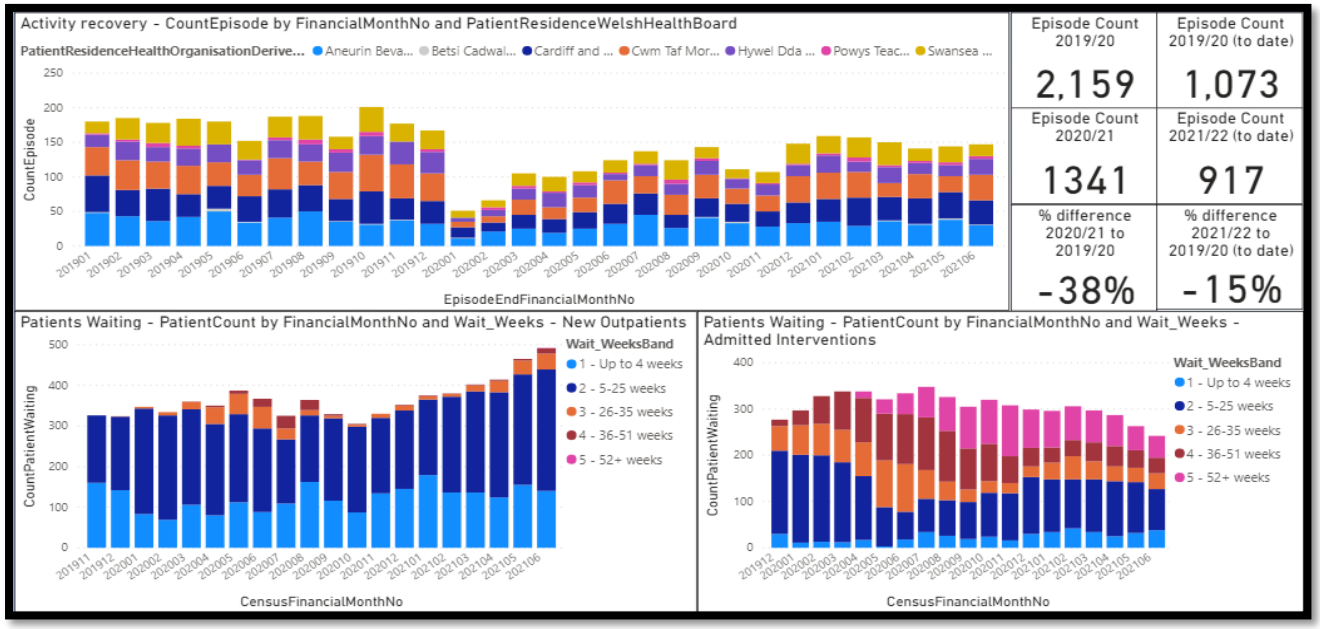
EpisodeEndFinancialYearStyle	2019/20		
PatientResidenceHealthOrganisationDerivedName	CountEpisode	ONS Population 2019	Episodes/ 100k population
Betsi Cadwaladr University Local Health Board	1,221	699,559	175
Cwm Taf Morgannwg University Local Health Board	510	448,639	114
Powys Teaching Local Health Board	130	132,435	98
Cardiff and Vale University Local Health Board	488	500,490	98
Swansea Bay University Local Health Board	368	390,308	94
Hywel Dda University Local Health Board	349	387,284	90
Aneurin Bevan University Local Health Board	521	594,164	88
Total	**3,587**	**3,152,879**	**114**

Data source: DHCW central data warehouse; all inpatient activity

Access rates across the HBs have not varied much during the past three years, as shown in the charts above. Inpatient episodes per 100k population in 2021-2022 so far vary from 33 to 74 across HBs in the bottom left chart, but it is noteworthy that the order of access rates has moved from the 2019-2020 list on the bottom right chart, although North Wales resident access remains the highest both years.

This may be related to the way activity is reported between the two main centres as being in different NHS countries. There is certainly a variance between elective/emergency activity as shown in the next section.

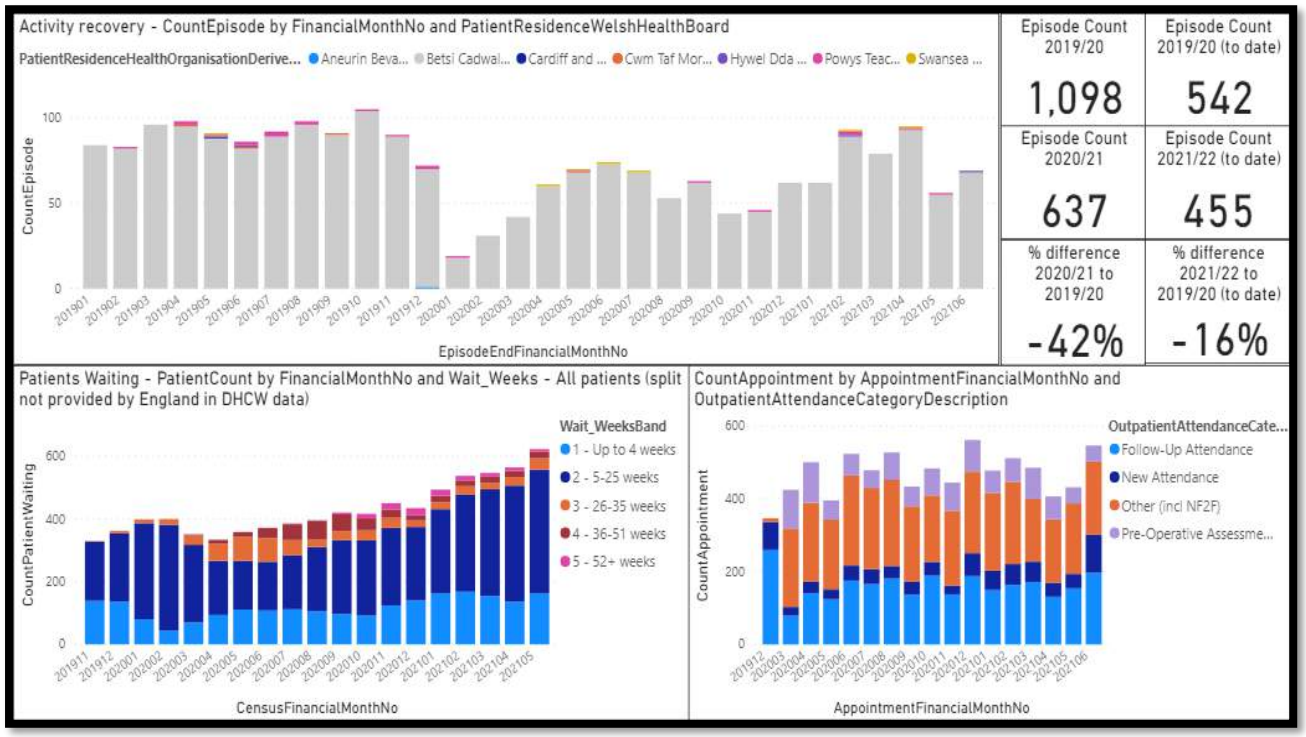
Neurosurgery – Recovery and Waiting Lists
Cardiff and Vale University Health Board (CVUHB)



Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at CVUHB in relation to Neurosurgery. Whilst the chart showing new out-patients shows a comparable rate in new referrals (those between 0-4 weeks), the total is now growing. While elective activity increased from the initial reduction, it has stayed static for a few months, yet the total waiting list for admissions has been steadily reducing.

The Walton Centre

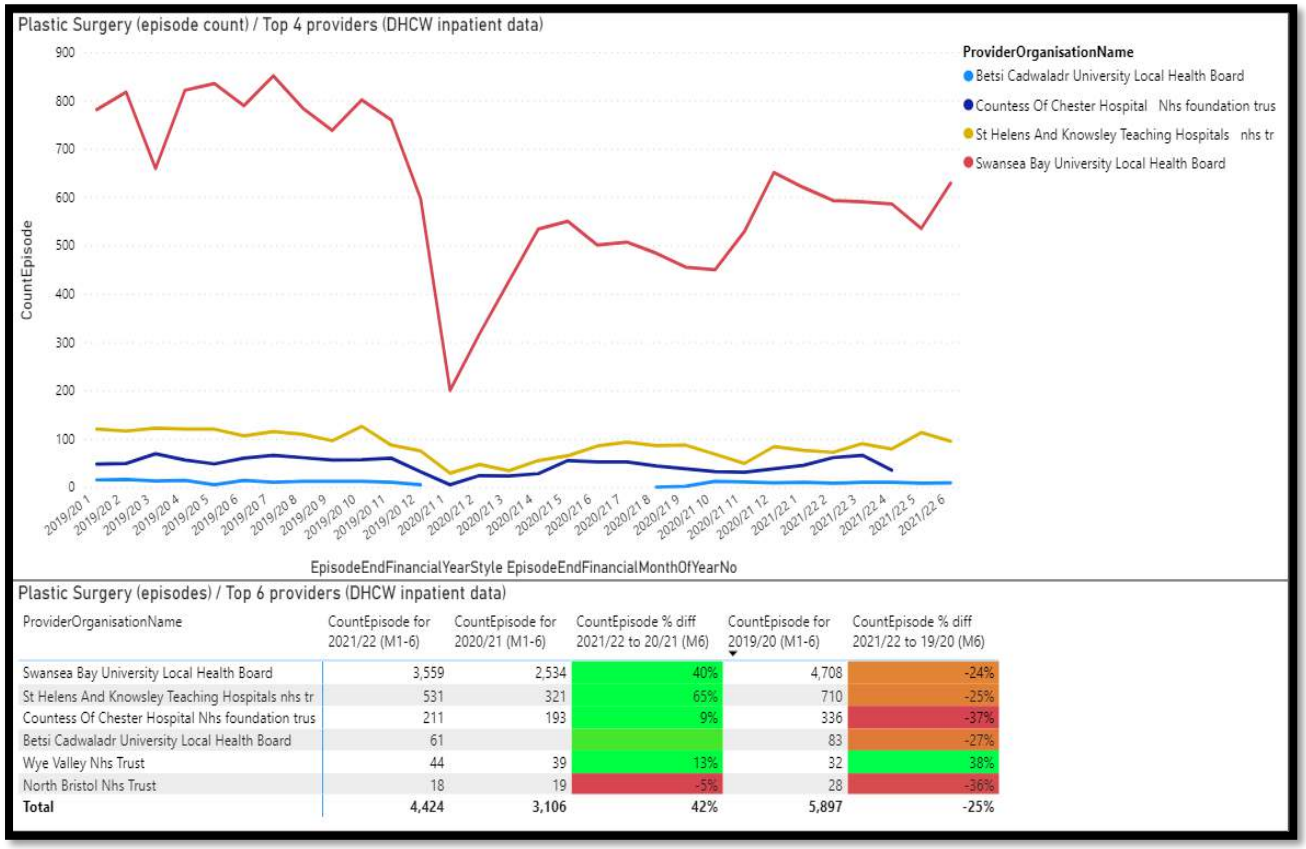


Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show a summary of the position at the Walton Centre in relation to Neurosurgery. Whilst activity is now 16% less this year than 2019-2020, the total patients waiting has been steadily increasing to almost double what it was as COVID-19 struck, and some patients have now been waiting more than a year.

One point to note is the bottom right chart, which shows the movement across types of Outpatient appointment since March 2020, new attendances in person are starting to increase, and it is notable that non face-to-face appointments have dramatically appeared during the COVID-19 period.

Plastic Surgery Plastic Surgery (excl. Burns)
Activity and Access Rate Summary



Plastic Surgery (episodes) / Top 6 providers (DHCW inpatient data)

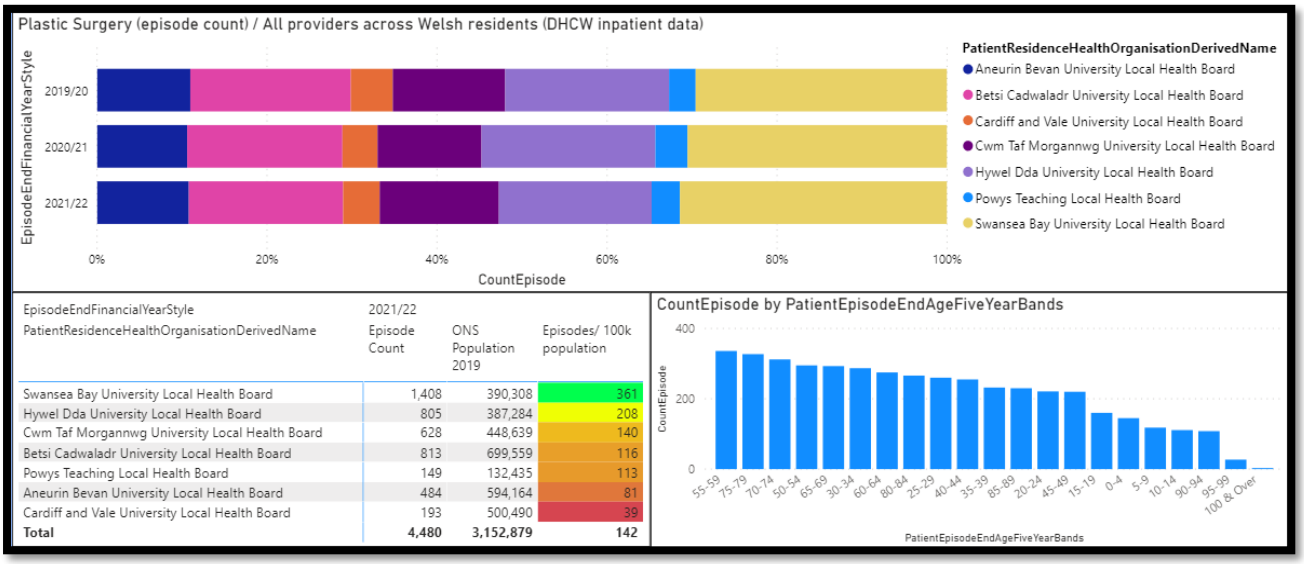
ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Swansea Bay University Local Health Board	3,559	2,534	40%	4,708	-24%
St Helens And Knowsley Teaching Hospitals nhs tr	531	321	65%	710	-25%
Countess Of Chester Hospital Nhs foundation trus	211	193	9%	336	-37%
Betsi Cadwaladr University Local Health Board	61			83	-27%
Wye Valley Nhs Trust	44	39	13%	32	38%
North Bristol Nhs Trust	18	19	-5%	28	-36%
Total	**4,424**	**3,106**	**42%**	**5,897**	**-25%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Plastic Surgery inpatient recovery across the main specialist providers, with an overall reduction of 25% so far this year compared to 2019-2020. The total reduction was 39% across the full year of 2020-2021. They all show the expected inverse relationship to the COVID-19 waves across the UK, with activity increasing again after the first few months.

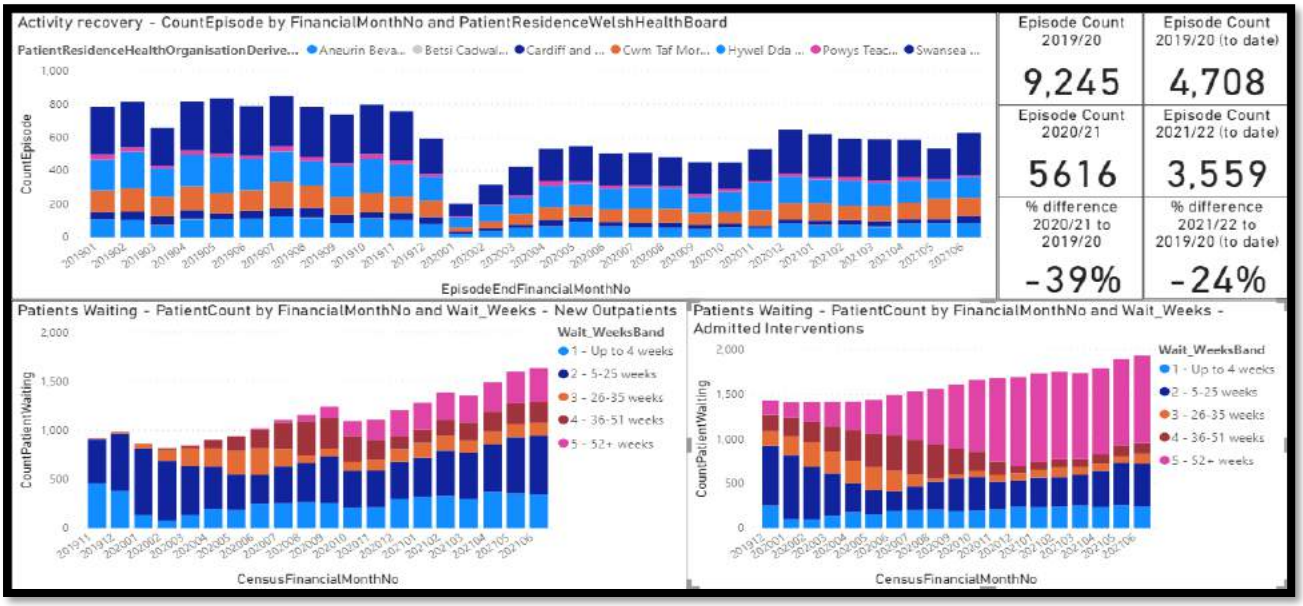
Note that the Countess of Chester Hospital activity above primarily relates to North Wales residents, which is paid for through a local contract and not via

WHSSC. Wye Valley patients are primarily Powys residents through the WHSSC contract.



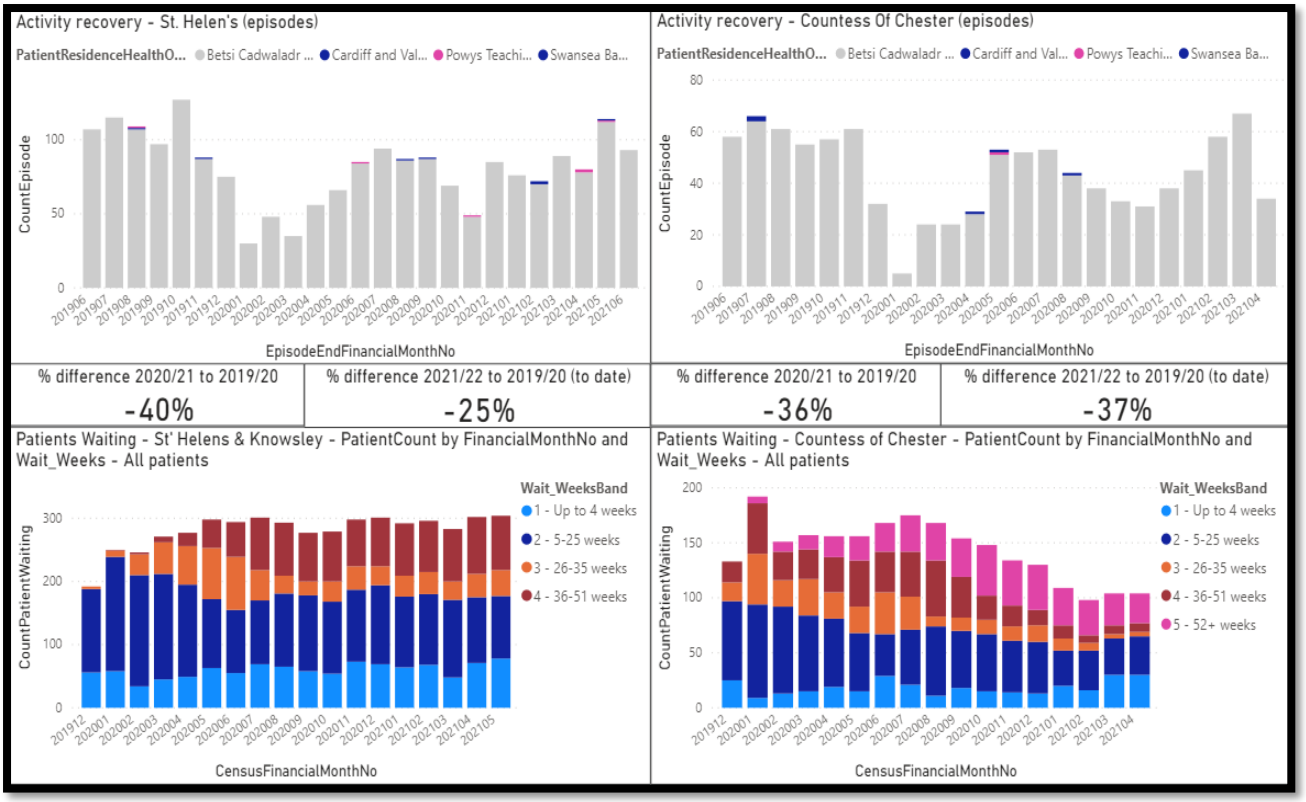
Access rates across the HBs do not appear to have varied much across the past 2 years, as shown in the charts above, however, there is a large variation across episodes/100k population, with inpatient episodes per 100k population in 2020-2021 varying from 58 to 552 across HBs, and between 39 and 361 in 2021-2022 in the bottom left chart. This is related to the current contract that SBUHB hold as the lead South Wales centre, which includes significant non-specialist activity for both SBUHB and HDUHB residents, and is being discussed internally. Non-specialist activity for other HBs is reported under non-WHSSC areas/specialties, and reporting is also linked to the specialty/grade of the treating medic (eg. Dermatology/Plastic Surgery).

Plastic Surgery (excl. Burns) – Recovery and Waiting Lists Swansea Bay University Health Board (SBUHB)



The tables above show a summary of the position at SBUHB in relation to Plastic Surgery. Whilst activity is now 24% less this year than 2019-2020, which is better than the 39% drop to this point in 2020-2021, the total patients waiting has been steadily increasing to almost double what it was at the beginning of the COVID-19 pandemic, and a significant number of patients have now been waiting more than a year. Within the total of patients waiting, those waiting for new outpatient appointments have doubled since February 2020, and those waiting for admissions have increased by almost 40%.

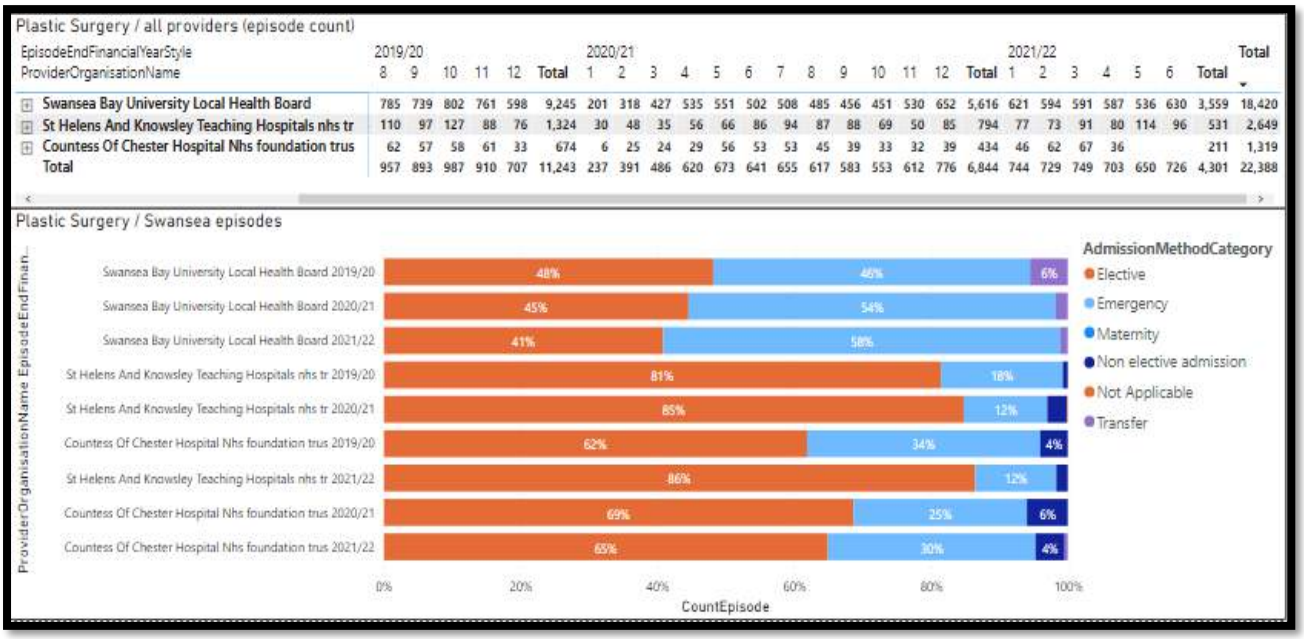
English providers – St. Helen's and Knowsley, Countess of Chester Hospital



Whilst English providers also reflect the trend of patients in general waiting longer than before the pandemic, the percentage of patients waiting over a year is much lower. Total waiting patients have increased at St Helen's, although no one has been waiting over a year. The total initially increased but has since decreased to pre-COVID-19 levels at Countess of Chester Hospital (local BCU contract).

Interestingly, data on the inpatient episodes shows an inverse of the elective/non-elective split for SBUHB and the English providers, with SBUHB having a higher proportion of emergency activity. Please see the below chart for the movements across the past three years. The episode counts have been included to give some perspective on the numbers, as SBUHB treats a far higher volume of Welsh patients.

Given the expected prioritisation weighted towards cancer work, it is likely that there will be a legacy of non-cancer elective waiting list cases, although the available data does not give the cancer breakdown.



Data source: DHCW central data warehouse; all inpatient activity

As noted in the comments above, variation across heath boards in utilisation of plastic surgery does not necessarily reflect variation in access to appropriate treatment since many procedures (the majority of activity) provided by plastic surgery are also provided by other specialties. Whether a particular patient is treated by a plastic surgeon or a surgeon from another specialty largely depends on the local services available in the patient's health board (unless it is a specialised procedure only offered by plastics). WHSSC will be working with SBUHB to support the recovery plan for plastic surgery to address the significant backlog of patients with long waiting times for treatment.

Bariatric Surgery

There has been limited operating activity for bariatric surgery throughout the past year, however there are plans to recommence activity in SBUHB by the end of the year. There is an anticipated residual gap which could be managed through alternate patient pathways.

Cleft Lip and Palate

- ***Paediatrics***

Good recovery has been made within SBUHB University Health Board and there are no anticipated problems moving forward. There are no current issues of concern within BCUHB. Both English providers (ACH and Manchester) are expected to deliver against pre-COVID-19 levels.

- ***Adults***

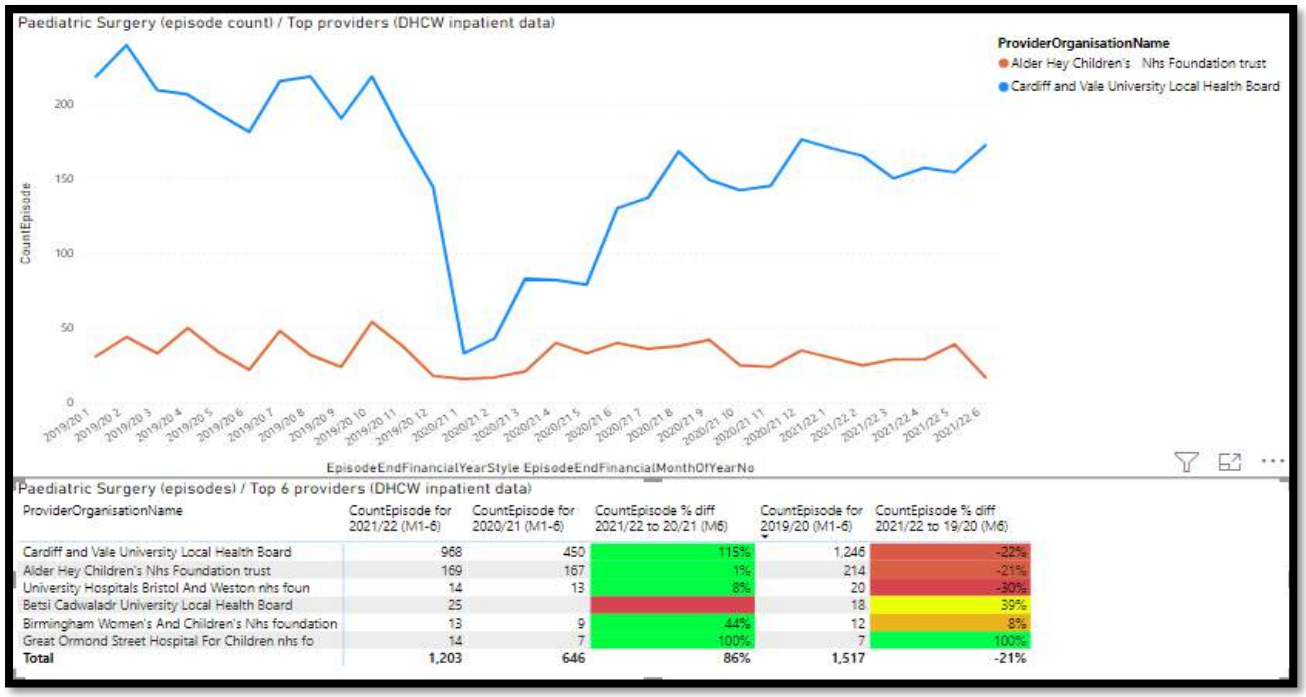
There remains a challenging position in respect of adult services for cleft lip and palate with exploration of alternate pathways being undertaken by the main South East Wales provider.

IVF

Activity is below contracted levels in the Welsh Fertility Centre, with alternate pathways being explored. Both English providers (Liverpool and Shrewsbury) have recovered and are expected to deliver above contracted activity.

Paediatric Surgery

Paediatric Surgery – Activity and Access Rate Summary



Paediatric Surgery (episodes) / Top 6 providers (DHCW inpatient data)

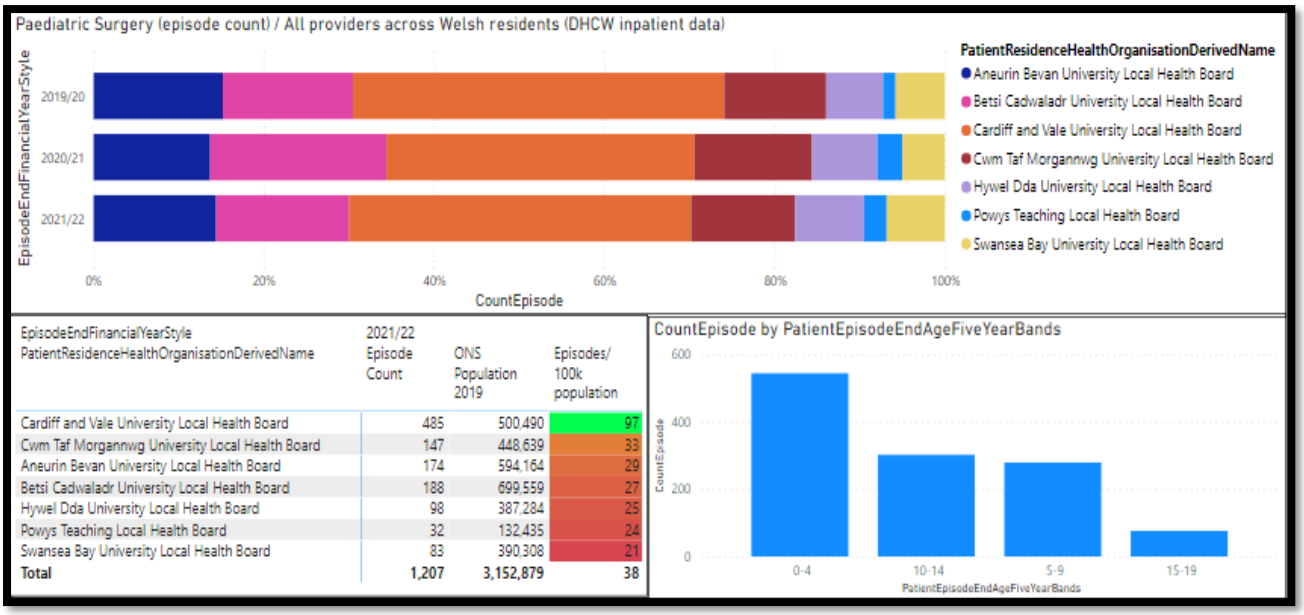
ProviderOrganisationName	CountEpisode for 2021/22 (M1-6)	CountEpisode for 2020/21 (M1-6)	CountEpisode % diff 2021/22 to 20/21 (M6)	CountEpisode for 2019/20 (M1-6)	CountEpisode % diff 2021/22 to 19/20 (M6)
Cardiff and Vale University Local Health Board	968	450	115%	1,246	-22%
Alder Hey Children's Nhs Foundation trust	169	167	1%	214	-21%
University Hospitals Bristol And Weston nhs foun	14	13	8%	20	-30%
Betsi Cadwaladr University Local Health Board	25			18	39%
Birmingham Women's And Children's Nhs foundation	13	9	44%	12	8%
Great Ormond Street Hospital For Children nhs fo	14	7	100%	7	100%
Total	**1,203**	**646**	**86%**	**1,517**	**-21%**

Data source: DHCW central data warehouse; all inpatient activity

The above table highlights the variance in Paediatric Surgery inpatient recovery across the main specialist providers, with ACH initially showing the highest and quicker recovery. The main 2 providers show the expected inverse relationship to the COVID-19 waves across the UK, with activity increasing again.

There was a drop in the volume of Paediatric Surgery inpatient activity reported during the period, which is recovering but was 38% less activity overall in 2020-2021 compared to 2019-2020.

Activity so far in 2021-2022 shows a 86% increase compared to last year at this point, and 21% less than 2019-2020, with the 2 main providers being roughly the same.



EpisodeEndFinancialYearStyle PatientResidenceHealthOrganisationDerivedName	2021/22 Episode Count	ONS Population 2019	Episodes/ 100k population
Cardiff and Vale University Local Health Board	485	500,490	97
Cwm Taf Morgannwg University Local Health Board	147	448,639	33
Aneurin Bevan University Local Health Board	174	594,164	29
Betsi Cadwaladr University Local Health Board	188	699,559	27
Hywel Dda University Local Health Board	98	387,284	25
Powys Teaching Local Health Board	32	132,435	24
Swansea Bay University Local Health Board	83	390,308	21
Total	**1,207**	**3,152,879**	**38**

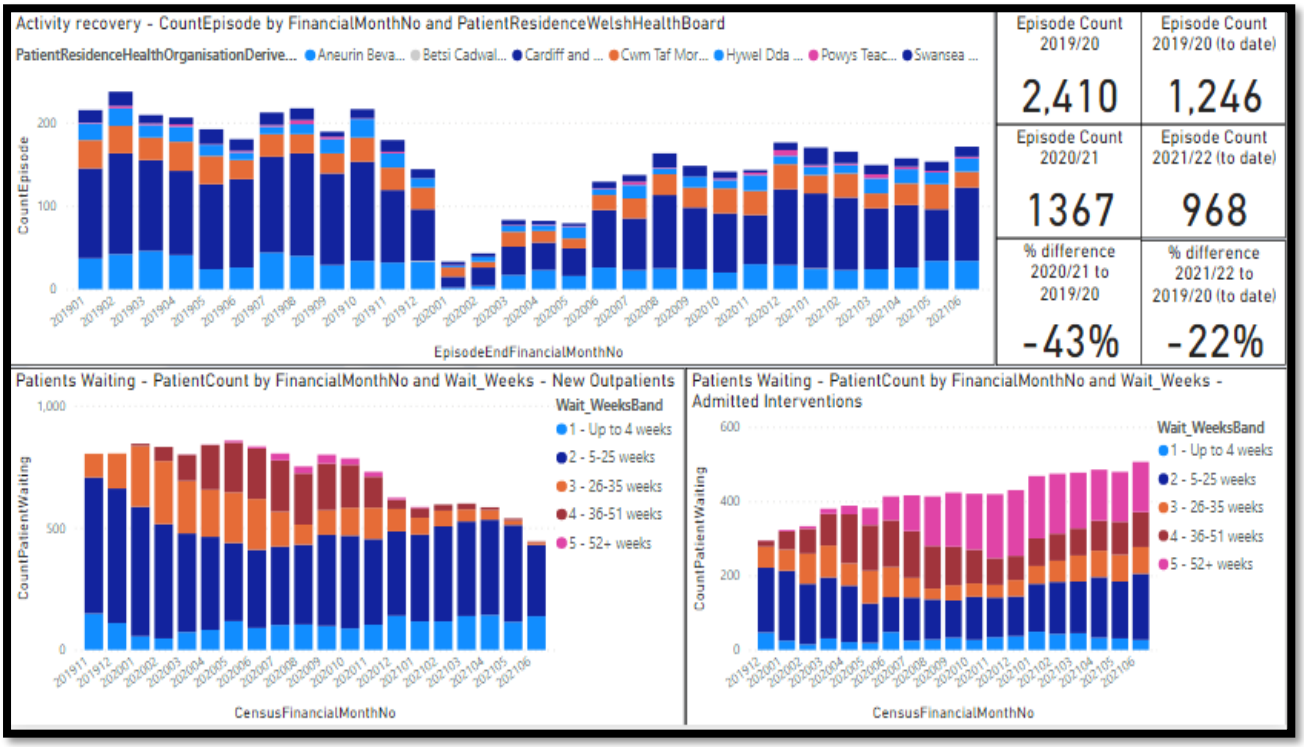
Data source: DHCW central data warehouse; all inpatient activity

Access rates across the HBs varied as the pandemic initially hit, but have now stabilised to roughly the same split as last year. The highest age group having inpatient episodes are by far the 0-4 age group.

However, inpatient episodes per 100k population varies significantly overall across the Health Board areas, from 21 to 97 as per the small table above, with CVUHB being by far the highest. This may be linked to CVUHB being the contracted provider of this service, with all activity passing through the WHSSC contract, and is being considered internally.

Paediatric Surgery – Recovery and Waiting Lists

Cardiff and Vale University Health Board (CVUHB)

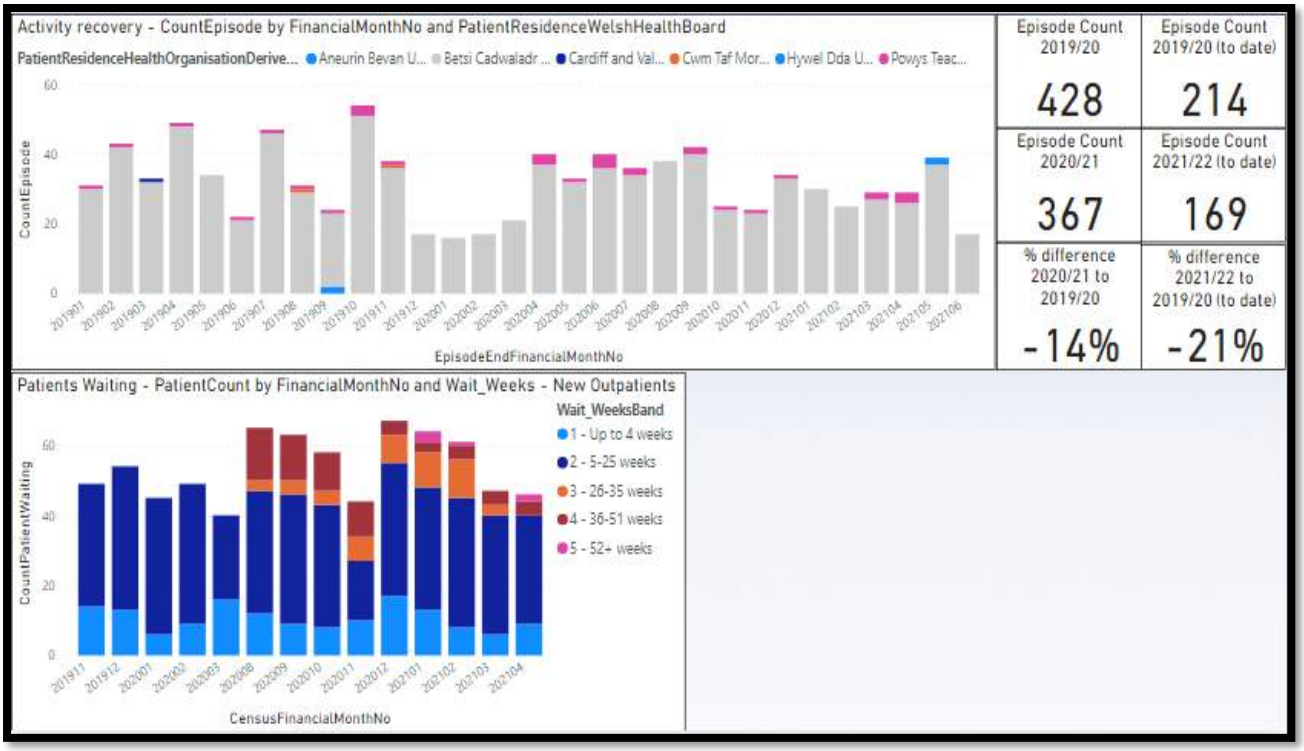


Data source: DHCW central data warehouse; all patients waiting with an open pathway

The tables above show the progression of patients waiting for Paediatric Surgery services at CVUHB. As the main provider, CVUHB shows mixed results – while patients waiting for outpatient appointments have reduced, particularly for follow-ups, patients waiting for admitted interventions have increased, with almost 30% now having waited for over a year. Given that the highest age band of this specialty is in the 0-4 age band, this is particularly significant. Whilst tackling the New Outpatient waiting list is to be commended, it appears to then adversely affect the waiting list for admissions.

Previous experience emphasizes the importance of maintaining elective waiting lists delivered on a timely basis, given the qualitative impact on the development of children. It will be important to see a more rapid increase in activity if waiting times for children are to be kept to tolerable levels. Meanwhile it will be essential for the provider to have in place appropriate systems to monitor the risk of these patients waiting for surgery.

Alder Hey Children's Hospital (ACH)



Data source: DHCW central data warehouse; all inpatient activity

The tables above show a summary of the position at ACH in relation to Paediatric Surgery. Whilst the recovery position to the current month is actually less than last year (14% less in 2020-2021 compared to 2019-2020 in total, and 21% less to date this year compared to 2019-2020), the total waiting list has reduced to pre-COVID-19 levels.

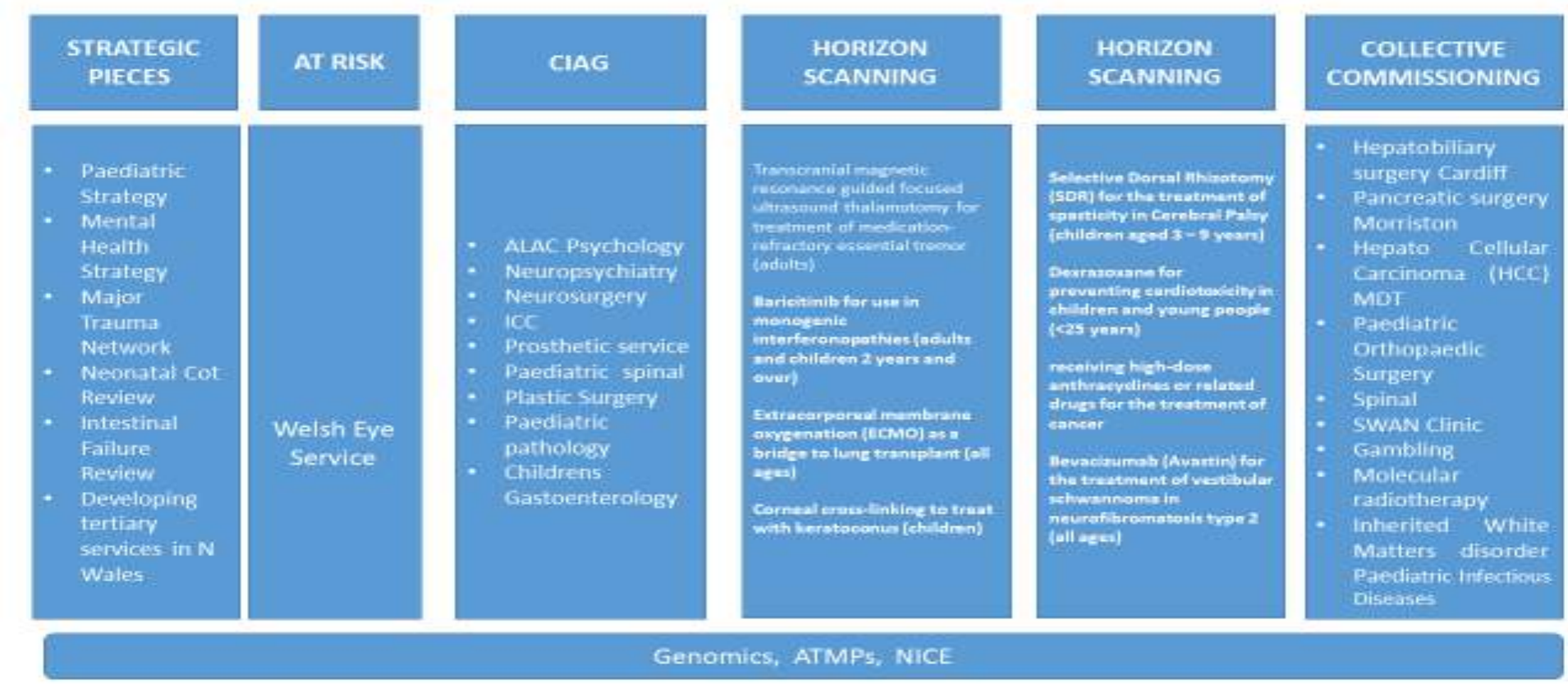
ACH had previously reported to WHSSC through their recovery plans that activity was currently higher than pre-COVID-19 levels and a robust plan is in place to manage the small number of patients waiting over 52 weeks. The provider has confirmed that all patients waiting over 52 weeks will be treated before the end of March 2022.

CVUHB are reporting a significant number of patients waiting over 52 weeks. In dialogue with the provider, there are a number of contributing factors to the waiting list including nurse capacity, bed capacity and theatre availability. The Health Board are refining the recovery plan for paediatrics to detail the trajectory for managing the patient cohort. WHSSC have sought assurance on the clinical review and communication with patients on the waiting list. There are 50 newly qualified nurses due to start within the Children's hospital over the coming months, which will work towards alleviating the nursing and bed pressures.

BMT and CAR-T
There are capacity issues within CVUHB for the provision of BMT with discussions on-going as to whether more patients can be seen at SBUHB. There are currently no issues with NHS England providers.

There are also capacity issues within CVUHB for the provision of CAR-T. This is not just a recovery issue and there will need to be a strong plan for the provision of CAR-T within Wales moving forward. There are no issues with providers from within NHS England.

APPENDIX C - INTEGRATED COMMISSIONING PLAN: PLAN ON A PAGE



APPENDIX D – FINANCIAL TABLES

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	January ICP Revised Req.	December ICP Iteration	Reduction	Rationale to Reduce ICP Provision
	2022/23 WHSSC Requirement £m	2022/23 WHSSC Requirement £m	£m	
Recurrent Adjustments	0.975	3.227	(2.252)	Include a non recurrent performance provision in services where underperformance is expected
Full Year Effect of Prior Approved Commitments	4.152	4.622	(0.470)	Review FYE based on latest in year recruitment update
Unavoidable Growth & Cost Pressures	4.050	5.298	(1.248)	Review genetics TD growth in light of current TD slippage.
CIAG & Prioritisation Schemes	**1.240**	**1.544**	**(0.304)**	Review of schemes on case by case basis for likely impact
Strategic Specialist Priorities	**3.436**	**6.010**	**(2.574)**	Phase 1st year requirement considering time for extra capacity to come online and recruitment to standards
% Core Uplift Required	**4.02%**	**5.00%**	**-0.98%**	
COVID Recovery & Sustainability Allocation	6.699	11.153	(4.454)	Assume ERF is at 40% of 21/22 forecast levels, on basis of stable ERF threshold and non recurrent backlog activity delivered in H1 of 21/22
% Recovery & Sustainability Uplift Required	**0.94%**	**1.57%**	**-0.63%**	
Total Funding Requirement	35.272	**46.657**	**(11.385)**	
% Total Uplift Required	**4.97%**	**6.57%**	**-1.60%**	

	6.57%
	46.657
	-1.60%
	(11.385)

0.40000

4650

	Reduction £m
Total Reduction in Requirement	(11.385)
	-1.60%

	Core Plan £m
Core plan uplift	
ICP Investment 2022/23 December Iteration	**35.504**
ICP Investment 2022/23 January Revision	**29.135**
Reduction in Core uplift	**(6.369)**

	Recovery £m
Recovery Allocation pass through	
Recovery 2022/23 December Iteration	**11.153**
Recovery 2022/23 January Revision	**6.699**
Reduction in Recovery Allocation	**(4.454)**

	Total Requirement £m
Core & Recovery Total Requirement	
Recovery 2022/23 December Iteration	**46.657**
Recovery 2022/23 January Revision	**35.834**
Total Reduction in Requirement	**(10.823)**
	-1.60%

WHSSC 2022-23 ICP Financial Summary

	Aneurin Bevan UHB £m	Betsi Cadwaladr UHB £m	Cardiff & Vale UHB £m	Cwm Taf Morgannwg UHB £m	Hywel Dda UHB £m	Powys THB £m	Swansea Bay UHB £m	2022/23 WHSSC Requirement £m
2021/22 Closing Income	136.045	149.083	122.980	104.236	81.251	29.942	90.359	713.897
Hand back 21/22 NR Recovery Provision	(0.750)	(0.892)	(0.633)	(0.568)	(0.491)	(0.168)	(0.497)	(4.000)
2022/23 Opening Income	135.295	148.192	122.347	103.668	80.760	29.773	89.862	**709.897**
Neonatal Rebasing (2019 - 2021 average)	(0.408)	0.000	0.548	(0.304)	(0.272)	(0.129)	(0.344)	(0.909)
21/22 Utilisation Adjusted Income Baseline	134.887	148.192	122.895	103.364	80.488	29.645	89.518	**708.989**
Recurrent Adjustments	0.264	0.134	0.153	0.106	0.119	0.122	0.077	0.975
Re-stated Rollover Requirement	(0.144)	0.134	0.701	(0.198)	(0.153)	(0.007)	(0.267)	0.066
Full Year Effect of Prior Approved Commitments	0.905	0.399	1.051	0.740	0.463	0.129	0.464	4.152
Unavoidable Growth & Cost Pressures	0.782	0.851	0.656	0.592	0.499	0.165	0.505	4.050
New VBC Workstreams	(0.251)	(0.080)	(0.223)	(0.201)	(0.148)	(0.039)	(0.158)	(1.100)
Underlying Rollover & Growth	1.293	1.304	2.185	0.933	0.662	0.248	0.543	7.168
CIAG & Prioritisation Schemes	0.263	0.191	0.240	0.196	0.143	0.044	0.164	**1.240**
Strategic Specialist Priorities	0.902	0.000	0.619	0.646	0.564	0.150	0.555	**3.436**
NHS England Provider Inflation	0.546	2.161	0.385	0.374	0.307	0.205	0.329	4.306
NHS Wales Provider Inflation	2.557	1.553	2.436	2.033	1.638	0.375	1.830	12.423
ICP Investment 2022/23	5.561	5.209	5.865	4.182	3.314	1.022	3.420	28.573
Total WHSSC Funding 2022/23	140.856	153.401	128.212	107.851	84.074	30.795	93.282	738.471
% Core Uplift Required	**4.11%**	**3.52%**	**4.79%**	**4.03%**	**4.10%**	**3.43%**	**3.81%**	**4.02%**

COVID Recovery & Sustainability Allocation	1.208	2.852	0.912	0.865	0.377	0.146	0.340	6.699
% Recovery & Sustainability Uplift Required	**0.89%**	**1.92%**	**0.75%**	**0.83%**	**0.47%**	**0.49%**	**0.38%**	**0.94%**
Total Funding Requirement	**6.769**	**8.061**	**6.776**	**5.048**	**3.691**	**1.168**	**3.761**	**35.272**
% Total Uplift Required	**5.00%**	**5.44%**	**5.54%**	**4.87%**	**4.57%**	**3.92%**	**4.18%**	**4.97%**

2022-25 Financial Plan
WHSSC ICP Financial Tables

Commissioner Split

Income Assumptions

Table 2

Ref	Opening Income 2021/22		2022/23 £m	2023/24 £m	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Cwm Taf (Bridgend) UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	SB UHB	Total
	21/22 Opening Income Expections		695.812	-	131.179	149.445	118.352		102.251	78.875	29.091	86.619	695.812
	Remove: NR Vertex 20/21 Allocation		(19.057)		- 3.300	- 4.871	- 2.661		-3.922	-1.748	- 0.545	- 2.011	(19.057)
	Remove NR slippage return for MTC		2.935		0.744	-	0.610		0.506	0.493	0.041	0.541	2.935
	Remove NR slippage return for LTV		0.624		0.156	-	0.128		0.106	0.103	0.018	0.113	0.624
	Remove NR Traumatic Stress		(0.447)		- 0.082	- 0.090	- 0.064		-0.070	-0.056	- 0.026	- 0.059	(0.447)
	Remove NR Vulnerable groups		(0.108)		-	-	-		-0.108	0.000	-	-	(0.108)
	Add: 21/22 Allocation letter Genomics Strategy uplift		0.431		0.082	0.092	0.062		0.069	0.052	0.018	0.056	0.431
	Add: 21/22 Allocation Letter Major Trauma FYE uplift		0.655		0.166	-	0.136		0.113	0.110	0.009	0.121	0.655
	21/22 EASC ICP investment		0.000		0.000	0.000	0.000		0.000	0.000	0.000	0.000	0.000
	21/22 WHSSC ICP investment		33.052		7.100	4.507	6.418		5.292	3.422	1.336	4.978	33.052
													0.000
													0.000
													0.000
													0.000
													0.000
	Opening Income April 2021 (Pre riskshare adj)		**713.897**		**136.045**	**149.083**	**122.980**	**0.000**	**104.236**	**81.251**	**29.942**	**90.359**	**713.897**
													0.000000
													0.000000
	Opening Income April 2021 (Pre riskshare adj)		**713.897**		**136.045**	**149.083**	**122.980**	**-**	**104.236**	**81.251**	**29.942**	**90.359**	**713.897**
			-										-
	Opening Income April 2020		**713.897**	**-**	**136.045**	**149.083**	**122.980**	**-**	**104.236**	**81.251**	**29.942**	**90.359**	**713.897**

Riskshare Tables

Commissioner Split

Table 3a

Reported Financial Position	2022/23 £m	2023/24 £m	2024/25 £m
M6 Reported Position	(9.765)	(9.765)	(9.765)
20/21 Non recurrent writebacks	2.399	2.399	2.399
Reported Financial Position	**(7.365)**	**(7.365)**	**(7.365)**

Split Code		SB UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	CT Bridgend UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Total
	M6 Reported	(0.832)	(1.797)	(2.680)	(1.914)		(1.360)	(0.816)	(0.366)	(9.765)
	19/20 Non recurrent writebacks	0.231	0.423	0.452	0.674	0.000	0.284	0.205	0.131	2.399
		(0.601)	**(1.374)**	**(2.228)**	**(1.240)**	**-**	**(1.076)**	**(0.611)**	**(0.235)**	**(7.365)**

Table 3c

Full Year Effect of Prior Year Developments	2022/23 £m	2023/24 £m	2024/25 £m
PET new indications & growth			
PET Indications	0.425	0.425	0.425
Paediatric Neurology	0.300	0.400	0.400
Neuropsychiatry	0.077	0.077	0.077
Paediatric Gastroenterology	0.263	0.300	0.300
Intestinal Failure	0.263	0.300	0.300
Prosthetic and Amputee Rehab	0.042	0.042	0.042
SABR for Oligometastatic Disease and HCC	0.387	0.387	0.387
Paediatric Rheumatology	0.190	0.225	0.225
Tuberous Sclerosis	0.048	0.048	0.048
Clinical Immunology Paediatrics	0.035	0.035	0.035
Paediatric Radiology	0.150	0.300	0.300
HDR Brachytherapy	0.100	0.100	0.100
Cardiac MRI - funded through risks	0.125	0.125	0.125
Inherited Cardiac Conditions	0.051	0.051	0.051
Neurosurgery Oncology Service	0.225	0.300	0.300
Relocation of Rehabilitation Services	0.188	0.188	0.188
All Wales Gender Service	0.460	0.920	0.920
WBS EU Directive (IVDD/IVDR) Regulation	0.500	0.500	0.500
Spinal Rehabilitation	0.324	0.648	0.648
Stem Cell Transplantation for adults with sickle cell disease		-	-
GammaCore for cluster headaches		-	-
Stem cell transplantation for relapsing remitting multiple sclerosis		-	-
Total Full Year Effect of Prior Year Developments	**4.152**	**5.371**	**5.371**

Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Cwm Taf (Bridgend) UHB	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Total
187	IPM Eculizumab	0.000	-	-	-	-	-	-	-	-
187	IPM Eculizumab	0.053	0.080	0.095	0.067	-	0.060	0.052	0.018	**0.425**
36	Cardiff & Vale Paediatric Neurology	0.011	0.070	-	0.153	-	0.047	0.016	0.003	**0.300**
58	Cardiff & Vale Neuropsychiatry	0.010	0.018	0.002	0.032	-	0.007	0.006	0.002	**0.077**
38	Cardiff & Vale Paediatric Gastroenterology	0.005	0.074	-	0.131	-	0.041	0.002	0.008	**0.263**
54	Cardiff & Vale Home TPN	0.006	0.049	-	0.096	-	0.078	0.028	0.005	**0.263**
189	IPM ALAS (War veterans)	0.005	0.008	0.009	0.007	-	0.006	0.005	0.002	**0.042**
187	IPM Eculizumab	0.048	0.072	0.086	0.061	-	0.055	0.047	0.016	**0.387**
331	Cardiff & Vale Paediatric Rheumatology	0.031	0.047	-	0.040	-	0.036	0.031	0.005	**0.190**
50	Cardiff & Vale Medical Genetics	0.006	0.009	0.011	0.008	-	0.007	0.006	0.002	**0.048**
31	Cardiff & Vale Clinical Immunology	0.006	0.009	-	0.007	-	0.007	0.006	0.001	**0.035**
332	Cardiff & Vale Paediatric Radiology	0.019	0.043	-	0.039	-	0.032	0.016	0.001	**0.150**
187	IPM Eculizumab	0.012	0.019	0.022	0.016	-	0.014	0.012	0.004	**0.100**
7	Cardiff & Vale ACHD	0.016	0.023	0.028	0.020	-	0.018	0.015	0.005	**0.125**
68	ABMU Cardiology	0.021	0.000	0.000	0.001	-	0.005	0.022	0.001	**0.051**
13	Cardiff & Vale Neurosurgery	0.035	0.053	0.001	0.050	-	0.052	0.030	0.004	**0.225**
18	Cardiff & Vale Neuro Rehab	0.000	0.060	-	0.088	-	0.037	0.002	0.000	**0.188**
204	Mental Health Gender	0.057	0.086	0.103	0.073	-	0.065	0.057	0.019	**0.460**
317	2020/21 Plan Developments Wholesale Commercial Products Riskshare	0.074	0.114	0.042	0.094	-	0.085	0.072	0.020	**0.500**
17	Cardiff & Vale Spinal Injuries	0.048	0.069	-	0.069	-	0.088	0.038	0.012	**0.324**
282	2018/19 Plan Reserves Contingency for in year plan pressures	0.000	-	-	-	-	-	-	-	-
282	2018/19 Plan Reserves Contingency for in year plan pressures	0.000	-	-	-	-	-	-	-	-
282	2018/19 Plan Reserves Contingency for in year plan pressures	0.000	-	-	-	-	-	-	-	-
		0.464	**0.905**	**0.399**	**1.051**	**-**	**0.740**	**0.463**	**0.129**	**4.152**

Table 3d

Recurrent performance adjustment	2022/23 £m	2023/24 £m	2024/25 £m
Gender	0.350	0.500	0.500
NHS Blood & Transplant	0.274	0.274	0.274
University Hospitals of North Midlands NHS Trust	0.104	0.104	0.104
DRC Staff Resource uplift	0.247	0.247	0.247
TAVI	0.791	0.791	0.791
Thoracic Surgery	0.063	0.063	0.063
Paediatrics Renal	0.160	0.160	0.160
Paediatrics Oncology	0.300	0.300	0.300
RF Ablation - Barretts Oesophagus	0.321	0.321	0.321
TAVI	0.397	0.397	0.397
Lymphoma Panel	0.220	0.220	0.220
NR Underperformance adjustment	- 2.252	-	-
Total Recurrent Performance Adjustment	**0.975**	**3.377**	**3.377**

Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Cwm Taf (Bridgend) UHB	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Total
204	Mental Health Gender	0.043	0.066	0.078	0.055	0.000	0.050	0.043	0.015	0.350
320	Non Welsh SLAs NHS Blood & Transplant	0.002	0.153	0.000	0.053	0.000	0.022	0.044	0.000	0.274
179	Non Welsh SLAs University Hospitals of North Staffordshire NHS Trust	0.001	0.001	0.000	0.002	0.000	0.001	0.004	0.095	0.104
310	DRC WHSSC - Core Staffing	0.030	0.045	0.056	0.043	0.011	0.022	0.028	0.012	0.247
6	Cardiff & Vale Cardiac Surgery-TAVI	0.000	0.407	0.000	0.268	0.000	0.090	0.000	0.026	0.791
11	Cardiff & Vale Thoracic Surgery	0.001	0.021	0.000	0.025	0.000	0.014	0.002	0.001	0.063
34	Cardiff & Vale Paediatric Renal	0.013	0.028	0.000	0.070	0.000	0.041	0.006	0.001	0.160
35	Cardiff & Vale Paediatric Oncology	0.038	0.087	0.000	0.078	0.000	0.064	0.031	0.002	0.300
57	Cardiff & Vale Hepatology	0.053	0.080	0.000	0.067	0.000	0.060	0.052	0.009	0.321
67	ABMU TAVI	0.205	0.002	0.000	0.009	0.000	0.017	0.160	0.005	0.397
30	Cardiff & Vale Lymphoma Panel	0.027	0.041	0.049	0.035	0.000	0.031	0.027	0.009	0.220
	Custom to negate recurrent performance provision	(0.337)	(0.665)	(0.049)	(0.551)	0.000	(0.317)	(0.279)	(0.053)	(2.252)
		0.077	**0.264**	**0.134**	**0.153**	**0.011**	**0.095**	**0.119**	**0.122**	**0.975**

2022-25 Financial Plan
WHSSC ICP Financial Tables

Table 4

Commissioner Split

Welsh Inflation

Table 4a - Welsh Inflation @ 2%

Provider	Service	Annual Budget Table 3a	2022/23 £m	2023/24 £m	2024/25 £m	ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Total
Welsh Providers	**Inflation**		12.423	12.423	12.423	1.830	2.557	1.553	2.436	0.080	1.953	1.638	0.375	**12.423**
						14.73%	20.58%	12.50%	19.61%	0.65%	15.72%	13.18%	3.02%	

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Welsh Inflation	Table 4a - Welsh Inflation @ 2.8%					Remove Pass Through	Add performance provision	Budget to apply inflation	Inflation 2.8%
Provider	**Service**	**Annual Budget Table 3a**	**Programme Team**	**2021-22**		**£'000**	**£'000**	**£'000**	**£'000**
Aneurin Bevan	Cardiology	1.307	Cardiao-Thoracic	0.037				1.307	0.037
Aneurin Bevan	AB ICD Repatriation from C&V	0.409	Cardiao-Thoracic	0.011				0.409	0.011
Aneurin Bevan	Neonatal Care - NICU/HDU/SCBU	6.944	Women and Childrens	0.194				6.944	0.194
Aneurin Bevan	Pay Award	0.152	Unallocated	0.004				0.152	0.004
Aneurin Bevan	RF ablation	0.122	Cancer and Blood	0.003				0.122	0.003
BCU	ACHD	0.146	Cardiao-Thoracic	0.004				0.146	0.004
BCU	ALAS	6.571	Neuro and LTC	0.184				6.571	0.184
BCU	Angioplasty	3.081	Cardiao-Thoracic	0.086				3.081	0.086
BCU	BAHA	0.561	Women and Childrens	0.016				0.561	0.016
BCU	BMT	0.096	Cancer and Blood	0.003				0.096	0.003
BCU	CAMHS - Inpatient unit	2.994	Adult Mental Health	0.084				2.994	0.084
BCU	Cervical screening capital charge adjustment	- 0.033	Unallocated	- 0.001				- 0.033	- 0.001
BCU	Cochlear Implants	1.758	Women and Childrens	0.049				1.758	0.049
BCU	Haemophilia	1.656	Cancer and Blood	0.013		1.200		0.456	0.013
BCU	ICD	2.557	Cardiao-Thoracic	0.072				2.557	0.072
BCU	Medical Genetics	0.186	Cancer and Blood	0.005				0.186	0.005
BCU	Medium Secure Mental Health	5.445	Adult Mental Health	0.152				5.445	0.152
BCU	NICU	1.168	Women and Childrens	0.033				1.168	0.033
BCU	Pay Award	0.941	Unallocated	0.026				0.941	0.026
BCU	PET Scan	1.127	Cancer and Blood	0.032				1.127	0.032
BCU	Renal	15.618	Renal Network	0.437				15.618	0.437
BCU	Sarcoma	0.077	Cancer and Blood	0.002				0.077	0.002
Cardiff	AB ICD Repatriation	- 0.410		- 0.011				- 0.410	- 0.011
Cardiff	ACHD	1.260	Cardiao-Thoracic	0.035				1.260	0.035
Cardiff	AICU	6.592	Unallocated	0.185				6.592	0.185
Cardiff	ALAS	17.728	Neuro and LTC	0.496				17.728	0.496
Cardiff	ATMPs - C&V Service	1.435	Cancer and Blood	0.040				1.435	0.040
Cardiff	BAHAS & Cochlears	4.927	Women and Childrens	0.138				4.927	0.138
Cardiff	BMT - Cardiff & SB	8.862	Cancer and Blood	0.234		0.507		8.355	0.234
Cardiff	Cardiac Surgery	15.126	Cardiao-Thoracic	0.424				15.126	0.424
Cardiff	Cardiac Surgery-TAVI	2.541	Cardiao-Thoracic	- 0.000		2.541		- 0.000	- 0.000
Cardiff	Cardiology for AB	2.074	Cardiao-Thoracic	0.058				2.074	0.058
Cardiff	Cardiology- Specialist Services	12.666	Cardiao-Thoracic	0.355				12.666	0.355
Cardiff	Children's Hospital for Wales	1.282	Women and Childrens	0.036				1.282	0.036
Cardiff	Clinical Immunology	9.269	Neuro and LTC	0.054		7.325		1.944	0.054
Cardiff	Contract Rebasing Difference	0.688	Unallocated	0.019				0.688	0.019
Cardiff	Critical Care Long Term Ventilation	0.864	Neuro and LTC	0.024				0.864	0.024
Cardiff	Cwm Taf Cardiology ICD's	0.423	Cardiao-Thoracic	0.012				0.423	0.012
Cardiff	Cystic Fibrosis	5.999	Cardiao-Thoracic	0.147		0.753		5.246	0.147
Cardiff	Enzyme Replacement Therapy	0.476	Women and Childrens	0.013				0.476	0.013
Cardiff	Epilepsy Surgery	0.413	Neuro and LTC	0.012				0.413	0.012
Cardiff	Excess INR Outsourcing	0.200		0.006				0.200	0.006
Cardiff	Fetal Cardiology	0.309	Cardiao-Thoracic	0.009				0.309	0.009
Cardiff	Foetal Medicine	0.317		0.009				0.317	0.009
Cardiff	Gender Identity Service	0.597	Adult Mental Health	0.017				0.597	0.017
Cardiff	Genetic Counsellor 8a	0.065	Cancer and Blood	0.002				0.065	0.002
Cardiff	Haemophilia	5.050	Cancer and Blood	- 0.000		5.050		- 0.000	- 0.000
Cardiff	Haemophilia Ref Centre	0.075	Cancer and Blood	0.002				0.075	0.002
Cardiff	HDU	0.729	Unallocated	0.020				0.729	0.020
Cardiff	Hepatology	0.268	Cancer and Blood	0.007				0.268	0.007
Cardiff	Hereditary Aneamia Service	0.400		0.011				0.400	0.011
Cardiff	Home Renal Dialysis	1.387	Renal Network	0.039				1.387	0.039
Cardiff	Home TPN	1.538	Neuro and LTC	0.043				1.538	0.043
Cardiff	Hospital Renal Dialysis	14.075	Renal Network	0.394				14.075	0.394
Cardiff	IBD Service Infrastructure	1.857	Cancer and Blood	0.052				1.857	0.052
Cardiff	ILD RHIG Funded	0.156	Cancer and Blood	0.004				0.156	0.004
Cardiff	INR Devices	1.628	Neuro and LTC	- 0.000		1.628		- 0.000	- 0.000
Cardiff	Liver Cancer Development	1.087	Cancer and Blood	0.030				1.087	0.030
Cardiff	LTV Consultant Sessions	0.039	Neuro and LTC	0.001				0.039	0.001
Cardiff	Lymphoma Panel	1.220	Cancer and Blood	0.034				1.220	0.034
Cardiff	Lynch Syndrome	0.304	Unallocated	0.009				0.304	0.009
Cardiff	Major Trauma Centre	11.446		0.320				11.446	0.320
Cardiff	Medical Genetics	9.182	Cancer and Blood	0.241		0.567		8.615	0.241
Cardiff	Nephrology	6.854	Renal Network	0.192				6.854	0.192
Cardiff	Neuro Rehab	3.688	Neuro and LTC	0.103				3.688	0.103
Cardiff	Neuroendocrine Tumours (NETs)	0.761	Cancer and Blood	0.021				0.761	0.021
Cardiff	Neuropsychiatry	2.996	Neuro and LTC	0.084				2.996	0.084
Cardiff	Neurosurgery	18.758	Neuro and LTC	0.525				18.758	0.525
Cardiff	NICE / High Cost Drugs	0.105	Unallocated	-		0.105		-	-
Cardiff	NICU BH	9.747	Women and Childrens	0.273				9.747	0.273
Cardiff	Nusinersen Additional Costs	0.064		0.002				0.064	0.002
Cardiff	Paediatric Cardiology	2.949	Cardiao-Thoracic	0.083				2.949	0.083
Cardiff	Paediatric ENT	1.589	Women and Childrens	0.044				1.589	0.044
Cardiff	Paediatric Gastroenterology	0.881	Women and Childrens	0.025				0.881	0.025
Cardiff	Paediatric Ketogenic Diet	0.100		0.003				0.100	0.003
Cardiff	Paediatric MRI Investment	0.346		0.010				0.346	0.010
Cardiff	Paediatric Neuro Rehab	0.267	Neuro and LTC	0.007				0.267	0.007
Cardiff	Paediatric Neurology	2.617	Neuro and LTC	0.073				2.617	0.073
Cardiff	Paediatric Oncology	9.969	Women and Childrens	0.279				9.969	0.279
Cardiff	Paediatric Renal	1.420	Women and Childrens	0.038		0.045		1.375	0.038
Cardiff	Paediatric Rheumatology	0.272	Women and Childrens	0.008				0.272	0.008
Cardiff	Paediatric Surgery	6.788	Women and Childrens	0.190				6.788	0.190
Cardiff	Paeds Cystic Fibrosis	0.576	Cardiao-Thoracic	0.016				0.576	0.016
Cardiff	Paeds Endocrinology	0.723	Cardiao-Thoracic	0.020				0.723	0.020
Cardiff	Paeds Respiratory Equipment	0.296	Cardiao-Thoracic	0.001		0.252		0.044	0.001
Cardiff	Pay Award	5.398	Unallocated	0.212			2.189	7.587	0.212
Cardiff	Perinatal	0.288	Adult Mental Health	0.008				0.288	0.008
Cardiff	PICU BH	4.926	Women and Childrens	0.138				4.926	0.138
Cardiff	Regional Pharmaceutical Service	0.757	Unallocated	0.021				0.757	0.021
Cardiff	Renal CAPD (Dialysis)	1.709	Renal Network	0.048				1.709	0.048
Cardiff	Renal Surgery	3.625	Renal Network	0.101				3.625	0.101
Cardiff	Renal Transplants	6.143	Renal Network	0.133		1.381		4.762	0.133
Cardiff	RF Ablation - Barretts Oesophagus	0.120		0.003				0.120	0.003

Welsh Inflation	Table 4a - Welsh Inflation @ 2.8%					Remove Pass Through	Add performance provision	Budget to apply inflation	Inflation 2.8%
Provider	**Service**	**Annual Budget Table 3a**	**Programme Team**	**2021-22**		**£'000**	**£'000**	**£'000**	**£'000**
Cardiff	SB Cardiology	0.148	Cardiao-Thoracic	0.004				0.148	0.004
Cardiff	Spinal Implants	1.375	Neuro and LTC	-		1.375		-	-
Cardiff	Spinal Injuries	3.381	Neuro and LTC	0.095				3.381	0.095
Cardiff	Thoracic Surgery	4.292	Cancer and Blood	0.118		0.066		4.226	0.118
Cardiff	UK GTN Send out tests	0.392	Cancer and Blood	-		0.392		-	-
CTM	CAMHS T4	4.277	Adult Mental Health	0.120				4.277	0.120
CTM	Cochlear	0.314	Women and Childrens	0.009				0.314	0.009
CTM	FACTS	0.497	Adult Mental Health	0.014				0.497	0.014
CTM	ICD	0.676	Cardiao-Thoracic	0.019				0.676	0.019
CTM	Neonatal Care - NICU/HDU/SCBU	3.997	Women and Childrens	0.112				3.997	0.112
CTM	Pay Award	0.335	Unallocated	0.009				0.335	0.009
CTM	Residual Capital Charge	0.049	Unallocated	0.001				0.049	0.001
Hywel Dda	Cervical Screening Capital Charges	0.017	Unallocated	0.000				0.017	0.000
Hywel Dda	Neonatal Care - NICU/HDU/SCBU	1.591	Women and Childrens	0.045				1.591	0.045
Hywel Dda	Pay Award	0.054	Unallocated	0.002				0.054	0.002
Mental Health	Case Management Investment - BCU	0.171	Adult Mental Health	0.005				0.171	0.005
Mental Health	Case Management Investment - SB	0.339	Adult Mental Health	0.009				0.339	0.009
Renal	ABHB Gwent Nephrology Sessions	0.159	Renal Network	-		0.159		-	-
Renal	All Wales Dialysis Price Inflation 2019/20		Renal Network	-				-	-
Renal	BCU Home Dialysis Contract HDF Hire		Renal Network	-				-	-
Renal	BCU Home Dialysis Utilities Re-alignment	0.026	Renal Network	-		0.026		-	-
Renal	C&V Psychology	0.099	Renal Network	-		0.099		-	-
Renal	Hywel Dda LHB Support Costs	0.677	Renal Network	-		0.677		-	-
Renal	LHB contribution into secondary care centre in UHW	0.088	Renal Network	-		0.088		-	-
Renal	LHB contribution into secondary care centre in Wrexham	0.450	Renal Network	-		0.450		-	-
Renal	NWSSP Procurement Support Costs	0.059	Renal Network	-		0.059		-	-
Renal	Swansea Area Medical Service Transport Contract		Renal Network	-				-	-
Renal	WBS WTAIL Transplant Laboratory - scientific staff	0.050	Renal Network	-		0.050		-	-
Renal	WBS WTAIL Transplant Laboratory - Tissue Typing	0.444	Renal Network	-		0.444		-	-
Renal	West Wales Dialysis Transport (patient re-imbursement)	0.060	Renal Network	-		0.060		-	-
SB	ALAC	2.076	Neuro and LTC	0.058				2.076	0.058
SB	BAHA	0.063	Women and Childrens	0.002				0.063	0.002
SB	Bariatrics	0.763	Cardiao-Thoracic	0.021				0.763	0.021
SB	Burns	5.467	Cancer and Blood	0.153				5.467	0.153
SB	Cardiac Surgery	15.490	Cardiao-Thoracic	0.434				15.490	0.434
SB	Cardiology	11.127	Cardiao-Thoracic	0.312				11.127	0.312
SB	Clinical Genetics	0.065	Cancer and Blood	0.002				0.065	0.002
SB	CLP	1.508	Women and Childrens	0.042				1.508	0.042
SB	IBD Haemophilia	0.897	Cancer and Blood	0.004		0.755		0.143	0.004
SB	Major Trauma ODN	0.518	Unallocated	0.015				0.518	0.015
SB	Major Trauma Plastics	0.928	Unallocated	0.026				0.928	0.026
SB	Medium Secure Mental Health - East Forensics	14.663	Adult Mental Health	0.411				14.663	0.411
SB	Mental Health Academic Fee	0.133	Adult Mental Health	0.004				0.133	0.004
SB	Neonatal Care - NICU/HDU/SCBU	5.352	Women and Childrens	0.150				5.352	0.150
SB	NICE	0.160	Unallocated	-		0.160		-	-
SB	Paediatric Oncology	0.145	Women and Childrens	0.004				0.145	0.004
SB	Pay Award	2.363	Unallocated	0.066				2.363	0.066
SB	Plastics	18.588	Cancer and Blood	0.520				18.588	0.520
SB	Rehab	2.107	Neuro and LTC	0.059				2.107	0.059
SB	Renal	16.214	Renal Network	0.454				16.214	0.454
SB	Renal - West Wales ISP Units	2.792	Renal Network	- 0.000		2.792		- 0.000	- 0.000
SB	Sarcoma	1.025	Cancer and Blood	0.029				1.025	0.029
SB	Sentinel Node Biopsy	0.115	Cancer and Blood	0.003				0.115	0.003
SB	TAVI	3.326	Cardiao-Thoracic	0.035		2.090		1.236	0.035
SB	Thoracic	3.188	Cancer and Blood	0.089				3.188	0.089
SB	IVF	3.261	Unallocated	0.091				3.261	0.091
Velindre	Cancer Services (Main LTA)	10.946	Cancer and Blood	0.306				10.946	0.306492
Velindre	Melanoma Pathway Drugs	8.967	Cancer and Blood	-		8.967		-	-
Velindre	Other NICE cancer drugs	0.890	Cancer and Blood	-		0.890		-	-
Velindre	Pay Award		Unallocated	-				-	-
Velindre	SRS/SBRT/Cerebral Mets & IGBT	0.436	Cancer and Blood	0.012				0.436	0.012
Velindre	Welsh Blood Service	28.326	Cancer and Blood	0.793				28.326	0.793138
WHSSC	Traumatic Stress - Wales			0.033			1.161	1.161	0.033
WHSSC	DRC Core	3.073		0.086				3.073	0.086
WHSSC	DRC Renal	0.524		0.015				0.524	0.015
	Total	481.278		**12.423**		**40.953**	**3.350**	**443.675**	**12.423**
							3.689		

2022-25 Financial Plan
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Re-Commissioning Workstreams

Table 5

Ref	Value Based Commissioning Workstreams	2022/23 £m	2023/24 £m	2024/25 £m
All	Cystic Fibrosis savings	(0.500)	-	-
All	Neonatal out of area capacity transfers	(0.250)	(0.500)	(0.500)
All	New PAS Rebates	(0.350)	(0.350)	(0.350)
All				
	Total VBC	**(1.100)**	**(0.850)**	**(0.850)**

Commissioner Split

ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Cwm Taf (Bridgend) UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Total
(0.070)	(0.123)	(0.002)	(0.116)	-	(0.109)	(0.063)	(0.017)	**(0.500)**
(0.045)	(0.062)	-	(0.051)	-	(0.042)	(0.041)	(0.007)	**(0.250)**
(0.043)	(0.066)	(0.078)	(0.055)	-	(0.050)	(0.043)	(0.015)	**(0.350)**
-	-	-	-	-	-	-	-	**-**
(0.158)	**(0.251)**	**(0.080)**	**(0.223)**	**-**	**(0.201)**	**(0.148)**	**(0.039)**	**(1.100)**

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Riskshare Tables | **Commissioner Split**

Table 6a

Ref	Unavoidable Growth	2022/23 £m	2023/24 £m	2024/25 £m
PET	PET Scan volume	0.250	0.500	0.750
IPM	IPC High Cost Drugs growth	0.750	1.500	2.250
Cardiff	Paediatric Oncology growth @ 2%	0.200	0.200	0.200
Renal	ISP contract inflation	0.800	1.000	1.500
Cardiff	Genetic Test Directory		0.200	0.200
SB	Major Trauma (plastics)		0.248	0.248
Cardiff & SB	Thoracic SOC standards		0.500	1.000
	Thoracic SOC standards		0.500	1.000
	Total Unavoidable Growth	**2.000**	**4.648**	**7.148**

Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Total
187	IPM - Eculizumab	0.031	0.047	0.056	0.040	-	0.036	0.031	0.011	**0.250**
187	IPM - Eculizumab	0.093	0.141	0.167	0.119	-	0.107	0.092	0.032	**0.750**
35	Cardiff & Vale - Paediatric Oncology	0.025	0.058	-	0.052	-	0.043	0.021	0.001	**0.200**
261	Prior Year Developments up to 2016/17 - Dialysis Growth	0.097	0.150	0.183	0.120	0.036	0.077	0.101	0.036	**0.800**
263	Prior Year Developments up to 2016/17 - Genetics - New	-	-	-	-	-	-	-	-	-
316	2020/21 Plan Developments - Major Trauma updated Pov	-	-	-	-	-	-	-	-	-
38	Cardiff & Vale - Paediatric Gastroenterology	-	-	-	-	-	-	-	-	-
		0.247	**0.396**	**0.405**	**0.330**	**0.036**	**0.262**	**0.245**	**0.079**	**2.000**

Ref	NHS England New Tariff	2019/20 £m	2020/21 £m	2021/22 £m
NHS England	CQUINs element estimate			
	Total	**-**	**-**	**-**

Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Total
	CQUIN uplift 1.25%									-
		-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Table 6b

Planning Ref	Emerging Service Risks	2022/23 £m	2023/24 £m	2024/25 £m
All Wales	Welsh Eye Service	0.050	0.050	0.050
	Total	**0.050**	**0.050**	**0.050**
		2.050	**4.698**	**7.198**

Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Total
86	ABMU - Sarcoma	0.010	0.011	-	0.009	-	0.010	0.008	0.001	**0.050**
42	Cardiff & Vale - Paeds Cystic Fibrosis	-	-	-	-	-	-	-	-	-
		0.010	**0.011**	**-**	**0.009**	**-**	**0.010**	**0.008**	**0.001**	**0.050**
		0.256	0.407	0.405	0.339	0.036	0.272	0.253	0.080	2.050

Table 6c

Ref	NHS England Provider 2%	2022/23 £m	2023/24 £m	2024/25 £m
	Total	**4.306**	**4.306**	**4.306**

Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Total
	Total	0.329	0.546	2.161	0.385	0.018	0.357	0.307	0.205	**4.306**
		7.64%	12.67%	50.18%	8.93%	0.41%	8.28%	7.14%	4.75%	

Table 6d

Ref	Activity recovery contingency (England & Wales)	2022/23 £m	2023/24 £m	2024/25 £m
All Wales	Recovery Contingency		-	-
	Total	**-**	**-**	**-**

Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Total
187.000	**IPM - Eculizumab**	-	-	-	-	-	-	-	-	-
	Total	-	-	-	-	-	-	-	-	-

Table 6c

Ref	NHS England Provider 2.8%			2021/22 £m	ABM UHB	Aneurin Bevan UHB	Betsi Cadwalad UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf Morgannw UHB	Hywel Dda UHB	Powys THB	Total
Non Welsh SLA	Alder Hey Children's- Blood Factor Products	Cancer and Blo	0.676	0.019	0.002	0.004	0.004	0.003	-	0.003	0.002	0.001	**0.019**
Non Welsh SLA	Alder Hey Children's- ECMO	Cardio-Thoraci	0.060	0.002	0.000	0.000	0.000	0.000	-	0.000	0.000	0.000	**0.002**
Non Welsh SLA	Alder Hey Children's NHS Foundation Trust	Women and Ch	16.773	0.470	-	0.001	0.454	0.000	-	0.000	0.002	0.013	**0.470**
Non Welsh SLA	Birmingham Women's & Children's Hospital NHS Foundation Trust	Women and Ch	2.031	0.057	0.005	0.008	0.005	0.006	-	0.002	0.003	0.028	**0.057**
Non Welsh SLA	Cambridge University Hospitals NHS Foundation Trust - ERT	Cancer and Blo	0.506	0.014	0.002	0.003	0.003	0.002	-	0.002	0.002	0.001	**0.014**
Non Welsh SLA	Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's)	Women and Ch	0.224	0.006	0.000	0.001	0.002	0.001	-	0.000	0.001	0.000	**0.006**
Non Welsh SLA	Christie NHS Foundation Trust	Cancer and Blo	3.628	0.102	0.002	0.000	0.095	0.000	-	0.000	0.002	0.003	**0.102**
Non Welsh SLA	DDRC	Unallocated	0.271	0.008	0.001	0.001	0.002	0.001	-	0.001	0.001	0.000	**0.008**
Non Welsh SLA	Great Ormond Street Hospital for Children NHS Foundation Trust	Women and Ch	1.611	0.045	0.006	0.010	0.004	0.004	-	0.009	0.010	0.003	**0.045**
Non Welsh SLA	Great Ormond Street Hospital for Children NHS Foundation Trust - ECMO	Cardiao-Thorac	0.379	0.011	0.001	0.002	0.001	0.001	-	0.002	0.002	0.001	**0.011**
Non Welsh SLA	Guy's and St Thomas' NHS Foundation Trust	Unallocated	0.955	0.027	0.002	0.006	0.005	0.004	-	0.005	0.004	0.001	**0.027**
Non Welsh SLA	Guy's and St Thomas' NHS Foundation Trust - ECMO	Cardiao-Thorac	0.439	0.012	0.002	0.002	0.003	0.002	-	0.002	0.002	0.001	**0.012**
Non Welsh SLA	Heart of England NHS Foundation Trust	Cardiao-Thorac	0.429	0.012	0.000	0.001	0.002	0.001	-	0.000	0.001	0.006	**0.012**
Non Welsh SLA	Imperial College Healthcare NHS Trust	Unallocated	1.893	0.053	0.012	0.007	0.005	0.009	-	0.008	0.010	0.001	**0.053**
Non Welsh SLA	Imperial College Healthcare NHS Trust - PHT	Cardiao-Thorac	1.800	0.050	0.006	0.007	0.007	0.011	-	0.009	0.004	0.006	**0.050**
Non Welsh SLA	King's College Hospital NHS Foundation Trust	Unallocated	0.642	0.018	0.002	0.004	0.003	0.003	-	0.003	0.002	0.002	**0.018**
Non Welsh SLA	Leeds Teaching Hospitals NHS Trust	Unallocated	0.117	0.003	0.001	0.000	0.001	0.000	-	0.000	0.000	0.000	**0.003**
Non Welsh SLA	Liverpool Heart and Chest Hospital NHS Foundation Trust	Cardiao-Thorac	17.907	0.501	0.000	0.001	0.496	0.001	-	0.000	0.000	0.003	**0.501**
Non Welsh SLA	Manchester University Foundation Trust (previously Central & South)	Women and Ch	3.924	0.110	0.020	0.027	-	0.022	0.005	0.014	0.018	0.003	**0.110**
Non Welsh SLA	Newcastle Upon Tyne Hospitals NHS Foundation Trust	Neuro and LTC	0.040	0.001	0.000	0.000	0.000	0.000	-	0.000	0.000	0.000	**0.001**
Non Welsh SLA	NHS Blood & Transplant	Cancer and Blo	0.258	0.007	0.000	0.003	0.000	0.001	-	0.001	0.000	0.002	**0.007**
Non Welsh SLA	Papworth Hospital NHS Foundation Trust	Cardiao-Thorac	0.901	0.025	0.003	0.009	0.003	0.001	-	0.004	0.002	0.001	**0.025**
Non Welsh SLA	Robert Jones and Agnus Hunt Orthopaedic Hospital NHS Foundation Trust	Neuro and LTC	1.414	0.040	0.000	0.000	0.032	-	-	0.000	0.001	0.006	**0.040**
Non Welsh SLA	Royal Brompton & Harefield NHS Foundation Trust	Cardiao-Thorac	3.625	0.102	0.006	0.021	0.009	0.021	-	0.027	0.015	0.003	**0.102**
Non Welsh SLA	Royal Brompton & Harefield NHS Foundation Trust - PHT	Cardiao-Thorac	0.311	0.009	0.001	0.003	0.001	0.001	-	0.003	0.001	0.000	**0.009**
Non Welsh SLA	Royal Free London NHS Foundation Trust (Hampstead)	Unallocated	1.365	0.038	0.003	0.008	0.005	0.006	-	0.011	0.004	0.001	**0.038**
Non Welsh SLA	Royal Free London NHS Foundation Trust (Hampstead) - ERT	Women and Ch	0.555	0.016	0.002	0.003	0.003	0.002	-	0.002	0.002	0.001	**0.016**
Non Welsh SLA	Royal Free London NHS Foundation Trust (Hampstead) - PHT	Cardiao-Thorac	0.203	0.006	0.001	0.004	0.000	0.001	-	0.001	0.000	0.000	**0.006**
Non Welsh SLA	Royal Liverpool and Broadgreen University Hospitals NHS Trust	Cancer and Blo	0.168	0.005	0.000	0.000	0.005	0.000	-	0.000	0.000	0.000	**0.005**
Non Welsh SLA	Royal Liverpool and Broadgreen University Hospitals NHS Trust - Blood products	Cancer and Blo	1.283	0.036	0.004	0.007	0.008	0.006	-	0.005	0.004	0.002	**0.036**
Non Welsh SLA	Royal Liverpool and Broadgreen University Hospitals NHS Trust - Ocular Oncology	Cancer and Blo	0.703	0.020	0.002	0.002	0.008	0.002	-	0.003	0.002	0.001	**0.020**
Non Welsh SLA	Royal Marsden NHS Foundation Trust	Cancer and Blo	0.141	0.004	0.001	0.002	0.000	0.000	-	0.000	0.000	0.000	**0.004**
Non Welsh SLA	Royal Orthopaedic Hospital NHS Foundation Trust	Cancer and Blo	1.260	0.035	0.003	0.007	0.002	0.006	-	0.007	0.007	0.003	**0.035**
Non Welsh SLA	Salford Royal NHS Foundation Trust	Neuro and LTC	1.858	0.052	0.000	0.000	0.048	0.001	-	0.001	0.001	0.001	**0.052**
Non Welsh SLA	Salford Royal NHS Foundation Trust - ERT	Women and Ch	0.298	0.008	0.001	0.002	0.002	0.001	-	0.001	0.001	0.000	**0.008**
Non Welsh SLA	Sheffield Teaching Hospitals NHS Foundation Trust	Unallocated	0.602	0.017	0.001	0.003	0.010	0.001	-	0.001	0.001	0.001	**0.017**
Non Welsh SLA	St Helen and Knowsley Teaching Hospitals NHS Trust	Cancer and Blo	3.409	0.095	0.000	0.000	0.094	0.000	-	0.000	0.000	0.000	**0.095**
Non Welsh SLA	University College London Hospitals NHS Foundation Trust	Unallocated	1.391	0.039	0.006	0.007	0.008	0.007	-	0.003	0.006	0.002	**0.039**
Non Welsh SLA	University College London Hospitals NHS Foundation Trust - ERT	Women and Ch	0.118	0.003	0.000	0.001	0.001	0.001	-	0.000	0.000	0.000	**0.003**
Non Welsh SLA	University Hospitals Birmingham NHS Foundation Trust	Cardiao-Thorac	7.214	0.202	0.014	0.031	0.020	0.009	-	0.010	0.012	0.106	**0.202**
Non Welsh SLA	University Hospitals Birmingham NHS Foundation Trust - Transplant	Cardiao-Thorac	1.216	0.034	0.000	0.012	0.000	0.005	-	0.007	0.002	0.007	**0.034**
Non Welsh SLA	University Hospitals Bristol NHS Foundation Trust	Cardiao-Thorac	11.739	0.329	0.065	0.107	0.001	0.058	-	0.057	0.033	0.009	**0.329**
Non Welsh SLA	University Hospitals of North Midlands NHS Trust	Neuro and LTC	2.747	0.077	0.010	0.014	0.017	0.012	0.004	0.007	0.009	0.003	**0.077**
Non Welsh SLA	Walton Centre NHS Foundation Trust	Neuro and LTC	19.080	0.534	0.001	0.000	0.524	0.000	-	0.000	0.002	0.007	**0.534**
Non Welsh SLA	Wye Valley NHS Trust (Hereford)	Cardiao-Thorac	0.148	0.004	-	0.000	-	-	-	-	0.000	0.004	**0.004**
Mental Health	CAMHS OOA - BCU patients	Adult Mental He	1.124	0.031	-	-	0.031	-	-	-	-	-	**0.031**
Mental Health	CAMHS OOA - South Wales patients	Adult Mental He	1.383	0.039	0.008	0.017	-	0.001	-	0.003	0.002	0.008	**0.039**
Mental Health	Case Management Investment - BCU	Adult Mental Health		-	-	-	-	-	-	-	-	-	**-**
Mental Health	Case Management Investment - SB	Adult Mental Health		-	-	-	-	-	-	-	-	-	**-**
Mental Health	Deaf MH	Adult Mental He	0.198	0.006	0.001	0.001	0.001	0.001	-	0.001	0.001	0.000	**0.006**
Mental Health	Eating Disorders	Adult Mental He	1.993	0.056	0.007	0.010	0.012	0.009	-	0.008	0.007	0.002	**0.056**

Table 6c

Ref	NHS England Provider 2.8%			2021/22 £m	ABM UHB	Aneurin Bevan UHB	Betsi Cadwalad UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf Morgannw UHB	Hywel Dda UHB	Powys THB	Total
Mental Health	FACTS OOA - All-Wales	Adult Mental He	1.399	0.039	0.005	0.007	0.009	0.006	0.002	0.004	0.005	0.002	**0.039**
Mental Health	Forensic Mental Health	Adult Mental He	12.189	0.341	0.042	0.064	0.076	0.054	-	0.048	0.042	0.014	**0.341**
Mental Health	Gender	Adult Mental He	0.730	0.020	0.003	0.004	0.005	0.003	-	0.003	0.003	0.001	**0.020**
Mental Health	Medium secure DTOC recharges	Adult Mental Health		-	-	-	-	-	-	-	-	-	**-**
Mental Health	Other MH	Adult Mental He	0.071	0.002	0.000	0.000	0.000	0.000	-	0.000	0.000	0.000	**0.002**
Mental Health	Perinatal OOA	Adult Mental He	1.250	0.035	0.004	0.007	0.008	0.006	-	0.005	0.004	0.001	**0.035**
Mental Health	MH High Secure - Rampton	Adult Mental He	1.827	0.051	0.006	0.010	0.011	0.008	-	0.007	0.006	0.002	**0.051**
Mental Health	MH High Secure - Ashworth	Adult Mental He	12.338	0.345	0.043	0.065	0.077	0.055	-	0.049	0.042	0.015	**0.345**
Renal	Llandrindod Wells (Birmingham satellite unit)	Renal Network	0.402	0.011	0.001	0.002	0.003	0.002	0.001	0.001	0.001	0.001	**0.011**
Renal	Royal Liverpool and Broadgreeen Transplant Centre	Renal Network	1.376	0.039	0.005	0.007	0.009	0.006	0.002	0.004	0.005	0.002	**0.039**
Renal	Shrewsbury and Telford Dialysis unit	Renal Network	0.247	0.007	0.001	0.001	0.002	0.001	0.000	0.001	0.001	0.000	**0.007**
Renal	Wirral University Hospitals Dialysis LTA	Renal Network	3.924	0.110	0.013	0.021	0.025	0.016	0.005	0.011	0.014	0.005	**0.110**
	Adjust Powys contribution to 2%			(0.083)								(0.083)	**(0.083)**
	Total			**4.306**	**0.329**	**0.546**	**2.161**	**0.385**	**0.018**	**0.357**	**0.307**	**0.205**	**4.306**
				4.306									4.306

Table 6d

Ref	NHS England Provider activity growth of 2%			2020/21 £m	ABM UHB	Aneurin Bevan UHB	Betsi Cadwalad UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Total
Non Welsh SLA	Liverpool Heart and Chest Hospital NHS Foundation Trust	Cardiao-Thorac	17.907		-	-	-	-	-	-	-	-	**-**
Non Welsh SLA	Walton Centre NHS Foundation Trust	Neuro and LTC	19.080		-	-	-	-	-	-	-	-	**-**
Non Welsh SLA	Alder Hey Children's NHS Foundation Trust	Women and Ch	16.773		-	-	-	-	-	-	-	-	**-**
Non Welsh SLA	Manchester University Foundation Trust (previously Central & South)	Women and Ch	4,438		-	-	-	-	-	-	-	-	**-**
	Total			**-**	-	-	-	-	-	-	-	-	**-**
				1.108	0.329	0.546	2.161	0.385	0.018	0.357	0.307	0.205	4.306
-				5.414									4.306

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Riskshare Tables

Commissioner Split

High Cost Drugs / Horizon Scanning

Table 7a

Ref	Financial Framework- Growth Assessment: Horizon Scanning Evaluation	2021/22 £m	2022/23 £m	2023/24 £m	ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Total
Mandated	New NICE approvals	2.000	4.000	6.000	0.248	0.375	0.446	0.317	0.092	0.192	0.246	0.084	**2.000**
Velindre	Velindre Joint Commissioning group draft forecast												-
	Total New NICE Mandated approvals	**2.000**	**4.000**	**6.000**	**0.248**	**0.375**	**0.446**	**0.317**	**0.092**	**0.192**	**0.246**	**0.084**	**2.000**

Table 7b

Ref	Financial Framework- Growth Assessment Velindre High Cost Drugs & NICE approvals	2021/22 £m	2022/23 £m	2023/24 £m	ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Total
					-	-	-	-	-	-	-	-	-
	Total Velindre Commissioning	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
		2.000	4.000	6.000	0.248	0.375	0.446	0.317	0.092	0.192	0.246	0.084	2.000
		4.050	**8.698**	**13.198**	0.505	0.782	0.851	0.656	0.129	0.464	0.499	0.165	4.050

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Riskshare Tables | **Commissioner Split**

New Commissioned Services

Table 8

Ref			2022/23 £m	2023/24 £m	2024/25 £m
8b	**Strategic Priorities**				
N & S Wales	Paediatric Strategy		0.250	1.200	1.800
N & S Wales	Spinal ODN (JC Priority)		0.100		
SB	Major Trauma Network		1.181	1.948	1.700
S Wales	Neonatal Cot Review Capacity investment		0.628	1.256	1.256
S Wales	Neonatal Cot Review - Tariff investment		1.277	2.554	2.554
	Intestinal Failure Review				
			3.436	**6.958**	**7.310**

Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwalad UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf Morgannw UHB	Hywel Dda UHB	Powys THB	Total
313	2020/21 Plan Developments - Major Trauma / Thrombectomy Population/South Wales	0.045	0.062	-	0.051	0.011	0.032	0.041	0.007	**0.250**
313	2020/21 Plan Developments - Major Trauma / Thrombectomy Population/South Wales	0.018	0.025	-	0.020	0.004	0.013	0.017	0.003	**0.100**
316	2020/21 Plan Developments - Major Trauma updated Powys flow	0.218	0.299	-	0.245	-	0.203	0.198	0.017	**1.181**
315	2020/21 Plan Developments - Neonatal Transport	0.104	0.126	-	0.019	-	0.094	0.278	0.008	**0.628**
		0.170	0.389	-	0.283	-	0.289	0.030	0.116	**1.277**
		0.555	**0.902**	**-**	**0.619**	**0.015**	**0.631**	**0.564**	**0.150**	**3.436**

WHSSC ICP Financial Tables

Riskshare Tables **Commissioner Split**

Clinical Impact Schemes

Table 9a

CIAG Mean Score	Clinical Impact Assesment Schemes	2022/23 £m	2023/24 £m	2024/25 £m	Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf Morgannw UHB	Hywel Dda UHB	Powys THB	Total
23.01	ALAC Psychology	0.039	0.078	0.078	75	ABMU - ALAC	0.005	0.007	0.009	0.006	-	0.006	0.005	0.002	**0.039**
22.75	Neuropsychiatry	0.102	0.716	1.023	58	Cardiff & Vale - Neuropsychiatry	0.014	0.024	0.002	0.042	-	0.009	0.008	0.003	**0.102**
21.04	Paediatric Orthopaedic Surgery	0.063	0.250	0.250	315	2020/21 Plan Developments - Neonatal Transport	0.011	0.016	-	0.013	-	0.011	0.010	0.002	**0.063**
20.71	Neurosurgery	0.085	0.340	0.340	13	Cardiff & Vale - Neurosurgery	0.013	0.020	0.000	0.019	-	0.020	0.011	0.002	**0.085**
20.58	Inherited Cardiac Conditions - ICC	0.090	0.360	0.360	328	2022/23 Plan CIAG - Inherited Cardiac Conditions	0.002	0.021	0.025	0.018	-	0.016	0.002	0.005	**0.090**
20.51	Prosthetic Service	0.022	0.089	0.089	75	ABMU - ALAC	0.003	0.004	0.005	0.004	-	0.003	0.003	0.001	**0.022**
20.25	Paediatric Spinal Surgery	0.014	0.058	0.058	315	2020/21 Plan Developments - Neonatal Transport	0.003	0.004	-	0.003	-	0.002	0.002	0.000	**0.014**
20.25	Plastic Surgery	0.064	0.127	0.127	70	ABMU - Plastics	0.024	0.009	0.000	0.004	-	0.011	0.013	0.002	**0.064**
19.97	Paediatric Pathology	0.133	0.133	0.133	327	2022/23 Plan CIAG - Paediatric Pathology	0.013	0.041	0.001	0.034	-	0.031	0.013	0.000	**0.133**
19.70	Children's Gastroenterology	0.011	0.011	0.011	103	BCU - Cochlear Implants	-	-	0.011	-	-	-	-	-	**0.011**
	Total	**0.623**	**2.161**	**2.468**			**0.088**	**0.146**	**0.053**	**0.143**	**-**	**0.109**	**0.068**	**0.016**	**0.623**

9b

CIAG Mean Score	Clinical Impact Assesment Schemes	2022/23 £m	2023/24 £m	2024/25 £m	Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf Morgannw UHB	Hywel Dda UHB	Powys THB	Total
19.24	Paediatric Infectious Diseases				323	2020/21 Plan Developments - South Wales population	-	-	-	-	-	-	-	-	-
19.14	Mesothelioma				329	2022/23 Plan CIAG - Cancer - All Wales	-	-	-	-	-	-	-	-	-
19.04	ALAS Eye				91	BCU - ALAS	-	-	-	-	-	-	-	-	-
18.96	Paediatric Endocrinology Nursing				35	Cardiff & Vale - Paediatric Oncology	-	-	-	-	-	-	-	-	-
18.84	Neonatal Nurse				315	2020/21 Plan Developments - Neonatal Transport	-	-	-	-	-	-	-	-	-
18.81	Thoracic Surgery				11	Cardiff & Vale - Thoracic Surgery	-	-	-	-	-	-	-	-	-
18.51	ALAS Seating				19	Cardiff & Vale - ALAS	-	-	-	-	-	-	-	-	-
17.58	Clinical Immunology				31	Cardiff & Vale - Clinical Immunology	-	-	-	-	-	-	-	-	-
17.22	Prolonged Disorders of Consciousness (PDOC)				49	Cardiff & Vale - Long-Term Ventilation	-	-	-	-	-	-	-	-	-
	Total	-	-	-		-	-	-	-	-	-	-	-	-	-

Prioritisation Panel 2021

Table 9c

Score	New Prioritisation	2022/23 £m	2023/24 £m	2024/25 £m	Split Code		ABM UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Bridgend	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Total
32.86	Selective Dorsal Rhizotomy	0.230	0.230	0.230	184	IPM - ECMO	0.029	0.043	0.051	0.036	-	0.033	0.028	0.010	**0.230**
30.36	Corneal cross	0.030	0.099	0.099	183	IPM - NCA / IPFR / Prior Approvals	0.003	0.007	0.006	0.004	-	0.004	0.002	0.003	**0.030**
30.16	ECMO as a bridge to lung transplant	0.240	0.240	0.048	184	IPM - ECMO	0.030	0.045	0.054	0.038	-	0.034	0.029	0.010	**0.240**
29.38	Transcranial magnetic resonance	0.037	0.124	0.124	184	IPM - ECMO	0.005	0.007	0.008	0.006	-	0.005	0.005	0.002	**0.037**
27.39	Bevacizumab for vestibular schwannoma	0.074	0.246	0.246	184	IPM - ECMO	0.009	0.014	0.016	0.012	-	0.010	0.009	0.003	**0.074**
27.36	Dexrazoxane for preventing cardiotoxicity	0.006	0.021	0.021	184	IPM - ECMO	0.001	0.001	0.001	0.001	-	0.001	0.001	0.000	**0.006**
	Total	**0.617**	**0.961**	**0.769**		-	**0.076**	**0.117**	**0.137**	**0.097**	**-**	**0.087**	**0.074**	**0.028**	**0.617**

		0.617	**0.961**	**0.769**			**0.076**	**0.117**	**0.137**	**0.097**	**-**	**0.087**	**0.074**	**0.028**	**0.617**

Table 10 - Recovery

Planned and Unsheduled Care Sustainability Commissioner Allocation Routed Through WHSSC for 2022/23	AB £	BC £	C&V £	CTM £	HD £	Po £	SB £	Total £
English Recovery Forecast	47,478	2,551,701	33,958	22,099	45,146		37,112	2,737,495
Velindre COVID Drug recovery	165,635	-	121,072	117,400	6,372	9,031	2,490	422,000
Velindre COVID Sustainability	541,957	-	396,146	384,133	20,850	29,549	8,147	1,380,781
WBS COVID Sustainability (4th Collection)	452,746	300,103	360,340	341,772	304,421	107,303	292,331	2,159,016
Total Sustainability Funding through WHSSC	**1,207,815**	**2,851,805**	**911,516**	**865,405**	**376,789**	**145,883**	**340,079**	**6,699,292**

Recovery £m	**1.208**	**2.852**	**0.912**	**0.865**	**0.377**	**0.146**	**0.340**	**6.699**

HB Allocations (rounded)	32,000,000	38,400,000	22,600,000	26,100,000	21,700,000	7,500,000	21,600,000	170,000,000
% of Allocation	3.77%	7.43%	4.03%	3.32%	1.74%	1.95%	1.57%	3.94%

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Ceri Phillips**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**30 March 2022**

Summary of key matters considered by the Committee and any related decisions made

Presentation/Patient Experience
Members received an informative and sensitive presentation from Locality Nurse Director for Cwm Taf Morgannwg University Health Board (CTMUHB) in relation to the findings and determinations of an inquest held into the death of a patient at Ty Llidiard in 2018.

The presentation explained the focus of the inquest and provided a detailed explanation of the narrative findings. The coroner issued a Regulation 28 Report to Prevent Further Deaths and this centres on the absence of a single patient record. A briefing was received from the Health Board on 2nd February.

Development Day Feedback
Feedback from the WHSSC QPSC Development Day which took place on February 10th, 2022 was received and members approved the amended Terms of Reference for QPSC for consideration and approval for onward recommendation to the Joint Committee.

Commissioning Team and Network Updates
Reports from each of the Commissioning Teams were received and taken by exception. Members noted the information presented in the reports and a summary of the services in escalation is attached to this report. The key points for each service are summarised below:

1.0 Welsh Renal Clinical Network
The Committee received the report. The Chair noted the WHSSC Integrated Governance Committee (IGC) had received a detailed update briefing from Stuart Davies, Executive Lead for the Network at their meeting on 30 March 2022. The Chair noted a number of reports were to be considered by the Committee in relation to the home dialysis service and peer review of Renal Units as discussed at IGC. The Chair further noted IGC had asked a number of questions about the nature of Vital Data and developments in data systems and that as a result the Network and Commissioning Team reports would be enhanced with that information in future.

2.0 Cancer & Blood

The Committee received a further update regarding the burns services at SBUHB that is currently in escalation level 3 because of the closure of the Morriston Hospital Burns ITU due to staffing constraints. The Swansea Bay University Health Board (SBUHB) Burns Service had re-opened on Monday 14 February 2022 with an interim service model delivered with the support of general anaesthetics and general ICU consultant. WHSSC would monitor the action plan with input and advice from the South West & Wales Burns Network (SW&WBN) with regard to maintaining burns standards of care through the process of transition to the new long-term service model,

Positron Emission Tomography Imaging Centre (PETIC) was still a cause for concern and **t**he WHSSC escalation process would be used to discuss the options and put in place an action plan for strengthening the NHS service element of PETIC. This would be of key importance given the planned capital investment by WG into PETIC and therefore WHSSC's long-term commitment to commissioning services from University Hospital of Wales run by Cardiff University,

Thoracic surgery had been reduced from risk level 15 to risk level 9 because of the reduction in waiting list times due to joint working between SBUHB and Cardiff & Value University Health Board (CVUHB).

Members queried waiting times for plastic surgery patients at SBUHB. Members were assured that a management plan for patients on the waiting list was in place and that SBUHB was managing patients in line with Royal College of Surgeon guidelines. SBUHB was planning to outsource some patients for treatment and reconfigure services between Morriston and Singleton Hospitals. A recovery plan from SBUHB had been requested.

It was noted that a Service Innovation Day for sarcoma had taken place and that the Neuro Endocrine Tumour (NET) service in CVUHB had recently been inspected for ENET accreditation. Whilst they had not received formal notification the feedback on the day was very positive.

3.0 Cardiac

An update was received on the action plan in place in response to the GIRFT report undertaken at SBUHB and the Committee received assurance that SBUHB was making good progress on its delivery. The Committee also noted that the Royal College of Surgeons review was taking place in April.

Bariatric surgery had restarted at SBUHB and a conversation was underway to ascertain if a second provider was required.

4.0 Mental Health & Vulnerable Groups

Members received the Mental Health & Vulnerable Groups Commissioning Team update and noted;

The CAMHS unit at Ty Llidiard remain at escalation Level 4. Health Inspectorate Wales (HIW) undertook an inspection on the unit in November 2021 and published its report on 4th March. In addition, the National Collaborative Commissioning Unit (NCCU) undertook their Annual Review of the unit. This was due to be published at the time of the meeting. Discussions remain ongoing with the Health Board through the escalation process and both reports will be considered through that process and fed back to the next committee meeting.

The Committee was updated regarding the notice of termination of the contract given by Oxford Health NHS Foundation Trust for Cotswold House their Specialist Eating Disorder Service. WHSSC is in the process of reviewing the specialised eating disorder services aligned to the development of the Specialised Services Strategy for Mental Health. In the meantime, NCCU had been scoping alternative providers and had identified a five-bedded unit which is potentially available from August 2022.

Dr Hiliary Cass published an interim report on Gender Identity Service for Children on 10 March 2022 WHSSC have subsequently met with Dr Cass and will be working with NHS England to consider the clinical model going forward.

5.0 Neurosciences

Members received the Neurosciences Commissioning Team update and noted;

The main risk remained around neurosurgical waiting lists which were reducing but theatre capacity had still not returned to pre COVID-19 levels. The WHSSC Team were working with CVUHB to discuss the recovery action plan and assurance had been given that they were prioritising patients in line with Royal College of Surgeons guidance. Outsourcing was also being considered

6.0 Women & Children

Members received the Women & Children Team update.

The committee was informed that there was an increased risk on Paediatric Intensive Care directly as a result of staffing issues. They were also assured that there were a number of control in place and ongoing monitoring at Quarterly Commissioner Assurance Meeting with the provider.

The committee heard that there was an ongoing risk in Paediatric Surgery with extensive waits for some children. The WHSSC team had asked for a recovery trajectory and plan and there is continuous monitoring with the Clinical Board at CVUHB and through SLA meetings.

Neonatal transport

Members noted that a Delivery Assurance Group was now in place chaired by the Director of Planning at WHSSC and that this was providing additional commissioner assurance. Additionally, members were updated on the progress being made to implement an operational delivery network. A task and finish group was in place chaired by the Executive Nurse Director of SBUHB.

Other Reports Received
Members received reports on the following:

- **Services in Escalation Summary**

WHSSC currently has seven services in escalation. PETIC is a new service in escalation since the last meeting and no services have been de-escalated since the last report.

- **Draft QPSC Annual Report 2021-2022**

Members approved the draft QPSC Annual Report 2021-2022 for forward distribution to the Joint Committee.

- **CRAF Risk Assurance Framework**
- **CQC/HIW Summary Update**
- **Incidents and Complaints Report**

Items for information
Members received a number of documents for information only which members needed to be aware of:

- National Reporting and Learning System Letter from Welsh Government;
- Chair's Report and Escalation Summary to Joint Committee 12 October 2021;
- Q&PS Forward Work Plan;
- Q&PS Circulation List.

Key risks and issues/matters of concern and any mitigating actions
The items highlighted above.

Summary of services in Escalation (Appendix 1 attached)

Matters requiring Committee level consideration and/or approval
The Terms of Reference and the Annual Report will be submitted to the Joint Committee for final approval.

Matters referred to other Committees
None identified

Confirmed minutes for the meeting are available upon request

Date of next scheduled meeting:	7 June 2022 at 13.00hrs

1.0 SERVICES IN ESCALATION

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
November 2017	North Wales Adolescent Service (NWAS)	BCUHB	2	• Medical workforce and shortages operational capacity • Lack of access to other Health Board provision including Paediatrics and Adult Mental Health. Number of Out-of- Area admissions	• QAIS report outlined key areas for development including the recommendation to consider the location of NWAS due to lack of access on site to other health board provision – This is being considered in the Mental Health Specialised Services Strategy. • Participation in weekly bed management panel meeting. • Medical workforce issues improved with further appointments made and the issue of GMC registration resolved for 1 clinician.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
March 2018 Sept 2020 Aug 2021	Ty Llidiard	CTMUHB	4	• Unexpected Patient death and frequent SUIs revealed patient safety concerns due to environmental shortfalls and poor governance • SUI 11 September	• Escalation meetings held monthly, however March 22 meeting stood down for the report on a visit from NCCU into the unit to be published to inform ongoing discussions. • Service spec discussions progressed with work ongoing to consider the requirements of the unit. • Awaiting publication and implementation of Medical Emergency Response SOP by CTM. • Coroner's inquest concluded. Implementation of outcomes of inquest to be incorporated into escalation plan alongside the outcomes of HIW and NCCU visits.	⟺

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
September 2020	FACTS	CTMUHB	3	• Workforce issue	• 10 CQV meetings have now been held and the service will remain at level 3 until all key actions are met. • Substantive Consultant Psychiatrist post is planned to go to advert in early May. • Clinical Lead to be advertised once CAMHS Consultant posts have been appointed. • The FACTS service specification is being finalized subject to input from CAMHS colleagues.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
July 2021	Cardiac Surgery	SBUHB	3	• Lack of assurance regarding current performance, processes and quality and patient safety based on the findings from the Getting It Right First Time review	• Six weekly meetings in place to receive and monitor against the improvement plan. • Service de-escalated on delivery of the immediate actions as outlined in the GIRFT recommendations, including moving to consultant only operating and only mitral valve specialists operating on mitral valve repairs. • Further work is required between SBUHB, C&VUHB and WHSSC to improve the aorto-vascular pathways and develop the preferred options. In the meantime due to the complexity, the	

					pathway will remain unchanged	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
July 2021	Cardiac Surgery	C&VUHB	2	• Lack of assurance regarding processes and patient flow which impact on patient experience	• C&VUHB have an agreed programme of improvement work to address the recommendations set out in the GIRFT report. • Bi- monthly meetings agreed for monitoring purposes. • C&VUHB have shared a plan setting out the intentions for improvements across the key process metrics outlined in the GIRFT report. However, the WHSS Team have again asked for a SMART action plan to enable appropriate monitoring of the actions within appropriate and realistic timeframes.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
November 2021	Burns	SBUHB	3	• The burns service at SBUHB is currently unable to provide major burns level care due to staffing issues in burns ITU.	• The burns ICU is restored to full capacity (3 beds) with support from general ICU and anaesthetics consultants (stage 1 of the plan). • Mutual assistance is available via the South West and Wales Burns Network and wider UK burns escalation arrangements, should it be required. • The three-stage plan has been agreed following advice and support from the Burns Network and a peer visit to Swansea. • The escalation meetings will be led by WHSSC with support	

					and advice from the Burns Network to ensure standards are maintained through the transition process.	

Date of Escalation	Service	Provider	Level of Escalation	Reason for Escalation	Current Position 21.03.2022	Movement from last month
February 2022	PETIC	Cardiff University	3	Concern over management capacity within the service to ensure a safe, high quality timely service is maintained for patients. These concerns include: • Recent suspension of production of PSMA due a critical quality control issue identified during MHRA inspection. Service slow to address impact on service for patients. • Failure to undertake a timely recruitment exercise leading to isotope production failures.	• The quality control issue has been addressed and isotope production restarted on 25 February after a three week suspension. • Analysis of the impact of the delays on patients indicates that while it caused patient anxiety and stress, it is unlikely there will be harm to patients' clinical outcomes. • Current waiting times are within the target turnaround time of 10 days. • The first escalation meeting is scheduled for Friday 25 March.	New N/A

				• Failure to produce a business case of sufficient quality in a timely manner for replacement of the scanner.		

Level of escalation reducing / improving position

Level of escalation unchanged from previous report/month

Level of escalation increasing / worsening position

Aneurin Bevan University Health Board

EMERGENCY AMBULANCE SERVICES COMMITTEE (EASC) Update Report – May 2022

Purpose of Report	
The purpose of this report is to provide an update to the Board in respect of the matters discussed and agreed at recent meetings of the Emergency Ambulance Service Committee as a Joint Committee of the Board.	
The Board is asked to: *(please tick as appropriate)*	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	√
Note the Report for Information Only	
Executive Sponsor: Interim Chief Executive	
Report Author: Interim Chief Executive	
Report Received consideration and supported by:	
Date of the Report: 11th May 2022	

Supplementary Papers Attached:

1) Chair's Summary of the Joint Committee Meeting held 15th March 2022

2) EASC Integrated Medium-Term Plan 2022-25, approved by the Joint Committee on 15th March 2022

3) Confirmed Minutes of the Joint Committee Meeting held 18th January 2022

Background and Context

The Emergency Ambulance Services Committee is a Joint Committee of all Health Boards in NHS Wales. The Minister for Health and Social Services appointed an Independent Chair through the public appointment process to lead the meetings and each Health Board is represented by their Chief Executive Officer; the Chief Ambulance Services Commissioner is also a member. It acts as a subcommittee to the individual Health Boards.

The Joint Committee has been established in accordance with the Directions and Regulations to enable the seven LHBs in NHS Wales to make joint decisions on the review, planning, procurement and performance monitoring of Emergency Ambulance Services (Related Services), the Emergency Medical Retrieval and Transfer Service (EMRTS) and the Non-Emergency Patient Transport Service and in accordance with their defined Delegated Functions. The Standing Orders of each of the seven Health Boards include the

Governance Framework for EASC, including a Scheme of Delegation as published on the EASC website Schedule 4 (nhs.wales).

Although the Joint Committee acts on behalf of the seven Health Boards in discharging its functions, individual Health Boards remain responsible for their residents and are therefore accountable to citizens and other stakeholders for the provision of Emergency Ambulance Services (EAS); Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) and Non-Emergency Patient Transport Services (NEPTS).

Specifically, the role of the EASC Joint Committee (as set out in Standing Order 1.1.3 Schedule 4 (nhs.wales)) is to:

- Determine a long-term strategic plan for the development of emergency ambulance services and non-emergency patient transport services in Wales, in conjunction with the Welsh Ministers;
- Identify and evaluate existing, new and emerging ways of working and commission the best quality emergency ambulance and non-emergency patient transport services;
- Produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee following the publication of the individual Health Boards Integrated Medium Term Plans;
- Agree the appropriate level of funding for the provision of emergency ambulance and non-emergency patient transport services at a national level, and determining the contribution from each Health Board for those services (which will include the running costs of the Joint Committee and the EASC Team) in accordance with any specific directions set by the Welsh Ministers;
- Establish mechanisms for managing the commissioning risks; and
- Establish mechanisms to monitor, evaluate and publish the outcomes of emergency ambulance and non-emergency patient transport services and take appropriate action.

Each of the seven Health Boards have agreed a Memorandum of Agreement (MEMORANDUM OF AGREEMENT (nhs.wales)) in respect of the Joint Committee and in doing so have agreed that each Health Board recognises the following principles, aligned to the agreed Standing Orders:

- The Emergency Ambulance Services Committee Team (EASCT) will be held to account by the EAS Joint Committee for the delivery of a strategy for the provision of emergency and non-emergency ambulance services for Wales as well as providing assurance that the systems of control in place are robust and reliable.
- That any decision taken and approved by the Joint Committees in respect of the provision of the Relevant Services is binding on the constituent LHBs and may not be undermined by any subsequent decision or action taken by a constituent LHB.
- That each individual LHB is responsible for the people who are resident in their area. This means that the Joint Committee of which each Chief Executive is a member is acting on behalf of the 7 LHBs in undertaking its role.
- That their respective Chief Executives have an individual responsibility to contribute to the performance of the role of the Joint Committee and to share in the decision making in the interests of the wider population of NHS Wales. At the same time, they acknowledge their own Chief Executive's individual accountability to their constituent LHB and their obligation to act transparently in the performance of their functions.

- That each Chief Executive as a member of the Joint Committee will require EASC Team of the EAS Joint Committee to ensure that, in the timetabling of the annual work programme, sufficient time will normally be allowed to enable each Chief Executive to consult with their own LHB and appropriate local partners and stakeholders.
- That when an individual Chief Executive is unable to attend a meeting of the Joint Committee, he/she will appoint in advance and identify to the Committee Secretary a deputy to attend on their behalf. The nominated deputy should be an Executive Director of the same organisation. Nominated deputies will formally contribute to the quorum and will have delegated voting rights.

Assessment and Conclusion

This report provides an update regarding business undertaken during the last reporting period.

The Joint Committee held its most recent meeting on 10 May 2022. The papers for the meeting are available at: May 2022 - Emergency Ambulance Services Committee (nhs.wales)
A summary of the business held is outlined as follows:

Items for Discussion

1. Ambulance service performance – discussion regarding actions being taken and impact on wider system of risk to patients awaiting emergency conveyance, ambulance handover delays and timely access in Emergency Departments (ED),
2. Ambulance handover delays – covered in previous discussion,
3. Welsh Ambulance Services NHS Trust Update – noted
4. Chief Ambulance Services Commissioner's Report – noted
5. Chair's Summary EASC Management Group (21 April 2022) – noted
6. EASC Commissioning Update – noted
   a. Commissioning Framework
   b. EASC Integrated Medium Term Plan
   c. Commissioning Intentions
   d. EASC Action Plan
7. Focus on Non-Emergency Patient Transport – presentation received including analysis of current provision and eligibility / usage
8. Finance report – 2021/22 outturn position noted, subject to external audit review
9. Sub-group minutes – minutes approved
10. EASC governance overview – noted and approved
11. Forward look and Annual Business Plan – approved, includes bringing forward actions on ambulance handover delays.

Items for Information

12. WAST Integrated Medium Term Plan – noted
13. Emergency Medical Retrieval and Transfer Service (EMRTS) Service Evaluation review – noted.

This report also provides as supplementary papers a Chair's Summary of the Joint Committee Meeting held on 15th March 2022 (attachment 1) and EASC's Integrated-Medium Term Plan 2022-25 as approved by the Joint Committee for submission to Welsh Government (attachment 2).

Recommendation
The Board is asked to receive this report for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are no key risks with this report.
Financial Assessment, including Value for Money	There is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	A quality, safety and patient experience assessment has not been undertaken for this report as it is for assurance purposes.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has not been undertaken for this report as it is for assurance purposes only.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to the Plan associated with this report, however the work of the Joint Committee contributes to the overall implementation and monitoring of health board IMTPs.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within the Joint Committee's considerations, where appropriate.
Glossary of New Terms	EASC – Emergency Ambulance Services Committee EMRTS – Emergency Medical Retrieval and Transfer Service WAST – Welsh Ambulance Service Trust
Public Interest	This report is written for the public domain.

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	15 March 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: March 2022 - Emergency Ambulance Services Committee (nhs.wales) Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee.

Suzanne Rankin, CEO for Cardiff and Vale and Hayley Thomas, Deputy CEO from Powys were welcomed to her first meeting. Nick Wood, Deputy Chief Executive NHS Wales at Welsh Government was also welcomed to the meeting.

The minutes of the EASC meetings which took place on 18 January 2022 were approved.

The Chair also took opportunity to reaffirm the role of the EAS Committee in terms of its role within the EASC Directions to plan and secure sufficient ambulance services in Wales in line with Welsh Government and NHS Planning Frameworks.

In terms of context for many of the discussions to take place at the meeting, the Chair reminded Members of the agreed deliverables. In particular, the previous agreed commitment to reducing handover delays – no handover delays over 4 hours and reduce the average time of lost hours by 25% from October 2021 level. It was noted that the current position needed to be significantly improved. In addition, Members noted the phasing out of the military support to the Welsh Ambulance Services NHS Trust (WAST) at the end of March and the likely impact on performance.

PERFORMANCE REPORT

Received as the first standing agenda item at each meeting of the EASC Joint Committee as agreed with the Minister for Health and Social Care.

Members noted that the Ambulance Quality Indicators would be published monthly from April 2022 providing an opportunity to discuss more recent information. The following areas were highlighted:

- the continued challenges around 999 call wait times
- the growing gap between the number of calls answered and the number of incidents generated
- slightly less incidents in January and February
- mitigating action taken including investment in staff and technology
- significant challenges in achieving red 65th percentile

- growth in red demand – at 53% response and median 7mins and 30secs; joint work with Welsh Government and Digital Health and Care Wales looking at linked data sets related to patient outcomes and would report findings at a future meeting
- amber responsiveness 95th percentile continued to grow with significant waits seen; Amber median 1hour 30mins (ongoing impact on patient journey)
- More media stories and political interest being seen
- in light of previous commitments to reduce ambulance handover delays, increases over recent months were noted, with the trend continuing into March (currently 700 hours per day)
- with reducing staffing capacity, WAST forecasting the impact and the level of the Clinical Safety Plan to ensure response at red and amber 1.

Nick Wood asked regarding the EASC perspective and the need for a joint response from WAST and health boards in relation to the safety of the service and meeting community expectations; the impact of the significant drift in lost hours, the deterioration in response rates, the increasing numbers of concerns and increasing numbers of serious adverse incidents. Members were asked if they were confident that their actions would mitigate against the identified risks and would lead to improvements in performance and reduce patient safety incidents.

Members felt this was a fair challenge although there were expectations that the actions identified in the health board plans would lead to improvements in reducing lost hours and a consequence improvement in working towards meeting the performance targets. The Chief Ambulance Services Commissioner (CASC) agreed that the Committee was not in a position to provide the level of assurance needed due to the position with handover delays. The Joint Committee had not been complacent and Members were aware that the planning assumptions had assumed a maximum of 5,000 handover hours in one month. Once these levels had been overtaken a number of mitigating actions had been put in place which included the WAST Clinical Safety Plan. At 20,000 lost hours per month Members were aware that ambulances would not be sent for Amber 2 patients.

Suggested solutions were proposed including to:
- provide temporary additional front-line ambulance capacity into WAST to support the system over the coming months to mitigate the removal of the support from the military and until the required improvements are in place to handover delays and impacting across the system
- continue to work with health boards to understand the variation across the system identified within the action plans submitted and to identify and share best practice
- ensure that the handover improvement plans deliver the required gains, to be monitored by the governance arrangements including the Commissioning Framework
- constantly challenge the current culture where handover delays are tolerated.

It was proposed that the following actions were put in place as the key elements of the system-wide handover improvement plan to address the patient safety concerns, particularly with the withdrawal of support from the military in April:
- maximise temporary additional front-line ambulance capacity during the coming period including overtime and WAST to operate at a higher state of emergency alert to maximise front-line resource
- use of the agreed whole system escalation process and the actions taken

- re-focus on 'red release' to allow WAST to respond appropriately and promptly (had been slippage)
- health board resources in place such as same day emergency care, urgent primary care centres, flow centres or communication hub etc and identify two or three deliverables as part of this Handover Improvement Plan. This would include managing or challenging slippage and monitoring the impact on the patient experience and recognised the need to move at pace.

The Chair thanked Members for the helpful discussion and emphasised the requirement for all Committee Members to respond urgently to the current position related to handover delays and to work with WAST to mitigate the impact of the loss of military resource at the end of March. The suggestions set out by the CASC were accepted and the Chair articulated the hope to see an improved position at the next meeting.

Following discussion, Members **RESOLVED** to:

- **NOTE** the content of the report and additional actions that would be taken to improve performance delivery to be included in the EASC Action Plan.
- **AGREE** to include the units of hours produced to the next iteration of the Performance Report.

PROVIDER ISSUES

Jason Killens, Chief Executive at the Welsh Ambulance Services NHS Trust (WAST) gave an overview of key matters including:

- phased withdrawal of the military support of approximately 250 staff (reduction in capacity of approximately 15% of production) by 31 March 2022
- approximately 100 members of staff were currently in operational training and would become operational in quarter 1, the capacity of the Clinical Service Desk would be doubled early in quarter 1 and this would allow the volume of calls closed via the 'consult and close' process to lift from 10-12% to approximately 15%
- the additional offer to roll on some winter schemes including cohorting and third-party support should the required support and funding be available (non core activities)
- red performance remained below target although an improving picture since December. A deep dive has been undertaken into red performance which was currently being finalised and would be presented to the EASC Management Group
- There were 503 long patient waits in January, this was a reduction compared to December, but rates were still very high with patients waiting excessively long times for services (some waiting more than 24 hours)
- the daily average handover position for the 10 services in England was shared, with WAST performance the worst, particularly in terms of the comparative fleet size
- electronic patient case card – this would be live in all health board areas by the end of March 2022, with many suggestions for improvements for phase 2 of the work
- the detailed briefing issued last week regarding roster changes had been extremely helpful in addressing the significant local, regional and national political interest. It was important for all to portray the positive story, (70 FTE additional staff) information would be circulated more widely to illustrate local level impacts including that 34.5 additional emergency ambulances would be operational across Wales as a result of this work. This would impact in Quarter 3 2022-23

- high sickness levels and the work being undertaken to achieve the trajectory to return to pre-pandemic levels of 6.5%. It was acknowledged that current levels were far too high and that there would be a plan to reduce these in the next few months.

The CASC emphasised the current focus in terms of:
- Being clear what could be delivered on a quarter by quarter basis
- Encourage health boards to include gaps within plans to identify key requirements
- Commissioning Framework to include detail in terms of what was required.

The Chair invited the CASC to outline other requirements for WAST which included:
- reducing sickness and setting the required improvement trajectory
- agreeing timescales for reducing post-production lost hours and managing the inefficiency in the system
- ensuring all roster changes would be in place by end of November 2022
- reducing the variation within the service by adopting good operational practice on a day by day basis.

The Chair asked Members to actively support the roster review changes and recommended the use of the detailed briefing which had recently been shared. This was cited as an example of good practice which could be replicated for other areas of work.

WELSH AMBULANCE SERVICES NHS TRUST DRAFT INTEGRATED MEDIUM-TERM PLAN (WAST IMTP) UPDATE

The WAST IMTP report was received. In presenting the report, Rachel Marsh highlighted the executive summary and key elements of the Plan including progress made in terms of:
- Progress to recruit the additional 127 full time equivalent (FTE) staff as agreed following the Emergency Medical Services Demand and Capacity Review
- doubling the capacity of the Clinical Support Desk
- introducing mental health practitioners to the organisation
- completing the roll-out of NHS Wales 111 with the programme team
- completing the transfers of Non-Emergency Patient Transport Services (NEPTS) from health boards.

Opportunities for joint working with academic institutions were noted and further discussions would be held outside of the meeting to consider opportunities across the system including joint appointments. The ongoing dialogue had continued between WAST and Health Education and Improvement Wales (HEIW) was noted along with WASTs ambitions to pursue University Trust status.

The CASC highlighted the consistency between the WAST IMTP, the agreed Commissioning Intentions (CIs) and Welsh Government targets.

Members **RESOLVED** to:
- **SUPPORT** the WAST IMTP, noting the risks and financial information to be worked through and mitigated,
- The Chair and the CASC to subsequently endorse the final plan in line with the discussions at the meeting following WAST Board approval and prior to submission to the Welsh Government by the 31 March 2022.

EASC INTEGRATED MEDIUM TERM PLAN

The EASC IMTP was received. In presenting the report, Ross Whitehead highlighted that the EASC IMTP was consistent with principles presented at the Joint Committee meeting in January 2022 and had been presented at the recent EASC Management Group for endorsement.

The plan focused on Commissioning Intentions (CIs) along with other priority areas for 2022-23 and the three-year planning cycle included the appetite for the commissioning of 111 Services and the development of a National Transfer and Discharge Service reflecting the regionalisation and reconfiguration of services.

The CASC highlighted to Members the key inefficiencies in the system which included:

- Handover delays - It was suggested that the required system improvements that would reduce ambulance handover delays sufficiently would not be in place for some time and that it would be sensible to retain front line ambulance resource for the start of the 2022-23 financial year to manage the clinical risk and patient safety concerns that exist, until wider system improvements could be made.
- WAST financial plan included a £1.8m cost reduction plan to impact on front line costs which would reduce overtime and hold vacancies - it was suggested that this £1.8m be waived due to the current issues related to handover hours and the loss of the military personnel on a 'non-recurrent basis'. The proposal for the temporary resource recognised both the need for action across the system but also the length of time that it was anticipated that required improvements would take place.

Nick Wood asked the CASC to confirm the detail in the financial year 2022-23 which related to the assumptions of a non-recurrent bid to the Welsh Government 6 Goals for Urgent and Emergency Care funding (£25m). Stephen Harrhy confirmed that the assumption within the financial plan was a minimum of £750k but possibly would require some additionality in terms of coverage for the ECNS scheme. Nick Wood noted this and explained that this was under discussion by the Welsh Government Policy Lead officials who were considering the allocation. Stephen Harrhy explained that this had been the approach suggested by health boards to apply for specific urgent and emergency care funding from the £25m which was reflected in the plan. Nick Wood thanked Stephen Harrhy for the clarification.

Members questioned the level of the CIP (1% would have been 2% if the £1.8m was included) and the CASC explained the WAST had also been asked not to make assumptions regarding their Transition Plan within the IMTP as this had not been widely supported at the scrutiny session. The option related to the WAST CIP which included the £1.8 million from front line staff remained contentious but the CASC suggested that the increasing concerns related to patient safety and the likelihood of harm within the current system this was an option to try and get to a balanced financial plan for WAST. Members confirmed that the financial envelope had been agreed by the Directors of Finance but questioned whether the CIP needed to be made from savings around front line staff, i.e. were there other options. Members explained that much higher levels of CIP had been agreed within health boards and felt that WAST should not be subject to different efficiency measures.

Members were keen that the CIP was revisited to be in line with health boards across Wales. The CASC responded and suggested that if additional funding, albeit on a temporary basis, was not provided to WAST the performance would deteriorate further and this would increase risks in terms of patient safety and experience. Stephen Harrhy suggested that if handover delays were reduced to 15,000 hours by April (which seemed unlikely) there remained a need for temporary funding for WAST. Furthermore, the CASC explained that without the temporary funding information would need to be provided to explain exactly what services could be offered by WAST.

Members suggested that they required more financial detail to discuss within health boards which would need to be balanced against other priority areas. Members felt they would need more granularity in relation to the ambulance services to balance for the wider health of local populations in decisions made by health boards.

Stephen Harrhy agreed to write to Members to explain clearly how the options and opportunities on a Health Board by Health Board basis. This information could be presented in different ways including having a 2% CIP and a non-recurrent allocation of £1.8m. The implications of all options would be clarified although the CASC felt it was essential that WAST have additional funding due to the level of inefficiency within the system at present. Members agreed to the need for additional non-recurrent funding to ensure additional front-line ambulance capacity however more detail would need to be provided, as requested.

Members **RESOLVED** to:

- **NOTE** the process of engagement undertaken in the development of the EASC Integrated Medium Term Plan
- **APPROVE** the EASC Integrated Medium Term Plan (2022-25) for submission to Welsh Government
- Receive information on a health board by health board basis in terms of the WAST CIP and additional temporary funding

CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT

Stephen Harrhy presented the report and highlighted the following:

- Non Emergency Patient Transport Services (NEPTS)

Members noted that detailed work was now being undertaken on NEPTS and the impact of health boards reset and reconfiguration on different elements of NEPTS activity, for example reduced outpatient journeys and an increase in demand for transfers and discharge. A 'Focus on' session will be held at the next EASC meeting exploring this on a health board by health board basis.

- EASC Action Plan

It was reported that the Minister had requested that the EASC Action Plan be updated to incorporate the expected impact of the actions being taken across the system. The latest version had been appended to the CASC report, this would now be updated.

- System Wide Escalation

Members noted that a conversation had been held at the recent NHS Wales Leadership regarding the final version of the System Escalation Plan. Members noted that the final version would be endorsed at the next meeting of the Leadership Board and implemented in April 2022.

Members **RESOLVED** to: **NOTE** the report

EMERGENCY MEDICAL SERVICES (EMS) COMMISSIONING FRAMEWORK

The EMS Commissioning Framework report was received. Ross Whitehead presented the report and noted previous discussions at EASC Management Group and the recent scrutiny panel on the WAST Transition Plan held with health board representatives.

Members noted that it had become clear from these recent discussions that health boards expected clarity on the commissioning of core ambulance service provision, separately from the transformation elements. This approach would provide health boards with the required clarity on how framework resources were being utilised to deliver the priorities of the Committee and would allow the development of different and transformational service offers within each health board areas to address the needs of their populations. Members were also reminded that the framework was a live document that would be refreshed every 6 months, responding to developments within the service.

Following discussion Members **RESOLVED** to:

- **APPROVE** the development of a framework that distinguishes between core service provision and transformational services
- **APPROVE** the extension of the interim arrangements until the May Committee meeting.

FOCUS ON SESSION – HEALTHCARE INSPECTORATE WALES (HIW) - REVIEW OF PATIENT SAFETY, PRIVACY, DIGNITY AND EXPERIENCE WHILST WAITING IN AMBULANCES DURING DELAYED HANDOVER

The HIW review was received. Ross Whitehead presented the session and Members noted that many elements of this 'Focus On' agenda item had already been discussed earlier in the meeting.

Members noted that the HIW report focusing on ambulance handover delays had already been considered at many health board sub committees. Twenty recommendations had been made which required a system wide response and it was confirmed that the action plan had been accepted by HIW. The EASC Management Group (EASC MG) agreed to establish a task and finish group to deliver the recommendations. Draft terms of reference had been circulated to EASC MG members with dates of the first two meetings and a request for clinical and operational representatives from each health board. It was agreed that regular updates on this work would be provided at future meetings of the Committee and the EASC Team would work closely with HIW on this matter. The first meeting would take place in early April and had been planned for 6 months in the first instance.

Members **RESOLVED** to:

- **RECEIVE** the HIW Review and responses to the recommendations
- **NOTE** the establishment of a task and finish group to focus on delivery of the recommendations via the EASC Management Group.

FINANCE REPORT

The EASC Finance Report was received. Stuart Davies presented the report and highlighted no significant changes and forecast end of year position of a £383k underspend. No significant movements were anticipated.

Members **RESOLVED** to: **NOTE** the report.

EASC SUB GROUPS

The confirmed minutes from the following EASC sub-groups were received and **APPROVED**:

- EASC Management Group – 21 Oct 2021
- NEPTS Delivery Assurance Group – 12 Oct 2021
- NEPTS Delivery Assurance Group – 30 Nov 2021

EASC GOVERNANCE INCLUDING THE RISK REGISTER

The report on EASC Governance was received.

Members **RESOLVED** to:

- **APPROVE** the risk register including 2 new risks and the three red risks which were also being reported to the CTMUHB Audit and Risk Committee
- **APPROVE** the Model Standing Financial Instructions
- **APPROVE** the final information for the model Standing Orders namely the Delegation of Powers and Scheme of Delegation
- **NOTE** and **APPROVE** the Draft Annual Business plan
- **NOTE** the updates relating to red performance and the additional new risks
- **NOTE** the progress with the actions to complete the EASC Standing Orders and the aim to complete all actions by the next meeting
- **NOTE** the Internal Audit on EASC Governance and the plans to track the recommendations.

Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance
- Handover delays
- Withdrawal of support from the military to WAST
- Continuing impact of the Covid 19 Pandemic

Matters requiring Board level consideration and/or approval

- Standing Orders and Standing Financial Instructions would be forwarded as soon as documentation finalised

Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	**10 May 2022**			

Emergency Ambulance Services Committee

Integrated Medium Term Plan

2022/2025

CONTENTS

FOREWORD

Welcome to the Emergency Ambulance Services Committee's Integrated Medium-Term Plan for 2022/25.

In developing this plan, the Committee acknowledges and values the effort made by frontline staff across the urgent and emergency care system in responding to the pandemic. Recognising the extraordinary pressures placed upon the system, the Committee has taken a pragmatic approach during this period, adopting a supportive and enabling role, prioritising work that both reduces harm and improves patient outcomes and experience.

This plan will describe the Committee's approach and priorities for commissioned services, with a particular focus on supporting the work to deliver improvements in the unprecedented levels of ambulance handover hours lost, securing the availability of safe levels of ambulance provision, and contributing to the wider transformation of the urgent and emergency care system over the duration of this planning cycle.

We are confident that this plan strikes the appropriate balance between a continued focus on core service provision, strengthening the role of commissioning and enabling transformation.

The Committee has aligned the commissioning cycle to the 3-year planning cycle adopted across NHS Wales and will continue to work with stakeholders to ensure that existing and new services commissioned via the Committee are integrated and add value at the patient and system level.

We will continue to work collaboratively to enable providers to effectively deliver and improve services and to contribute to the required transformation agenda that is underway across NHS Wales.

CHRISTOPHER TURNER
INDEPENDENT CHAIR

STEPHEN HARRHY
CHIEF AMBULANCE SERVICES COMMISSIONER

EXECUTIVE SUMMARY

The Emergency Ambulance Services Committee (the Committee) Integrated Medium Term Plan (IMTP) for 2022/25 sets out the work programme expectations and deliverables for EASC for the next 3 years.

The portfolio of EASC commissioned services includes:

- Emergency Ambulance Services (EAS)
- Non-Emergency Patient Transport Services (NEPTS) and the
- Emergency Medical Retrieval and Transfer Service (EMRTS Cymru), including the Adult Critical Care Transfer Service (ACCTS)

EASC recognises its role in enabling commissioned services to support the wider urgent and emergency care system to reduce the unprecedented levels of ambulance handover delays, minimise clinical risk and improve patient safety.

Meeting the overarching Ministerial priorities set out in the NHS Wales Planning Framework 2022/25 is an integral part of the plan. In addition, EASC will contribute to the work of the Six Goals for Urgent and Emergency Care in Wales, in particular Priority Delivery Measure 11 (Phase One), contributing to the development of measures as part of phases two to four and the Goal 4 Action Plan to increase patient safety and the patient experience, minimise clinical risk and improve performance.

This plan also identifies a number of wider system work programmes to support transformation over the life cycle of this plan.

These work programmes have also been developed to respond to the plans for transformational change that are being developed across the Health Boards. The Committee will continue to adapt and respond to changing service models at a local, regional and national level.

This plan will focus on:

- Commissioning intentions for commissioned services (2022/23)
- Commissioning priorities (2022/25) including:
    - Quality and Safety
    - Informatics and Ambulance Quality Indicators with an increased focus on data integrity and quality assurance
    - Development and delivery of the vision for a modern emergency ambulance service
    - Supporting the implementation of the Six Goals for Urgent and Emergency Care
    - National Transfer and Discharge Services
    - NHS 111 Wales
    - Emerging System Transformational Change
- EASC Financial Plan

EXECUTIVE SUMMARY

The commissioning priorities that have been described are aligned to a number of the overarching priorities and relevant national programmes. These priorities are in addition to the ongoing delivery of agreed commissioning actions, the focus on essential operational service provision and the prioritisation of the core responsibility to minimise risk and harm through the provision of timely responses to patients, both virtually and physically.

The details within this plan are consistent with those of the Welsh Ambulance Services NHS Trust, EMRTS Cymru and Health Boards.

The plan focuses on the services currently commissioned by EASC. However, the Committee recognise that work will be undertaken during the life of this plan regarding the commissioning arrangements of NHS 111 Wales and is committed to supporting this work.

RESETTING SERVICES AND DRIVING RECOVERY

This plan describes the pragmatic and considered approach that the Committee has taken to resetting services and ensuring a renewed focus on driving recovery across our commissioned services over the next three years.

The plan will drive a refocusing of efforts on ensuring commissioned services deliver their core and fundamental roles to a standard and consistency that meets the needs of the population whilst also responding to the unprecedented levels of ambulance handover delays and securing safe levels of ambulance provision.

From the EASC Team perspective, the impact of the pandemic on day-to-day activities has been successfully mitigated and the team's core enabling function has been maintained during this time of significant service change. During this period, the team has developed a commissioning cycle with stakeholders, strengthening the collaborative commissioning approach.

The team will continue to utilise this approach to support the work to improve service delivery, service quality, patient safety and performance with a view always to optimise patient outcomes and the patient experience.

EASC COMMITTEE

BACKGROUND

The Committee comprises the Chief Executives of the seven Local Health Boards, an Independent Chair and a Chief Ambulance Services Commissioner (CASC). The NHS Trusts in Wales are represented as Associate Members.

The seven Local Health Boards in Wales are required under the legislation to work jointly to exercise functions relating to the planning and securing of emergency ambulance services. The CASC exercises these duties on behalf of the Committee.

Working with providers on behalf of the Committee, the CASC and the EASC Team enact the priorities of the Committee for their populations, with benefits delivered to patients and the Welsh public, Welsh Government, Clinical Networks, Health Boards and other elements of the NHS Wales system.

Work will also be undertaken with commissioned services to ensure compliance with Ministerial priorities and statutory requirements including Welsh Health Circulars, the decarbonisation agenda and CoVID-19 inquiry.

GOVERNANCE

The EASC Model Standing Orders outline the expectation that safe, effective, and timely services are delivered, robust quality assurance and risk management systems support this. An overview of the governance process is provided in Figure 1.

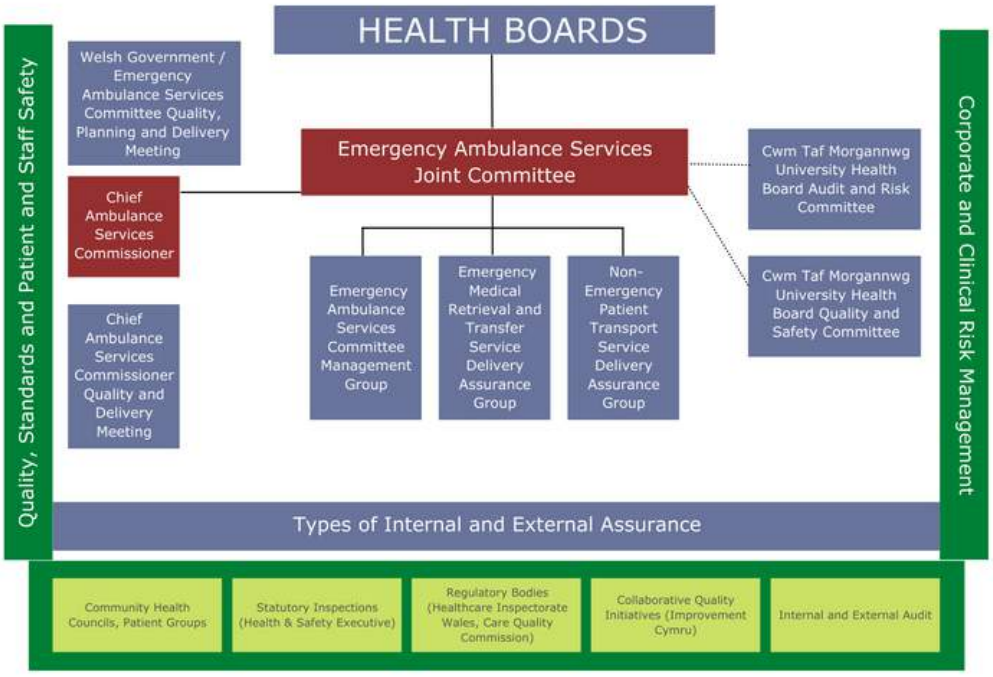


Figure 1 - EASC Governance Process

GOVERNANCE AND ASSURANCE

The established EASC Management Group and NEPTS and EMRTS Delivery Assurance Groups are the key governance and assurance mechanisms that ensure robust collaborative partnership arrangements with key stakeholders. These groups enable detailed oversight of delivery, performance and the strategic direction of commissioned services.

This the mechanism through which Health Boards and commissioned services will jointly plan and take collective action to deliver the Committee's priorities. Collaborative partnership working and a whole system approach is at the heart of these arrangements, ensuring that there is appropriate challenge, collaboration and a drive to build on the learning and experiences across the system and to improve integration, quality of care and patient outcomes.

These groups are tasked with enacting the commissioning responsibilities of the Committee to ensure the provision of safe, effective, equitable and sustainable services for the population of Wales.

Membership of these groups is regularly reviewed in order to ensure appropriate representation of Health Boards and Trusts.

EASC JOINT COMMITTEE

It is important to recognise the opportunities arising from a Joint Committee mechanism. The Committee is independently chaired and has strong governance and accountability frameworks as already described. These arrangements have been demonstrated to provide an appropriate forum for making decisions with national or regional implications.

Supported by the independence and expertise of the EASC Team, the Committee provides a system-wide view ensuring valuable insights in to the whole patient pathway and appropriate challenge to the system.

EASC TEAM

In terms of the wider system, the EASC Team is well-positioned in terms of its collaborative partnership arrangements with WAST and Health Boards and therefore is able to support, negotiate and arbitrate on new and existing services. This system-wide collaboration ensures that the team is able to engage the wider system both locally and nationally in order to support the work to improve service delivery, quality, patient safety and performance with a view always to optimise patient outcomes and the patient experience.

The EASC Team deliver:

- Collaborative commissioning quality and delivery frameworks which enable the planning and securing of ambulance services
- Incident and complaint reviews
- Performance reviews
- Clinical and risk assurance reviews
- Facilitation of collaborative working across the system
- Facilitate the Ambulance Services Indicator Group
- Publication and analysis of a comprehensive suite of Ambulance Quality Indicators (AQI), including enhanced and interactive user-friendly reporting of AQIs
- Development of a comprehensive suite of performance and outcome measures across clinical services, patient experience and value for money which are regularly reported
- Working in collaboration develop, implement, and monitor commissioning intentions
- On behalf of the Committee manage commissioning funding allocations, work in collaboration to deliver cost effective, safe services
- Deliver bespoke reviews and work programmes commissioned by the Committee or by other bodies
- Provide expert independent advice as required across the system
- Support the Committee to discharge its responsibilities in line with the legislation and regulatory framework

Any additional requirements of the EASC team will need to be negotiated with the Committee.

QUALITY AND SAFETY

National incident reporting in NHS Wales has changed and the new National Patient Safety Incident Reporting Policy brings about a number of key changes, including to empower NHS Wales responsible bodies to take more ownership and accountability for incident reporting.

With the national oversight provided by the NHS Wales Delivery Unit, there is an increasing request on the EASC team in relation to supporting this interface between WAST and Health Boards, supporting organisations to develop the required quality and patient safety systems and processes.

One of the EASC Team's priorities during this planning period will be to explore the opportunities to strengthen in this area to ensure that sufficient resource is in place to support the CASC and the Committee.

Working with organisations across NHS Wales, the new arrangements will strengthen the reporting and provision of assurance to the Welsh Government Integrated Quality, Delivery and Planning meetings and the CASC & WAST Quality and Delivery meetings.

RISK MANAGEMENT FRAMEWORK

EASC and its supporting structures are hosted by Cwm Taf Morgannwg University Health Board (CTMUHB) and utilise the CTMUHB risk management approach.

The risk management framework for EASC strengthens the control environment and sustains good corporate governance, implementing effective internal controls and monitoring activities in support of EASC.

The EASC Risk Register is reviewed and updated throughout the year and approved by the Committee and each meeting of the CTMUHB Audit & Risk Committee for assurance.

EASC COMMISSIONING CYCLE

The EASC Team has capitalised on the current transitionary year and, by working with the EASC Management Group, has developed a commissioning cycle. The cycle will ensure appropriate engagement with stakeholders in a timely manner in relation to the update and refresh of EASC commissioning frameworks and in the development and review of EASC commissioning intentions.

The commissioning cycle has already supported the update of the EMS commissioning framework during this financial year. In line with the commissioning cycle, the refresh of NEPTS (2022/23), EMRTS (2023/34) and again EMS (2024/25) commissioning frameworks will be undertaken during this IMTP period.

The update and refresh of each framework will require early engagement and collaborative discussions with commissioned services and Health Boards.

The commissioning cycle will also ensure a timely and collaborative approach to the development of commissioning intentions on an annual basis. Commissioning intentions will build on the progress made in the previous year and, while not setting out the full work programme for our commissioned services, will continue to reflect the strategic priorities of the Committee.

The agreed EASC commissioning cycle is included at Appendix 1.

QUALITY AND DELIVERY FRAMEWORKS

These frameworks are a key element of EASC's collaborative commissioning approach and are in place for each of the commissioned services.

Frameworks are designed to support system leaders to work in a collaborative way, encouraging open and transparent discussions between commissioners and providers and to ensure engagement with other key stakeholders in the wider urgent and emergency care system. The aim is to support an improvement in service delivery, service quality, patient safety and performance with a view always to optimise patient outcomes and the patient experience.

There are a number of proven benefits to utilising the commissioning framework approach as part of the collaborative commissioning process, these include:

- Delivery of safe and timely care to all patients
- Improved patient outcomes with patients directed to the right service, first time
- Ensuring a value-based approach which enables an equitable, sustainable, and transparent use of resources to achieve better outcomes for patients
- Reduction of unwarranted variation in service operational delivery
- Development and use of alternative pathways ensuring an integrated approach across the health and social care system
- Clear commissioning expectations
- Facilitation of collaborative and integrated commissioning as part of a system-wide response across the urgent and emergency care services system
- The adoption of a consistent commissioning process and approach and improved sharing of best practice. This will support sustainable service delivery and commissioning going forward

Commissioning frameworks will be used to take forward key actions and priorities for Health Boards and WAST with specific schedules making the required actions clear, regularly monitored by the Committee.

The updated framework will also provide Health Boards with the required clarity on how framework resources are being utilised to deliver the priorities of the Committee and will allow the development of different and transformational service offers within each Health Board area to address the needs of their populations. The framework also incorporates a value-based commissioning model to more effectively identify the connectivity of factors that influence quality and performance from resource allocation through to outputs and outcomes.

It is felt that this approach will support the decision-making of the Committee, the EASC Management Group and sub-groups in terms of investment, resource utilisation and patient outcomes.

These changes will also be reflected as we update and refresh the frameworks during the lifetime of this plan.

COMMISSIONING INTENTIONS

Commissioning intentions are set for each of our commissioned services to provide a clear indication of the strategic priorities of the Committee for the next financial year. Intentions focus on outcomes, value, quality, and safety of service delivery and aim to ensure reasonable expectations for the ongoing improvement of these services.

Following discussion at EASC Management Group, a pragmatic approach has been agreed in the development of commissioning intentions for 2022/23. The principle of the incremental development of previous commissioning intentions, updated to reflect the progress made during 2021/22, has been adopted.

In developing these intentions, the Committee has sought to recognise the challenges of resetting in the post CoVID-19 environment and to limit the additional asks on commissioned services to focus on the pandemic response, stabilisation, and recovery of services. However, where possible, opportunities to fast-track service transformation have also been embraced.

It is important to note that commissioning intentions are not intended to set out all activity that will be undertaken by commissioners or the provider during the year and, therefore, other projects to deliver short term operational improvements will also be undertaken.

To complement the strategic focus of intentions, detailed service deliverables and metrics are included within the relevant commissioning framework, as part of the EASC collaborative commissioning approach.

EASC Management Group will continue to hold responsibility for the development, monitoring and reporting of progress against intentions to ensure the strategic intent is achieved. The agreement of the EASC commissioning cycle has already ensured increased engagement and a more timely approach to the agreement of commissioning intentions for 2022/23.

COMMISSIONED SERVICES 2021/22

Supported by the EASC collaborative commissioning approach and in response to the agreed commissioning intentions, each of our commissioned services has addressed the significant challenges presented over the course of the last year and made good progress in the following key areas.

KEY ACHIEVEMENTS IN 2021/22

Emergency Ambulance Services	Quarter
Delivery of additional front-line staff in line with the year 2 recruitment and training plan	Quarter 1 - 4
Expansion of the clinical support desk including mental health practitioners	Quarter 4
Implementation of ECNS clinical triage software	Quarter 4
Clinical support desk roster implementation	Quarter 4
Non-Emergency Patient Transport Services	
Completion of Transfers of Work	Quarter 3
Continue to improve the availability of plurality providers underpinned by quality assurance approach	Ongoing
Emergency Medical Retrieval and Transfer Service	
Consolidation of EMRTS service expansion (24/7 response)	Quarter 1 - 4
Implementation of Adult Critical Care Transfer Service	Quarter 3

Table 1 - Key Achievements in 2021/22

A performance overview is provided for each area:

- Emergency Ambulance Services – Appendix 2
- Non-Emergency Patient Transport Services – Appendix 3
- Emergency Medical Retrieval and Transfer Service – Appendix 4

COMMISSIONING PRIORITIES 2022/25

STRATEGIC PRIORITIES FOR COMMISSIONED SERVICES IN 2022/23

The priorities for our commissioned services are set out within the commissioning intentions for each service. As a collaborative commissioner, EASC recognise the responsibility of the wider system to enable the commissioned services to deliver these intentions.

Commissioning intentions for 2022/23 have been agreed by both the EASC Management Group and the Committee. These are not intended to set out all activity that will be undertaken this year by commissioners or the provider, but to provide a clear indication of the strategic priorities of the Committee.

Detailed content of the commissioning intentions, are available in the following appendices.

- Emergency Ambulance Services – Appendix 5
- Non-Emergency Patient Transport Services – Appendix 6
- Emergency Medical Retrieval and Transfer Service – Appendix 7

Tables 2, 3 and 4 provide a brief summary of the priorities for each commissioned service:

EMERGENCY AMBULANCE SERVICES

Summary of Priorities	Outcome	Performance Ambition
Focus on delivering improved patient and system outcomes at Step 2 (Answer my call) of the ambulance care pathway	Improving patient experience and outcomes by ensuring that they receive the right care at the earliest possible opportunity in their episode of care	Development of the remote clinical support strategy (Qtr. 4) and the reporting of clinical support desk outcomes (Qtr. 2)
Optimising conveyance and patient outcomes	Optimisation of decisions about conveyance, reduced unnecessary conveyance and reduction in variation	Implementation of conveyance improvement plan (Qtr. 3)
Completion of actions arising from the Demand and Capacity Review including workforce stability and availability	Ensuring the maximum number of front line staff are available to respond to demand	Response Roster Project to deliver rosters aligned with service demand (Qtr. 2)
Maximise productivity from resources, specifically: ◦ reducing post-production lost hours (PPLH) ◦ reducing notification to handover times	Addressing the drivers that lead to suboptimal productivity and delivering significant gains for emergency ambulance provision and the wider system. This will also include refining the approach and reporting of the unit hour utilisation metric	Set an agreed PPLH baseline and monitor against improvement trajectories (Qtr. 4) Monitor and report performance for each site against the set improvement trajectories (Qtr. 1)
Ongoing development of the value based approach to service commissioning and delivery	Making the best and most efficient use of the resources available and improve patient experience	Development of value-based approach (Qtr. 2)
Reducing and preventing harm and improving outcomes	Continuous improvement based on learning from errors and adverse events, supported by robust audit cycle	Implement a process for identifying harm prior to a complaint being logged (Qtr. 4)
Support the wider system to reset services and drive recovery	Integrated and proactive management of system flow escalation across the system	Development of an aligned system-wide escalation and clinical safety plan (Qtr. 2) Development of case for national transfer and discharge service (Qtr. 4)

Table 2 - Emergency Ambulance Services

NON-EMERGENCY PATIENT TRANSPORT SERVICES (NEPTS)

Summary of Priorities	Outcome	Performance Ambition
Demonstrate that resources are being utilised effectively following the transfers of work and the implementation of the full plurality model	Improve the efficiency, quality of service and outcomes for patients	Re-design and renewal of patient contracts to deliver the best patient transport model (Qtr. 2)
Understand and mitigate demand	Closer working with the patient and Health Boards to deliver effective, safe and people-centred care	Continuous improvement based on learning from data and feedback (Qtr. 4)
Maximise capacity	Increase and diversify capacity (internal and external resources) to meet the changes in patient demand and individual patient needs	Deliver improvement plans to reduce lost capacity due to system inefficiencies (Qtr. 2)
Support system transformation	Responsive to the new emerging demands and wider system transformation to enhance service delivery and improve patient experience	Development of forecasting and modelling framework setting out the work required over the next decade (Qtr. 4)

Table 3 - Non-Emergency Patient Transport Service

EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE

Summary of Priorities	Outcome	Performance Ambition
Implementation of enhanced CCP-led response	Building on the findings of recent winter initiatives, ensuring more effective use of resources, improved patient experience and workforce development opportunities	Service implementation (Qtr. 2)
Adult critical care transfer service (ACCTS) - Ongoing service delivery and service evaluation	Review and strengthen existing service model(s) to maximise clinical outcomes, value, quality and safety of service delivery	Year 1 service evaluation (Qtr. 4)

Table 4 - Emergency Medical Retrieval and Transfer Service

STRATEGIC PRIORITIES 2022/25

INFORMATICS AND INDICATORS

The original Ambulance Quality Indicators (AQI) were revised in October 2015 to reflect changes to the Welsh Ambulance Services NHS Trust's (WAST) Clinical Response Model. The AQIs provide detailed statistical information to the general public following quarterly publication on the EASC and StatsWales websites.

The Ambulance Services Indicators Group (ASIG) has now been established with membership from Welsh Government, Digital Health Care Wales, WAST, EASC Team, EMRTS and Community Health Councils. The group will ensure a strategic view with regard to issues surrounding ambulance service indicators and the collection and reporting of data, including data integrity and quality assurance.

The ASIG will oversee the implementation, management and ongoing development of the ambulance indicators. This will include responding to any adaptations to models of care by supporting the development of measures that provide assurance on clinical and operational performance and defining and reviewing the agreed indicators to ensure relevance and alignment to the six domains of health care quality.

During this planning cycle, the ASIG will initially focus on reviewing existing indicators. The focus will then move on to the development, publication and ongoing review of relevant and appropriate indicators, ensuring an increasing focus on quality.

AMBULANCE AVAILABILITY TASKFORCE

The Commissioner Ambulance Availability Taskforce is made up of senior organisational representatives and experts in relevant fields. The Taskforce is jointly chaired by Stephen Harrhy and Professor David Lockey, EMRTS Cymru National Director.

Having taken time to build an understanding of the current position in terms of the commissioning and provision of ambulance services in Wales, the Taskforce has now considered some key aspects relating to the vision for a modern ambulance service. The Taskforce will now continue to provide an independent advisory and scrutiny forum in relation to the development of the vision for a modern ambulance service.

TRANSPARENCY AND ACCOUNTABILITY

During the second half of 2021/22, at the request of the Minister for Health and Social Services, the EASC Team have developed and submitted monthly updates relating to the improvement actions being taken by the Committee in relation to commissioned services. This approach has been welcomed by the Committee and by Welsh Government officials and it is our intention to build on this during the course of this planning cycle.

The EASC Work Programme Status Update will include the delivery of operational improvements across the system in the short term as well as the progress made against strategic priorities. This status update will be presented at each Committee meeting, enabling Health Board colleagues to be regularly updated with regard the progress that EASC is making in these areas. Following the Committee meeting, this status update will also be circulated to relevant stakeholders, including Welsh Government, to ensure that they are sighted on the progress made.

WIDER SYSTEM WORK PROGRAMMES 2022/25

VISION FOR A MODERN AMBULANCE SERVICE

The current model for emergency ambulance services in Wales reflects the delivery of a traditional ambulance service that ultimately results in a conveyance to hospital. It is widely recognised that there is a need to adapt this model to reflect the vision for a modern ambulance service in Wales.

Work has been undertaken during 2021/22 during Committee 'Focus On' sessions regarding the emergency ambulance service's ambition to play a wider role across the system.

The high-level model shown below in Figure 2 outlines this ambition.

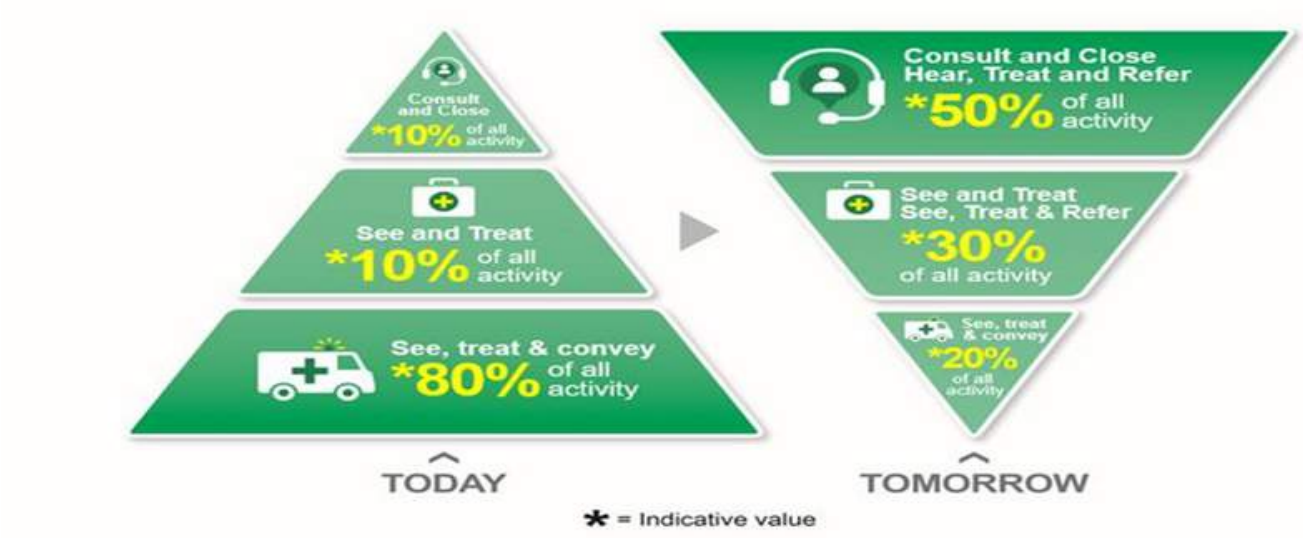


Figure 2 - Welsh Ambulance Services NHS Trust's Vision for a Modern Ambulance Service

The model aims to place the ambulance service at the heart of the urgent and emergency care system and maximises the benefits of a co-hosted 111 and 999 service. This includes a joint commitment to optimise conveyance, this requires a system-wide focus on:

- Capacity matched to demand across Wales to provide a quicker response
- Optimised response for the sickest patients
- More callers having a clinical assessment before response agreed
- Reducing the number of ambulances being sent to patients through 'hear and treat'
- Clinicians attending scene better equipped to assess, treat, and refer
- Right care, first time by delivering the most appropriate response
- Providing care closer to home
- Working with Health Board colleagues to develop clear and consistent pathways across Wales, other than to emergency department, with a particular emphasis on same day emergency care and urgent primary care centres
- Seamless, equitable advice and care tailored to local settings across Wales
- Improving the use of the available clinical data
- Maximising the use of available or emerging technology to support and improve patient pathways

Whilst the Committee is broadly supportive of the model, further work is required to develop consensus around this approach, recognising that the challenges of commissioning and operationalising this model cannot be underestimated. A radical approach to the performance management and oversight of the ambulance service will be required in order to drive this change.

Delivery of a modern ambulance service will require a substantial change programme. This change must ensure robust workforce planning and modernised workforce practices to ensure that improvements in efficiency, effectiveness and safety of service delivery are realised.

SIX GOALS FOR URGENT AND EMERGENCY CARE (GOAL 4)

Building on the Six Goals Priority Delivery Measure 11 (Phase One) and focusing on the percentage of total conveyances taken to a service other than a type one emergency department, EASC will ensure that local models and plans are developed within agreed timeframes to ensure that the fastest and best response is provided for people who are seriously ill or injured.

Complementing the work that is being undertaken within emergency ambulance services to optimise conveyance and patient outcomes, these plans will include arrangements for Health Board staff to provide advice and guidance to colleagues on the most appropriate pathway into their services for 999 and 111 patients.

This work will explore the benefits of national, regional, and local models in order to provide gains across the system that will underpin sustainable change and improvements in population outcomes.

As part of a whole system approach, the aim is to optimise capacity, efficiency, and effectiveness, supporting the ambition to deliver seamless care and tackle fragilities across the system.

The priority for Year 1 is the implementation and optimisation of the Emergency Communication Nurse System (ECNS). This provides a well-structured, auditable assessment tool that takes a safe reductionist approach to remote assessment and provides self-care and “worsening” advice. This allows positive patient care and active risk mitigation in an evidence-based, structured, auditable manner.

The "*Proposed use of the Emergency Communication Nurse System in Welsh Ambulance Service 999 Secondary Triage with Paramedic and Nurse Users*" has been published in the Annals of Emergency Dispatch & Response. The full implementation of ECNS for use by Paramedics and Nurses in WAST would be a first for ambulance services across the world and will be a key enabler of clinically managing the ambulance workload in a safe and effective manner.

As well as enhancing the assessment tools and safety net for patients, the ECNS system has the potential to significantly reduce the assessment time duration, enabling more patients to be assessed by each clinician. Work is underway to model the size of the workforce required to clinically assess 80% of 999 calls before an ambulance resource is dispatched, this will ensure patient receive the care they need. The initial funding for the purchase of ECNS was provided through the Urgent and Emergency Care programme and we are anticipating that the ongoing licensing costs and further workforce growth for this transformative system would be supported by the programme as a key enabler of the ambulance service's contribution to delivering the Six Goals.

NATIONAL TRANSFER AND DISCHARGE SERVICES

Effective transfer and discharge services will be required to ensure that increases in specialisation and regionalisation of services as part of clinical transformational change programmes meet the needs of the population. Historically, transfers and discharges have been undertaken by emergency ambulance services and non-emergency patient transport services as an addition to their core work.

During 2022/23, the EASC Team will facilitate the development of a business case for the delivery of a national transfer and discharge service. The scope of this work will cover both existing and future transfer requirements and will bring consistency and oversight to a fragmented system, improving responsiveness and quality for patients and the wider system.

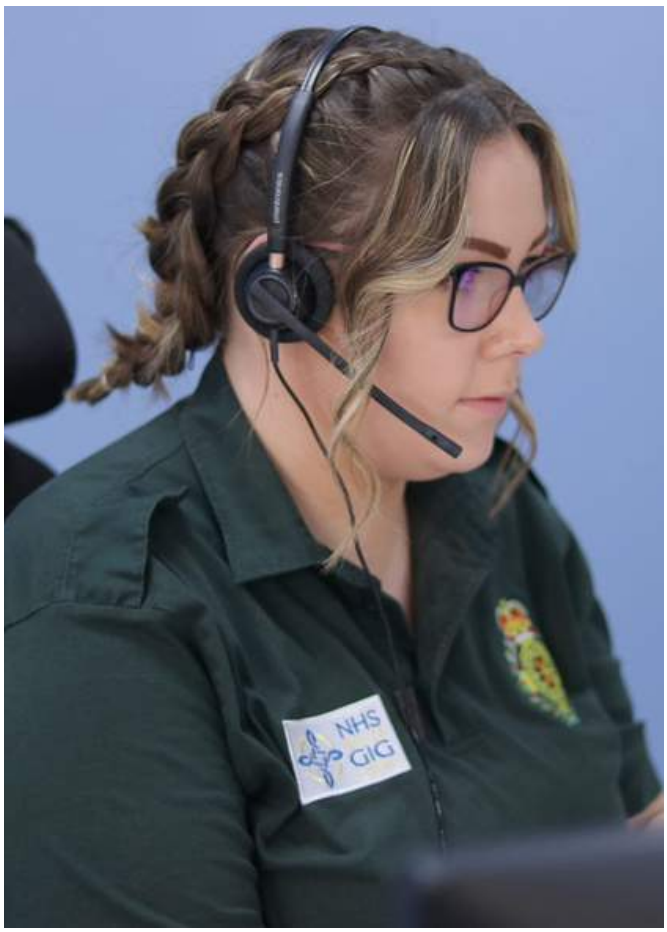
This work will specifically support the aspirations of the national clinical networks and will utilise the key enabling function of EASC and the importance of transport to improve patient flow within the system in support of the Six Goals for Urgent and Emergency Care.

It is expected that additional income will be required to fund the implementation of the business case. This will be taken through EASC in line with governance arrangements, no additional financial implications are anticipated for 2022/23.

NHS 111 WALES

The Committee recognises that 2022/23 will be a key year for NHS 111 Wales as the programme transitions into the phase of 'business as usual' service delivery.

The Committee will ensure that NHS 111 Wales and the emergency ambulance 999 system are complementary to each other in enabling an effective and efficient services for the population. In line with Welsh Government and Ministerial expectations, during the first year of this plan, the Committee will undertake a collaborative programme of work with WAST and the 111-programme team to explore and develop proportionate resource allocations without cross-subsidy and appropriate commissioning arrangements for NHS 111 Wales.



EMERGING SYSTEM TRANSFORMATIONAL CHANGE

The Committee and its subgroups play a key role in terms of assessing the plans for transformational change that are being developed across organisations.

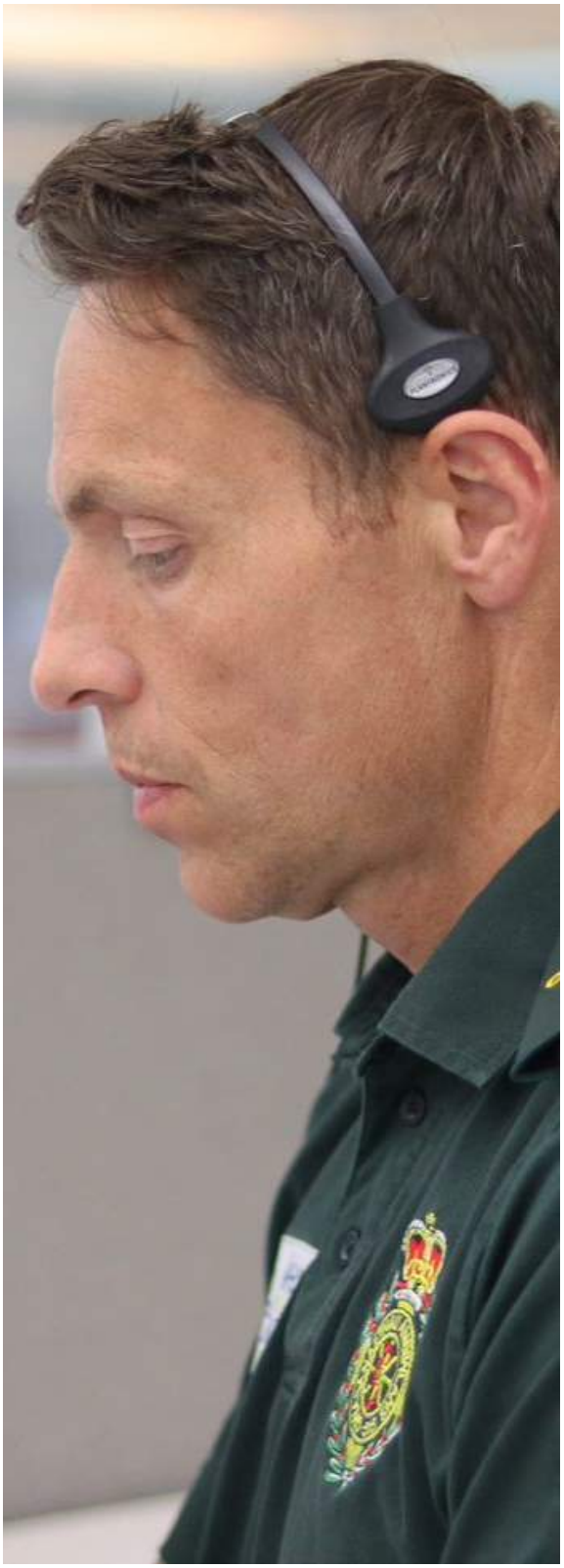
These governance arrangements will ensure the involvement of Health Boards and Trusts, facilitating discussions regarding these plans at the earliest opportunity and ensuring that implications for our commissioned services and the wider health and social care system are understood and addressed.

The Committee is well-placed to ensure that commissioned services are an enabler to innovation and the development of new services where required.

The EASC Team will continue to support and engage with the wider system and will work with Committee (and subgroup) members to understand, to adapt and to respond to changing service models at a local, regional and national level ensuring that services are integrated and add value to the system.

The EASC Team on behalf of the Committee will work with individual Health Boards to ensure sufficient and appropriate levels of resources are provided to enable commissioned services to act as enablers of transformational change.

COMMISSIONING PRIORITIES SUMMARY 2022/25



The commissioning priorities that have been described are aligned to a number of the overarching priorities and relevant national programmes. This includes:

- An improvement in population outcomes
- Working together, across organisational boundaries, to plan and ensure equitable delivery of services on a regional or national basis
- Taking local, regional and national actions to deliver sustainable change
- Optimising conveyance and patient outcomes
- The development of national pathways to support local improvement in the quality of services and address unwarranted variations in care
- A whole system approach building on the learning and experiences across health and care
- The use of prudent health care principles and value based healthcare as the basis for planning and delivering services in order to optimise capacity, efficiency and effectiveness

These priorities are in addition to the ongoing delivery of agreed commissioning actions, a focus on essential operational service provision and the prioritisation of the core responsibility to minimise risk and harm through the provision of timely responses to patients, both virtually and physically.

Tables 5a and 5b provide an overview of these commissioning priorities for 2022/25

EASC COMMISSIONING PRIORITIES

Work Progrmme	Summary of Priorities	Outcome
Informatics and Ambulance Quality Indicators	• Review existing indicators • Development and ongoing review process to ensure relevant and appropriate indicators	Refinement of existing AQIs to ensure an increased focus on quality
Commissioner Ambulance Availability Taskforce	• Utilise the expertise of stakeholders • Act as an independent advisory and scrutiny forum	Development of the vision for a modern ambulance service
Increasing the transparency and accountability of the Committee	• Build on the existing monthly EASC Action Plan updates • Include the delivery of operational improvements and progress against strategic priorities	Development of the EASC Work Programme Status Update for presentation at each EASC Committee meeting and circulation to relevant stakeholders

Table 5a - Priorities

WIDER SYSTEM WORK PROGRAMMES

Commissioned Service	Summary of Priorities	Outcome
Vision for a modern emergency ambulance service	• Continue to engage and to develop the consensus around the vision • Develop the key elements of the vision including workforce planning, digital transformation	Refinement of existing AQIs to ensure an increased focus on quality

Work Progrmme	Summary of Priorities	Outcome
Commissioner Ambulance Availability Taskforce	• Development of plans that ensure access to the most appropriate pathway in to services for 999 and 111 patients • Scoping any commissioning arrangements	Plans that ensure seamless care and improvements in population outcomes
Six goals for Urgent and Emergency Care (Goal 4)	• Development of plans that ensure access to the most appropriate pathway in to services for 999 and 111 patients • Scoping any commissioning arrangements	Plans that ensure seamless care and improvements in population outcomes
National Transfer and Discharge Services	• Scope the scale of transfer and discharge activity and providers by the end of Quarter 2 • Develop the business case for the establishment of a national transfer and discharge service by Quarter 4	A consistent, timely and adaptable national transfer and discharge service for Wales that is responsive to the changing health care system and service provision.
NHS 111 Wales	• Exploration of options for commissioning of NHS 111 Wales • Robust analysis of commissioning options • Establish commissioning arrangements for NHS 111 Wales	Appropriate commissioning arrangements in pace for NHS 111 Wales.
Emerging system transformational change	• To utilise the Committee and its sub groups to ensure timely discussions around plans for transformational change • To ensure that the implications of the plans across NHS Wales are understood	A system that is able to adapt and respond to change, ensuring that services are integrated and add value with a view to ultimately improving patient outcomes and the patient experience.

Table 5b - Priorities

EASC FINANCIAL PLANNING ALLOCATIONS 2022/23

The 2022/23 Annual Planning allocations for EASC commissioned services are consistent with the details set out in the Welsh Government allocation letter.

This is an initial allocation and additional funding for key priorities will be allocated as appropriate when costs are confirmed.

Emergency Ambulance Services Committee 2022/23 Summary	Total £m
EAS Allocation	198.238
NEPTS Allocation	26.911
EMRTS Allocation	6.215
Ring-Fenced Commissioning Allocation	2.340
Specialist commissioning Allocation	0.155
EASC Commissioning Funds from LHBs	233.859
EASC Team resourcing	0.627
EASC Total Funds from LHBs	234.486

Table 6a - Financial Planning

Temporary funding is also required to maximise additional front-line ambulance capacity to support the system and to mitigate the lost military support until the required improvements in handover lost hours are delivered across the system. This will maximise front line ambulance resource in order to minimise clinical risk and improve patient safety. Further discussions will need to take place during the year on additional investment if system improvements are not forthcoming.

Temporary Funding Requirement 2022/23 Summary	Total £m
Total Contribution from LHBs	1.800

Table 6b - Financial Planning

A detailed breakdown of the funding requirements by Health Board is provided in Appendix 8 along with more detailed financial assumptions in Appendix 9. The following section provides an overview of the key initiatives included in 2022/23 Financial Plan to support the delivery of the commissioning intentions and a breakdown of the temporary funding requirement by Health Board.

EAS ALLOCATION

DEMAND AND CAPACITY PROGRAMME 2022/23

- **£5.640m** recurrent funding included to sustain the additional 127 WTE front line staff in 2021/22 as part of a successful Phase 2 delivery

- **£0.685m** non recurrent funding is included to support front line resource allocation as emergency military support required during CoVID will cease from 1st April 2022

OPERATIONAL DELIVERY UNIT

- **£0.883m** recurrent funding to support the continued commissioning of the Operational Delivery Unit

THE GRANGE UNIVERSITY HOSPITAL

- **£4.420m** included in the Aneurin Bevan UHB allocation to fund EAS delivery to The Grange University Hospital as per the Service Level Agreement

NEPTS ALLOCATION

- The NEPTS funding position reflects the in year 2021/22 transition of services. NEPTS funding will be requested as an allocation to EASC for 2022/23 in line with commissioning arrangements

EMRTS ALLOCATION

- **£1.257m** recurrent funding allocated to EMRTS for continued commissioning of the 24/7 expansion following successful scale up in 2021/22

- **£1.700m** Adult Critical Care Transfer Service ring fenced commissioning allocation will be fully allocated to EMRTS service from 2022/23

RING-FENCED COMMISSIONING ALLOCATION

- **£1.700m** recurrent funding to deliver the Adult Critical Care Transfer Service
- **£0.640m** recurrent funding to deliver the Major Trauma Network service development
- EASC will allocate these funds across the EASC commissioned services in order to meet the service delivery objectives

SPECIALIST COMMISSIONING ALLOCATION

- **£0.155m** recurrent funding from Cardiff and Vale, Aneurin Bevan and Cwm Taf Morgannwg UHBs to continue the delivery of the South-East Wales Regional Acute Coronary Syndrome Treat and Repatriate Service

TEAM RESOURCING ALLOCATION

- No assumption has been made for additional EASC Team resourcing wider than the normal uplift position

EFFICIENCY PROGRAMMES

- EASC commissioned services are expected to deliver an efficiency programme in line with those of Health Boards, Trusts and Special Health Authorities. Any savings resulting from these programmes will be re-invested in service development opportunities in agreement with the Commissioner on behalf of the Committee and in line with the commissioning intentions for the service
- Where appropriate, the EASC Team will work with commissioned services on behalf of Health Boards to realise these opportunities
- It is expected that WAST will deliver a cost reduction programme equivalent to at least 1% of the EASC Commissioning Funds allocated from LHBs

TEMPORARY FUNDING REQUIREMENT

Emergency Ambulance Services Committee 2022/23 Summary	Total £m
Aneurin Bevan University Health Board	0.3044
Betsi Cadwaladr University Health Board	0.4700
Cardiff and Vale University Health Board	0.2138
Cwm Taf Morgannwg University Health Board	0.2348
Hywel Dda University Health Board	0.2502
Powys Teaching Health Board	0.1360
Swansea Bay University Health Board	0.1863
Total Contributions from LHBs	1.800

Table 7- Financial Planning

CONCLUSION

The EASC Integrated Medium Term Plan describes the Committee's priorities for commissioned services. The plan has a particular focus on supporting the work to deliver improvements in the unprecedented levels of ambulance handover hours lost, securing the availability of safe levels of ambulance provision and contributing to the wider transformation of the urgent and emergency care system over the duration of this planning cycle. The plan also describes the pragmatic and considered approach to resetting across the system ensuring a renewed focus on driving recovery across our commissioned services.

The actions within the plan will be translated through to the commissioning framework which will be used to take forward key actions and priorities for Health Boards and WAST. These will be regularly monitored by the Committee to ensure delivery and improvements in 2022/23 and beyond.

The plan will drive a refocusing of efforts on ensuring that commissioned services deliver their core and fundamental roles to a standard and consistency that meets the needs of the population.

The plan focuses on:

- Commissioning intentions for commissioned services (2022/23)
- Commissioning priorities (2022/25) including:
    - Quality and Safety
    - Informatics and Ambulance Quality Indicators with an increased focus on data integrity and quality assurance
    - Development and delivery of the vision for a modern emergency ambulance service
    - Supporting the implementation of the Six Goals for Urgent and Emergency Care
    - National Transfer and Discharge Services
    - NHS 111 Wales
    - Emerging System Transformational Change
- EASC Financial Plan

The details within this plan are consistent with those of the Welsh Ambulance Services NHS Trust and Health Boards.

APPENDIX 1

COMMISSIONING CYCLE 2022/25

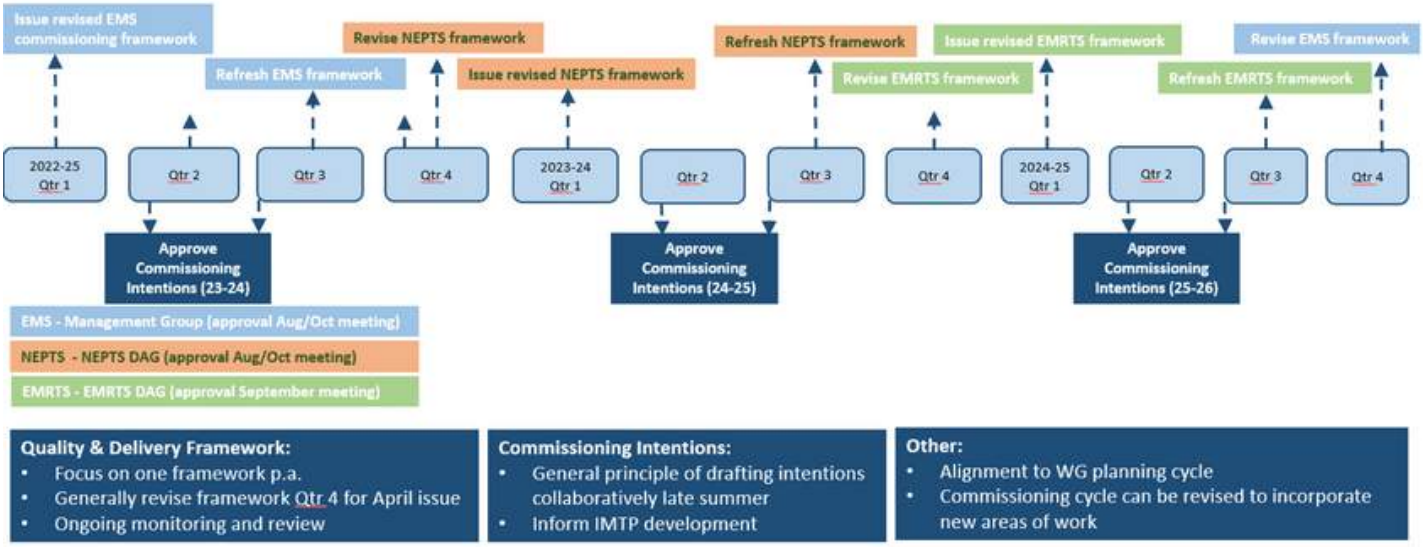


Figure 3 - Commissioning Cycle

APPENDIX 2

EAS PERFORMANCE OVERVIEW 2021

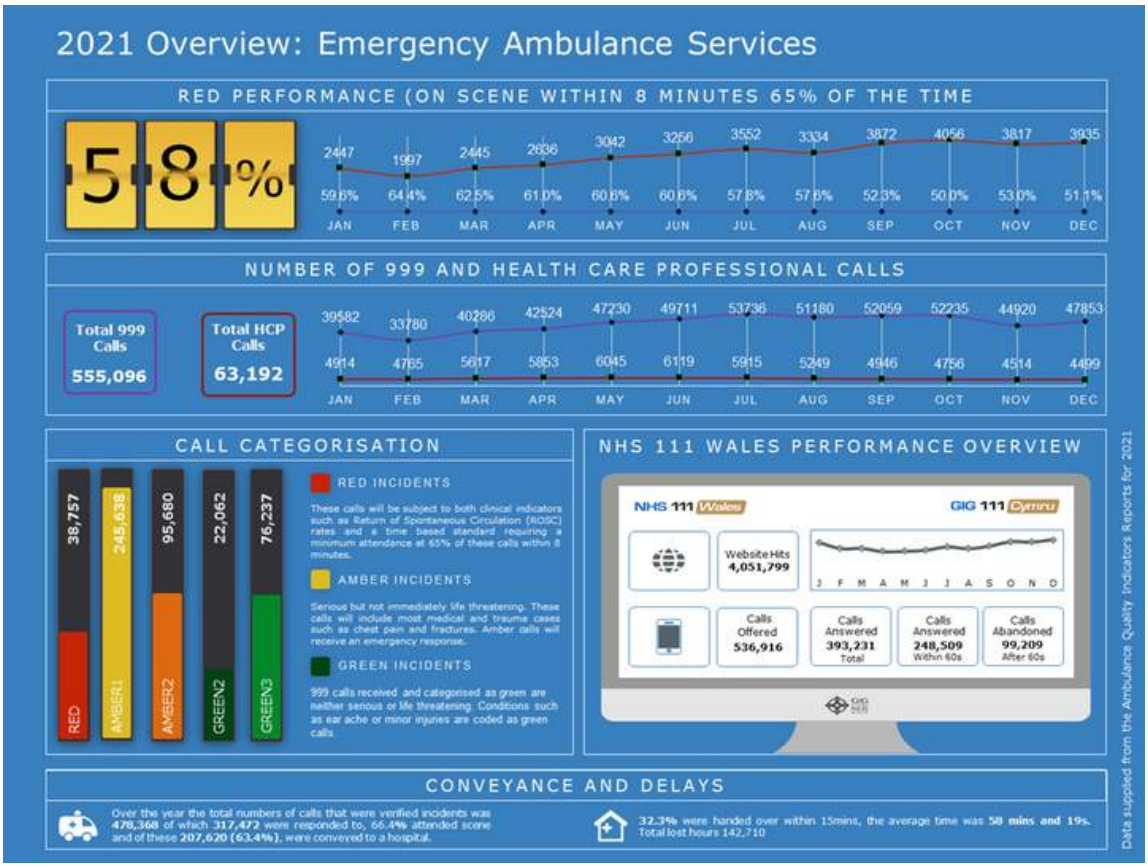


Figure 4- EAS Performance Overview

APPENDIX 3

NEPTS PERFORMANCE OVERVIEW 2021

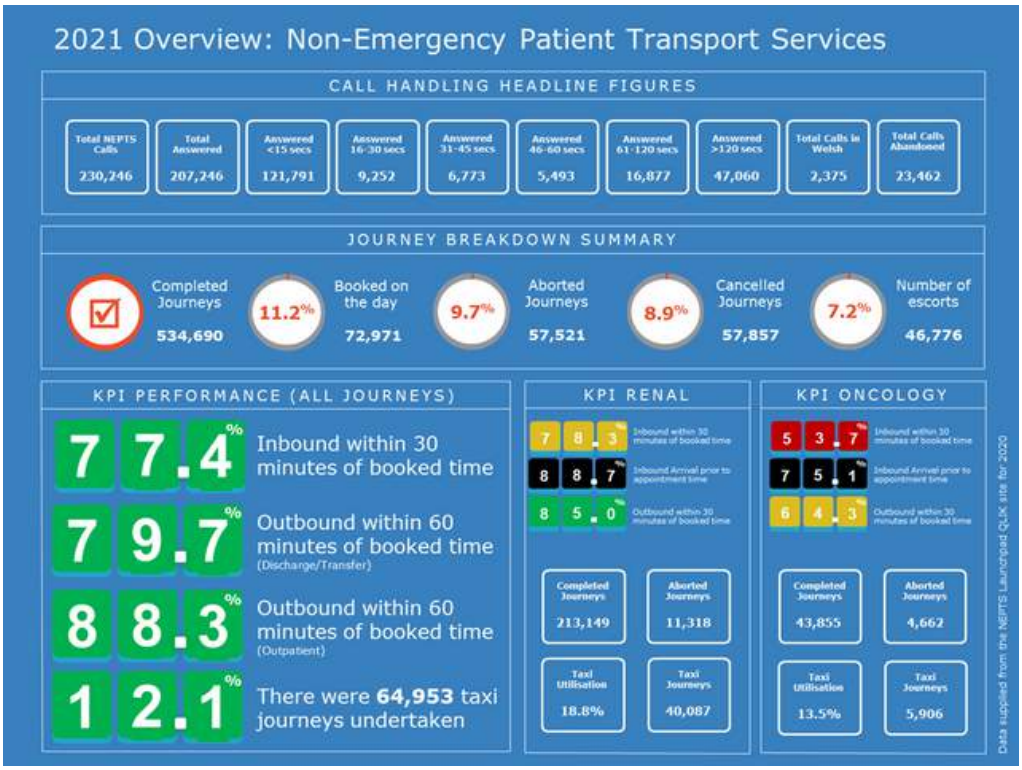


Figure 5- NEPTS Performance Overview

APPENDIX 4

EMRTS PERFORMANCE OVERVIEW 2021

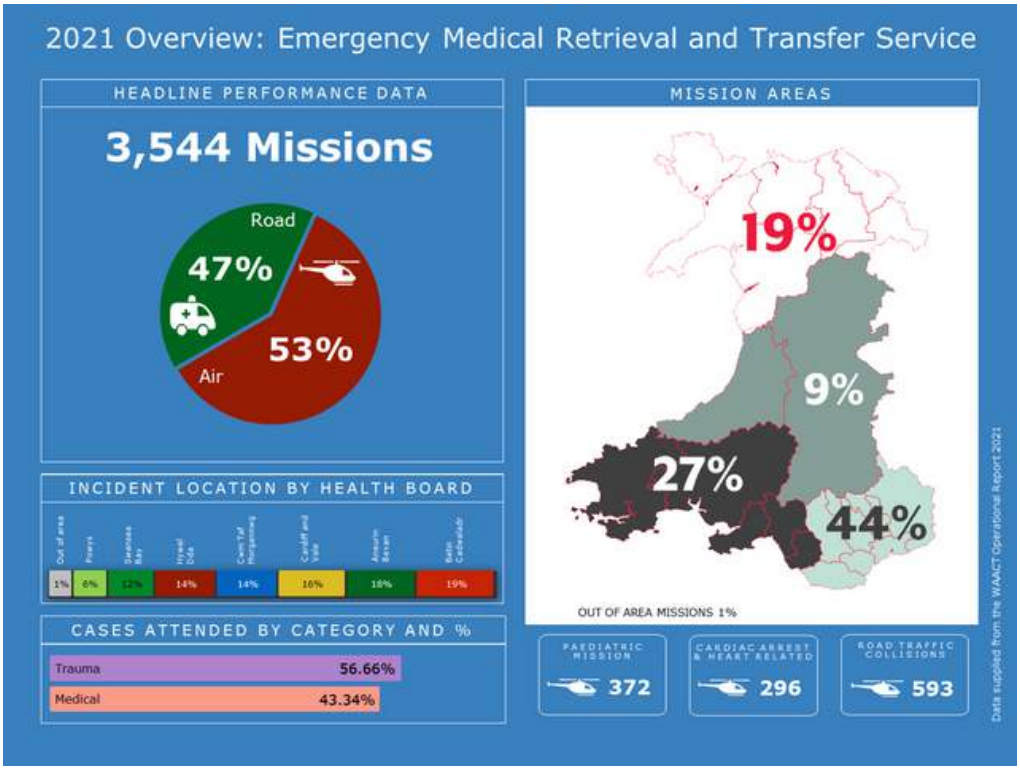


Figure 6- EMRTS Performance Overview

APPENDIX 5-EMS COMMISSIONING INTENTIONS 2022/23

This section sets out the revised approach and guiding principles to the Emergency Ambulance Services commissioning intentions for 2022/23 and beyond.

These intentions aim to reflect the direction from Committee members to limit the additional asks on commissioned organisations this year including, but not limited to, minimising meetings, reporting and developments in order to allow for commissioned organisations to focus on the pandemic response, stabilisation and recovery of services.

Intentions aim to support the implementation of the new commissioning framework and transition of performance management arrangements to focus on outcomes, value, quality and safety of service delivery.

These commissioning intentions are not intended to set out all activity that will be undertaken this year by commissioners or the provider, but to provide a clear indication of the strategic priorities of the Committee for the provider of Emergency Ambulance Services in Wales for 2022/23.

Guiding Principles for 2022/23, the commissioning intentions will:

- Be at the strategic level and will be extant for a minimum of 3 years
- Focus on outcomes, value, quality and safety of service delivery
- Support the delivery of the quadruple aims
- Have annually agreed aim(s), product(s) and indicator(s) that will provide an outline of what will be provided within each intention
- Ensure reasonable expectations for the improvement of Emergency Ambulance Services
- Recognise the challenges of resetting in the post-CoVID environment and the opportunities to fast track service transformation
- Ongoing engagement and review between WAST and Commissioners will allow the detail of each intention to be refined during the period, if required
- Intentions will not replace or override extant requirements within the commissioning framework or statutory targets or requirements

Development and monitoring

- In line with the agreed commissioning cycle, organisations have been asked for their view on the priorities for next year and consequently a principle of the incremental development of existing commissioning intentions has been adopted
- Intentions have been developed in alignment with the 6 Goals for Urgent and Emergency Care
- EASC Management Group will hold ultimate responsibility for the development and monitoring of progress against intentions to ensure the strategic intent is achieved
- Regular updates will be provided against commissioning intentions to EASC Management Group
- Future intentions will continue to be developed in a collaborative and timely manner in line with the agreed commissioning cycle

Commissioning Intention – CI1: Clinical Response Model	
The Emergency Ambulance Service and its Commissioners will seize the opportunities afforded by the Welsh Clinical Response Model and the 5 Step Ambulance Pathway (EMS).	
Commissioning Statement	
The 5 step Ambulance Pathway (EMS) provides a simplified framework for health systems to collaborate to optimise the care patients receive at each step. A high performing health system will enable services and practitioners at each step to resolve a patient episode of care without the need to progress further along the pathway. Maximising the potential of this opportunity will require system wide collaboration that transcends traditional organisational and professional boundaries.	
Aims	
CI1-A1	**Increase the proportion of activity resolved at Step 2 –** Using the activity within the demand and capacity review as a baseline, this aim requires the proportion of activity resolved at step 2 to increase. The improvement trajectory will be included in the new commissioning framework that will be collaboratively agreed ahead of 1st April 2022.
CI1-A2	**Right response first time – Optimising multiple responses at Step 3 –** Using activity within the demand and capacity review as a baseline, this aim requires an improvement in the multiple response rate and the resolution of that episode of care by a single resource (excluding red response as multiple responses are expected). The improvement trajectory will be included in the new commissioning framework.
Products	
CI1-P1	**Remote Clinical Support Strategy** – The first element will be to finalise an integrated remote clinical support strategy and infrastructure that outlines the organisational ambition for remote clinical support at the forefront of ambulance service care.
CI1-P2	**Optimising Conveyance Improvement Plan –** Development and implementation of an improvement plan or programme that supports the optimisation of decisions about conveyance. This will include non-conveyance as well as improving conveyance destination decisions and reducing variation for example.
Indicators	
CI1-I1	**Clinical Support Desk Outcomes** – The development of quarterly reports that describe the patient level outcomes for clinical support desk care episodes.
CI1-I2	**Outcome by Response Type –** The development of quarterly reports will be available that describe the patient level outcomes for different response types.

Figure 7- Commissioning Intentions - CRM

Commissioning Intention – CI2: Availability	
The Emergency Ambulance Service and its Commissioners will optimise the availability and flexibility of front-line resources to meet demand.	
Commissioning Statement	
The Emergency Ambulance Services Committee holds statutory responsibility for the planning and securing of sufficient ambulances services for the population of Wales. Discharging this responsibility requires close collaboration between commissioners and the provider to ensure that all available resources are used effectively.	
Aims	
CI2-A1	**Workforce Stability -** Maintaining the increased staff base following closure of the relief gap identified in the ORH Demand and Capacity Review (2019). Maximising the availability of these staff through reducing sickness levels and abstractions by ensuring that their wellbeing needs are appropriately supported.
CI2-A2	**Workforce Availability -** Grow the workforce in line with the strategic ambition, agreed forecasting and modelling and within financial allocation when made available by Commissioners.
CI2-A3	**Rosters Aligned to Demand -** The current demand profile is not matched by available resource. This has a significant impact on quality of service for patients and wellbeing of staff. Roster reviews have been undertaken with partners throughout 2021-22 to agree core principles and working parties have progressed the design and building of rosters. Rosters aligned to demand will be available for each area in 2022-23 and an implementation programme will be developed and delivered.
Products	
CI2-P1	**Forecasting and Modelling Framework -** A collaboratively developed forecasting and modelling framework that underpins a demand and capacity approach that will set out the ongoing arrangements for proactively undertaking this work for the next decade, this will include demand-led iterative forecasting and modelling and health economic evaluations. This will ensure the required strategic, tactical and operational focus to plan and forecast seasonal fluctuation and to ensure resource and resilience during times of system pressure.
Indicators	
C2-I1	**Workforce Additionality Measure** – A collaboratively agreed baseline and workforce additionality requirement will continue to be reported and refined, including vacancy factors, turnover and other confounders.

Figure 8- Commissioning Intentions - Availability

Commissioning Intention – CI3: Productivity	
The Emergency Ambulance Service and its Commissioners will maximise productivity from resources and demonstrate continuous improvement.	
Commissioning Statement	
Ensuring appropriate levels of productivity from the resources available is a key component of delivering an effective ambulance service. There are a number of external and internal drivers leading to suboptimal productivity. Addressing these areas has the potential to deliver significant gains for emergency ambulance provision and the wider emergency and urgent care system.	
Aims	
CI3-A1	**Reducing Post-Production Lost Hours –** Post-production lost hours have long been a significant contributor to reduced productivity. Using an agreed baseline measurement period, post-production lost hours will be reduced in line with a quarterly agreed improvement trajectory. The improvement trajectory will be included in the new commissioning framework that will be collaboratively agreed ahead of 1st April 2022.
CI3-A2	**Reducing Notification to Handover Time** – NHS Wales is a significant outlier in the UK and internationally for lost productivity due to extended notification to handover times. EASC is committed to delivering less than 150 hours per day across Wales and 95% of handovers completed within 1 hour, with a backstop of no handover taking more than 4 hours. Individual improvement trajectories will be agreed for each site and will be included in the new commissioning framework.
Indicators	
CI3-P1	**Modernising Workplace Practices Implementation Plan –** There will be an implementation plan and supporting structures in place to ensure workforce practices and policies are reviewed, modernised and improved. The wellbeing of the workforce and safety of patients will be paramount within this. The improvement trajectory will be included in the new commissioning framework.
Indicators	
CI3-I1	**Unit Hour Utilisation Metric –** continue to refine the approach and reporting in order to actively improve patient safety, performance and efficiency.

Figure 9- Commissioning Intentions - Productivity

Commissioning Intention – CI4: Value	
The Emergence Ambulance Service and its Commissioners will develop a value-based approach to service commissioning and delivery, which enables an equitable, sustainable and transparent use of resources to achieve better outcomes for patients.	
Commissioning Statement	
Value is created when we achieve the best possible healthcare outcomes for the Welsh population with the most efficient and effective use of available resources. We also recognise that value can be depleted and therefore the development of a value-based strategy will need to identify ways to effectively manage and mitigate the risks of value depletion in addition to identifying opportunities for value creation.	
Aims	
CI4-A1	**Value-Based Healthcare for the Welsh Ambulance Service** Building on the engagement already undertaken, develop and embed a value-based approach for the Welsh Ambulance Service which enables better collective decision making across the whole urgent and emergency care system and accounts for WAST's use of, and impact on, economic, social and environmental resources over the short, medium and long term. This will include: • Development of WAST's strategy and approach to Value-Based healthcare which links outcomes, patient experience and use of resources • Implementation of a costing model for "5 step" pathway • Improvement in ability to identify areas of unwarranted variation in service delivery across Wales
Products	
CI4-P1	**Value-Based Strategy** The Trust will develop a strategy to implement a value-based approach across the organisation and outline its role in delivering value across the wider UEC system. The value-based strategy will be integrated with and align to existing organisational strategies (e.g., clinical, quality, long term, digital, environmental etc) and the Commissioning Intentions outlined in this document in order to ensure goal congruence.
CI4-P2	**Value-Based Tools and Methods** In order to monitor and measure value-based performance, the Trust will need to design, develop and implement a range of tools including, but not limited to, the following: • Patient Level Costing Model • Benchmarking Dashboard(s)
CI4-P3	**Value-Based Reporting** WAST will enable a clear line of sight from commissioner allocation through to utilisation and the outcomes delivered by the services. WAST will holistically demonstrate through its reporting all separate revenue streams and associated costs of broader service provision (e.g., NHS 111 Wales, NEPTS etc.). WAST receives a capital allocation directly from Welsh Government. The utilisation of the capital budget and the use of the ring-fenced depreciation allocation will need to be clearly identified in any report. As a result, WAST will be able to demonstrate how its capital allocation is being invested to deliver on the commissioning intentions.
Indicators	
CI4-I1	**Value-Based Core Requirement to be agreed with Commissioner by the end of quarter 2:** • WAST Value Based Strategy • Plan for Value Based Tools and Methods design, development and implementation • Value Based Reports developed for revenue and capital • Value-Based indicators developed in line with broader indicators outlined in CI1 to CI5 • Connections to system-wide urgent and emergency care performance measures as identified in CI6 – Wider Health System

Figure 10- Commissioning Intentions - Value

Commissioning Intention – CI5: Harm & Outcomes	
The Emergency Ambulance Service and its Commissioners will collaborate to reduce and prevent harm and improve quality of service and outcomes for patients.	
Commissioning Statement	
Emergency ambulance services operate in complex and challenging environments. The delivery of a quality ambulance service requires effective, safe and people-centred care. To realize the benefits of quality health care, ambulance services must be timely, equitable, integrated and efficient. A mature health system proactively seeks opportunities to reduce and prevent harm. Continuous improvement based on learning from errors and adverse events must be a cornerstone of emergency ambulance provision.	
Aims	
CI5-A1	**Proactively Identifying Harm** – There will be a process for identifying harm/near misses prior to a complaint or report being logged. This will include process for reviewing patient clinical records and engagement with the wider health system (i.e., sharing information around patients impacted by CSP levels).
Products	
CI5-P1	**Clinical Indicator Plan and Audit Cycle –** Implementation of the clinical indicator plan and audit cycle, this will provide a forward view of the type, content and regularity of clinical indicator and audit reporting. Specific seasonal and responsive (to emerging trends) reports and audits will be included within the plan.
Indicators	
CI5-I1	**Call to Door Times** – Call to door times for STEMI and stroke will be produced on a monthly basis.

Figure 11- Commissioning Intentions - Harm and Outcomes

Commissioning Intention – CI6: Wider Health System	
The Emergency Ambulance Service and its Commissioners will collaboratively develop and deliver services that allow the ambulance service to contribute to the wider health system and the ambition to reset services and drive recovery.	
Commissioning Statement	
The Emergency Ambulance Services has a unique role as the only all Wales operational service. Today, ambulance services provide mobile urgent treatment services with staff educated and trained to deal with a wide range of emergency and urgent conditions. Maximising both of these opportunities will benefit the whole of NHS Wales and will be an important part of the pandemic response.	
Aims	
CI6-A1	**System Flow –** Optimise the flow of ambulances into hospital sites in Wales, reducing batching and increasing the timeliness of patients accessing secondary care. The implementation of rosters aligned to demand for each area in 2022-23 will address this, with the improvement trajectory included in the new commissioning framework that will be collaboratively agreed ahead of 1st April 2022.
CI6-A2	**Transfer and Discharge Service –** To reduce the number of transfers and discharges being undertaken by the EMS fleet. This will include the development of a case for a new national transfer and discharge service.
Products	
CI6-P1	**Aligned Escalation and Clinical Safety Plan –** A single WAST escalation and clinical safety plan will be in place that is aligned with system-wide escalation processes, responding to areas of greatest clinical risk.
CI6-P2	**National Transfer and Discharge Commissioning Framework –** A collaborative commissioning framework for a national transfer and discharge service will be agreed following the development of the business case.
Indicators	
CI6-I1	**System Pressures Dashboard** – WAST and Health Boards will collaborate to ensure that a live system pressures dashboard is in place that enables users to understand current and emerging pressures.

Figure 12- Commissioning Intentions - Wider Health System

APPENDIX 6-NEPTS COMMISSIONING INTENTIONS 2022/23

This section sets out the approach and guiding principles to the Commissioning Intentions for Non-Emergency Patient Transport Services (NEPTS) for the period 2022/23 and beyond.

These intentions aim to reflect the strategic direction from Committee Members to limit the additional asks on commissioned organisations this year including, but not limited to, minimising meetings, reporting and developments in order to allow for NEPTS to focus on the pandemic response, stabilisation and recovery of services but also to begin the next phase of the transformation and modernisation of NEPTS, following completion of the transfers of work.

Intentions aim to support the transition of performance management arrangements to focus on outcomes, value, quality and safety of service delivery.

These intentions are not intended to set out all activity that will be undertaken this year by commissioners or the provider, but to provide a clear indication of the strategic priorities of the Committee for NEPTS for 2022/23.

Guiding Principles for 2022/23, the commissioning intentions will:

- Be at the strategic level
- Focus on outcomes, value, quality and safety of service delivery
- Support the delivery of the quadruple aims
- Have annually agreed aim(s), product(s) and indicator(s) that will provide an outline of what will be provided within each intention
- Ensure reasonable expectations for the improvement of NEPTS
- Recognise the challenges of resetting in the post-CoVID environment and the opportunities to fast-track service transformation and modernisation
- Ongoing engagement and review between WAST, commissioners and Health Boards will allow the detail of each intention to be refined during the period, if required
- Intentions will not replace or override extant requirements within the Quality and Delivery Framework or statutory targets or requirements

- Intentions will recognise that some elements of work have taken longer than expected and next year will include an element of consolidation and review

Development and monitoring

- In line with the agreed commissioning cycle, organisations have been asked for their view on the priorities for next year and consequently a principle of the incremental development of existing commissioning intentions has been adopted
- EASC Management Group will hold responsibility for the development and monitoring of progress against these intentions to ensure the strategic intent is achieved
- Regular updates will be provided to the NEPTS DAG
- Future intentions will continue to be developed in a collaborative and timely manner in line with the agreed commissioning cycle

NEPTS Commissioning Intention – CI1: Plurality Model	
The Trust and its Commissioners will collaborate to improve the efficiency, quality of service and outcomes for patients.	
Commissioning Statement	
The delivery of a quality ambulance service requires effective, safe and people-centred care. To realize the benefits of quality health care, ambulance services must be timely, equitable, integrated and efficient. The plurality model creates a single national marketplace that sources a range of patient transport providers that are quality assured by a robust governance framework, creating opportunities to deliver a more efficient, timely and people-centred service.	
CI1a	**Resource Efficiency -** Demonstrate that resources are being utilised effectively following transfer of work. This will include the re-design and renewal of patient contracts inherited via the transfers of work to deliver the best patient transport model for Wales ensuring value and efficiency of utilisation. The second phase will of this work will focus on the procurement strategy, fully reviewing who is best placed to deliver the various aspects of patient transport in accordance with NEPTS objectives and standards.
CI1b	**Plurality Providers** - Continue to expand and improve the availability of plurality providers and to increase the focus on quality, improved patient experience, value and sustainability.

Figure 13- Commissioning Intentions - Plurality Model

NEPTS Commissioning Intention – CI2: Demand	
The Trust and its Commissioners will collaborate with stakeholders to understand system requirements in order to align resources to effectively manage service demand.	
Commissioning Statement	
Non-emergency patient transport services operate in a complex environment. The delivery of a quality ambulance service requires effective, safe and people-centred care. To realize the benefits of quality health care, ambulance services must be timely, equitable, integrated and efficient. A mature health system proactively seeks opportunities to improve quality and performance. Continuous improvement based on learning from data and feedback must be a cornerstone of ambulance provision.	
CI2a	**Planning -** Implement improved and dynamic planning process that maximises the utilisation of resources and ensure stability and resilience for future demand.
CI2b	**Demand Management -** Utilise a range of options including effective use of resources, effective rostering and closer working with the patient and Health Board colleagues to deliver appropriate transport requirements.

Figure 14- Commissioning Intentions - Demand

NEPTS Commissioning Intention – CI3: Capacity	
The Trust and its Commissioners will collaborate with stakeholders to understand system requirements in order to create, align and maximise resource capacity.	
Commissioning Statement	
Non-emergency patient transport services operate in a complex environment. The delivery of a quality ambulance service requires effective, safe and people-centred care. To deliver the benefits of a quality health care service, ambulance services must be timely, equitable, integrated and efficient. To ensure delivery of these benefits the Trust and stakeholders must work collaboratively to create, align and maximise resource capacity.	
CI3a	**Transforming Capacity -** Implement processes to increase NEPTS capacity within current internal and external resources including workforce and fleet.
CI3b	**Reducing Lost Capacity -** Implement improvement plans and oversight arrangements to deliver reduction in lost capacity due to system inefficacies. This includes a requirement on WAST to ensure more effective use of internal resources (workforce, fleet and estates), there is also a requirement for improved collaboration and communication with Health Boards to minimise lost time at hospital sites.

Figure 15- Commissioning Intentions - Capacity

NEPTS Commissioning Intention – CI4: System Transformation	
The Trust and its Commissioners will work collaboratively to transform internal systems and will work with stakeholders to understand the wider system transformation that is taking place.	
Commissioning Statement	
WAST and stakeholders will work collaboratively through the NEPTS Delivery Assurance Group to identify areas for improvement across WAST's internal operating systems and to understand the impact of reconfiguration across the wider health system.	
CI4a	**Forecasting and Modelling Framework -** A collaboratively developed forecasting and modelling framework will set out the ongoing arrangements for proactively undertaking this work for the next decade, this will include demand-led forecasting and modelling and health economic evaluations. This will ensure the required strategic, tactical and operational focus to tactically plan and forecast seasonal fluctuation and to ensure resource and resilience during times of system pressure.

Figure 16- Commissioning Intentions - System Transformation

APPENDIX 7-EMRTS COMMISSIONING INTENTIONS 2022/23

This section sets out the approach and guiding principles to the Commissioning Intentions for the Emergency Medical Retrieval and Transfer Service (EMRTS) for the period 2022/23 and beyond.

These intentions aim to reflect the strategic direction from Committee members to limit the additional asks on commissioned organisations this year including, but not limited to, minimising meetings, reporting and developments in order to allow for EMRTS to focus on consolidating following recent service expansion projects and embracing the findings of the EMRTS Service Evaluation.

These intentions are not intended to set out all activity that will be undertaken this year by commissioners or the provider, but to provide a clear indication of the priorities of the Committee for the Emergency Medical Retrieval and Transfer Service for 2022/23.

Guiding Principles for 2022/23, the commissioning intentions will:

- Be at the strategic level
- Focus on outcomes, value, quality and safety of service delivery
- Support the delivery of the quadruple aims
- Have annually agreed aim(s), product(s) and indicator(s) that will provide an outline of what will be provided within each intention
- Ensure reasonable expectations for the improvement of EMRTS
- Recognise the challenges of resetting in the post-CoVID environment and the opportunities to fast-track service transformation and modernisation
- Ongoing engagement and review between EMRTS, commissioners and Health Boards will allow the detail of each intention to be refined during the period, if required
- Intentions will not replace or override extant requirements within the EMRTS Quality and Delivery Framework or statutory targets or requirements

Development and monitoring

- In line with the agreed commissioning cycle, organisations have been asked for their view on the priorities for next year and consequently a principle of the incremental development of existing commissioning intentions has been adopted
- EASC Management Group will hold responsibility for the development and monitoring of progress against these intentions to ensure the strategic intent is achieved
- Regular updates will be provided to the EMRTS DAG
- Future intentions will continue to be developed in a collaborative and timely manner in line with the agreed commissioning cycle

EMRTS Commissioning Intention – CI1: Service Expansion	
CI1a	**Enhanced CCP-led response** – Building on the findings of recent winter initiatives and demand and capacity planning undertaken within the service, support the implementation of an enhanced daytime response that will ensure more effective use of resources, improve service quality and the patient experience and provide opportunities for workforce development.
CI1b	**Planning** – Build on the implementation and consolidation of Phase 1 of the EMRTS Service Expansion project, working collaboratively with commissioners to plan the implementation of the remaining phases of the EMRTS Service Expansion programme.

Figure 17- Commissioning Intentions - Service Expansion

EMRTS Commissioning Intention – CI2: Adult Critical Care Transfer Service (ACCTS)	
CI2a	**Service Delivery** – The ACCTS team will continue to manage ongoing service delivery and will ensure robust performance management with a focus on outcomes, value, quality and safety of service delivery.
CI2b	**Engagement** – Building on established relationships, continue to engage with all stakeholders to review and strengthen the service model(s) implemented to maximise the clinical outcomes, value, quality and safety of service delivery.
CI2c	**Evaluation and Review** – Undertake evaluation and review relating to the implementation of the ACCTS, reporting on lessons learned, service activity and providing the required assurance regarding the realisation of anticipated outcomes and benefits going forward.

Figure 18- Commissioning Intentions - Adult Critical Care Transfer Service (ACCTS)

EMRTS Commissioning Intention – CI3: Service Evaluation	
CI3a	**Improvement Plan** – Develop and implement an improvement plan in response to the EMRTS Service Evaluation Report.

Figure 19 - Commissioning Intentions - Service Evaluation

EMRTS Commissioning Intention – CI4: System Transformation	
CI4a	**Demand and Capacity Strategy** – To continue with the work on a collaboratively developed demand and capacity strategy will set out the ongoing arrangements for proactively undertaking this work for the next decade, this will include the use of forecasting, modelling and health economic evaluations.

Figure 20 - Commissioning Intentions - System Transformation

APPENDIX 8-FUNDING REQUIREMENTS

EASC SUMMARY

Emergency Ambulance Services Committee 2022/23 Summary	Aneurin Bevan UHB	Betsi Cadwaladr	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda UHB
	£m	£m	£m	£m	£m
EAS Allocation	37.436	50.066	23.566	25.952	26.706
NEPTS Allocation	3.490	5.904	4.945	2.315	3.143
EMRTS Allocation	1.151	1.412	0.950	0.873	0.781
Ring-Fenced Commissioner Allocations	0.587	-	0.481	0.399	0.389
Specialist Commissioning Allocation	0.051	-	0.026	0.078	-
EASC Commissioning Funds from LHBs 2022/23	42.715	57.382	29.968	29.616	31.019
EASC Team Resource	0.106	0.164	0.076	0.082	0.087
EASC Total Requirement from LHBs 2022/23	42.821	57.546	30.044	29.698	31.106
Summary of EASC Year on Year Funding Movements 2022/23					
Pay award - recurrent impact from 2021/22 (WG funded)	0.611	0.943	0.438	0.471	0.502
Band 6 Paramedics uplift (WG funded)	0.264	0.408	0.189	0.204	0.217
WAST Mental Health Improvements (WG funded)	0.107	0.165	0.076	0.082	0.088
WAST D&C Phase 2 recurrent impact	0.616	0.950	0.441	0.475	0.506
Operational Delivery Unit	0.149	0.231	0.107	0.115	0.123
NEPTS - Transfers of Service / in-year changes (per WAST figures)	0.465	0.672	0.056	0.015	- 0.333
2.8 % Uplift 2022/23 - Jan 22 Plan	1.131	1.521	0.793	0.781	0.820
EAS Allocation Front Line Reserve (Non Recurrent)	0.116	0.179	0.083	0.089	0.095
Temporary funding	0.304	0.470	0.218	0.235	0.250
Total Year on Year Movement for 2022/23	3.458	5.068	2.184	2.232	2.017

Figure 21a - EASC Allocation Summary

Emergency Ambulance Services Committee 2022/23 Summary	Aneurin Bevan UHB	Betsi Cadwaladr	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda UHB
	£m	£m	£m	£m	£m
EAS Allocation	37.436	50.066	23.566	25.952	26.706
NEPTS Allocation	3.490	5.904	4.945	2.315	3.143
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EAS Allocation Front Line Reserve (Non Recurrent)	0.116	0.179	0.083	0.089	0.095
Temporary funding	0.304	0.470	0.218	0.235	0.250
Total Year on Year Movement for 2022/23	3.458	5.068	2.184	2.232	2.017

Figure 21b - EASC Allocation Summary

Note: NETPS funding now flows directly to EASC and not WAST - See assumptions
Allocation Request to Deputy Directors of Finance in November 2021 for LHBs and Trusts to hold in their plans (including contingency):

EAS 2022/23

EASC: WAST EMS Provision 2021/22 Quality & Delivery Framework Agreement	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	EASC Requirement
	£m	£m	£m	£m	£m	£m	£m	£m
2020/21 Recurrent Baseline	26.784	41.271	19.209	20.659	22.005	11.952	16.393	158.272
2020/21 In Year Commissioning Allocation Adjustments								
2020/21 Forecast Outturn	30.985	43.141	20.516	22.579	23.195	12.438	17.516	170.370
Adjustments for 2020/21 In Year Non Recurrent Funds:								
Recurrent Impacts from 2020/21 Service Development Initiatives:								
2021/22 Revised Baseline	33.195	43.971	20.669	22.800	23.449	12.657	17.639	174.380
WG Uplifts and Expected Allocations 2021/22								
Uplift 2% on recurrent baseline	0.664	0.879	0.413	0.456	0.469	0.253	0.353	3.488
ARRP NR Allocation 2021/22	0.004	0.006	0.003	0.003	0.003	0.002	0.002	0.023
ESMCP Control Room Solution 2021/22 NR	0.129	0.199	0.093	0.100	0.106	0.058	0.079	0.764
ESMCP Project Team 2021/22 NR	0.030	0.046	0.021	0.023	0.024	0.013	0.018	0.176
Band 6 Paramedics Uplift	0.224	0.250	0.169	0.189	0.143	0.047	0.152	1.174
Service Development Initiatives 2021/22								
D&C Phase 2 Front Line In Year Allocation Reserve (Non Recurrent)	0.338	0.522	0.243	0.261	0.278	0.151	0.207	2.000
2021/22 Requirement from LHBs to EASC	34.584	45.874	21.610	23.832	24.473	13.181	18.450	182.005
EMS Commissioner Allocation 2021/22								
Major Trauma Ring Fenced Commissioner Allocation 2021/22	0.162	-	0.133	0.110	0.108	0.009	0.118	0.640
2021/22 WAST Funding Allocation from EASC	34.746	45.874	21.743	23.942	24.580	13.190	18.568	182.645
2021/22 In Year Commissioning Allocation Adjustments								
Clinical Service Desk Enhancement (Non Recurrent)	0.051	0.078	0.036	0.039	0.042	0.023	0.031	0.300
Critical Care Non Recurrent allocation 2021/22	0.070	-	0.057	0.048	0.046	0.008	0.051	0.280
Mental Health Conveyancing Pilot Non Recurrent 2021/22				0.823				0.823
NEPTS Planned Care Non Recurrent support 2021/22				2.000				2.000
ESCN Business Case Non Recurrent 2021/22				0.409				0.409
Grange University Hospital	- 0.429							- 0.429
ESMCP Control Room Solution 2021/22 NR	- 0.087	- 0.134	- 0.062	- 0.067	- 0.071	- 0.039	- 0.053	- 0.513
ESMCP Project Team 2021/22 NR	- 0.028	- 0.043	- 0.020	- 0.021	- 0.023	- 0.012	- 0.017	- 0.163
2021/22 WAST Funding Allocation from EASC Forecast Outturn	34.324	45.776	21.755	27.173	24.574	13.170	18.580	185.352
Adjustments for 2021/22 In Year Non Recurrent Funds:								
Clinical Service Desk Enhancement (Non Recurrent)	- 0.051	- 0.078	- 0.036	- 0.039	- 0.042	- 0.023	- 0.031	- 0.300
Critical Care Non Recurrent allocation 2021/22	- 0.070	-	- 0.057	- 0.048	- 0.046	- 0.008	- 0.051	- 0.280
Mental Health Conveyancing Pilot Non Recurrent 2021/22	-	-	-	- 0.823	-	-	-	- 0.823
NEPTS Planned Care Non Recurrent support 2021/22	-	-	-	- 2.000	-	-	-	- 2.000
ESCN Business Case Non Recurrent 2021/22	-	-	-	- 0.409	-	-	-	- 0.409
D&C Phase 2 Front Line In Year Allocation Reserve (Non Recurrent reversal)	- 0.338	- 0.522	- 0.243	- 0.261	- 0.278	- 0.151	- 0.207	- 2.000
Major Trauma Ring Fenced Commissioner Allocation 2021/22	- 0.162	-	- 0.133	- 0.110	- 0.108	- 0.009	- 0.118	- 0.640
Grange University Hospital	0.429							0.429
ESMCP Control Room Solution 2021/22 NR	0.087	0.134	0.062	0.067	0.071	0.039	0.053	0.513
ESMCP Project Team 2021/22 NR	0.028	0.043	0.020	0.021	0.023	0.012	0.017	0.163
Recurrent Impacts from 2021/22 Service Development Initiatives:								
D&C Phase 2 Additional Funding	0.954	1.473	0.684	0.736	0.784	0.426	0.584	5.640
Operational Delivery Unit	0.149	0.231	0.107	0.115	0.123	0.067	0.091	0.883
2022/23 Revised Baseline	35.349	47.055	22.159	24.422	25.102	13.523	18.919	186.528
WG Uplifts and Expected Allocations 2022/23								
Uplift 2.8% on recurrent baseline	0.990	1.318	0.620	0.684	0.703	0.379	0.530	5.223
2021/22 A4C / DDRB Pay Award recurrent impact	0.611	0.943	0.438	0.471	0.502	0.273	0.374	3.610
Band 6 Paramedics Uplift	0.264	0.408	0.189	0.204	0.217	0.118	0.162	1.561
Front Line Allocation Reserve (Non Recurrent)	0.116	0.179	0.083	0.089	0.095	0.052	0.071	0.685
ARRP NR Allocation 2022/23	-	-	-	-	-	-	-	-
ESMCP Control Room Solution 2022/23 NR	-	-	-	-	-	-	-	-
ESMCP Project Team 2022/23 NR	-	-	-	-	-	-	-	-
Service Development Initiatives 2021/22								
Mental Health Service Improvements (inc. Clinical Service Desk Enhancements)	0.107	0.165	0.076	0.082	0.088	0.048	0.065	0.631
2022/23 Requirement from LHBs to EASC	37.436	50.066	23.566	25.952	26.706	14.392	20.120	198.238
EMS Commissioner Allocation 2021/22								
Major Trauma Ring Fenced Commissioner Allocation 2022/23	0.162	-	0.133	0.110	0.108	0.009	0.118	0.640
2021/22 WAST Funding Allocation from EASC	37.598	50.066	23.699	26.062	26.814	14.401	20.238	198.878

Funding allocation by LHB per WHSSC tables	AB	BC	C&V	CTM	HD	Po	SB	Total
	16.91%	26.11%	12.13%	13.05%	13.90%	7.55%	10.35%	100.00%

Figure 22 - EAS Allocation

Note:

Band 6 Uplift: as per 2021/22 HB allocation tables A2 and B1
Major Trauma Ring Fenced Commissioner Allocation 2021/22: see allocation % split per commissioner allocations
Band 6 Paramedic Uplift: Table A3 in WG Guidelines - additional recurrent funding of £3.61m as advised by WAST
ARRP NR Allocation: any changes will be passed through financial flow from WG to LHB to EASC to WAST
ESMCP Control Room Solution 2022/23 NR: any changes will be passed through financial flow from WG to LHB to EASC to WAST
ESMCP Project Team 2022/23 NE: any changes will be passed through financial flow from WG to LHB to EASC to WAST
Major Trauma Ring Fenced Commissioner Allocation 2022/23: see allocation % split per commissioner allocations

NEPTS 2022/23

EASC: NEPTS Provision 2021/22 Quality & Delivery Framework Agreement	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	Velindre NHS Trust	EASC Requirement
	£m	£m	£m	£m	£m	£m	£m	£m	£m
2020/21 NEPTS Requirement from LHBs	2.835	4.914	4.626	2.045	3.255	1.070	4.610	0.677	24.033
Healthier Wales additional recurrent funding	0.038	0.057	0.048	0.027	0.036	0.016	0.045	0.005	0.272
Transfer of Services	-	-	-	0.121	0.033	0.337	-	-	0.491
2021/22 NEPTS Baseline	2.873	4.971	4.674	2.193	3.324	1.422	4.655	0.682	24.796
2% uplift*	0.057	0.099	0.080	0.044	0.066	0.028	0.093	0.014	0.482
2021/22 NEPTS Requirement from LHBs to EASC	2.930	5.071	4.754	2.237	3.391	1.451	4.748	0.696	25.278
NEPTS - Transfers of Service / in-year changes (per WAST figures)	0.465	0.672	0.056	0.015	- 0.333	0.017	0.006	0.002	0.900
2.8% uplift	0.095	0.161	0.135	0.063	0.086	0.041	0.133	0.020	0.733
2022/23 NEPTS Requirement from LHBs to EASC	3.490	5.904	4.945	2.315	3.143	1.509	4.888	0.718	26.911

Figure 23- NEPTS Allocation

Note:

*2% uplift not applied to C&V St Johns Discharge and Transfer Contract

EMRTS 2022/23

EASC: EMRTS Provision 2021/22 Quality & Delivery Framework Agreement	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	EASC Requirement
	£m	£m	£m	£m	£m	£m	£m	£m
2020/21 Outturn and 2021/22 EMRTS Baseline	0.855	1.072	0.702	0.650	0.586	0.227	0.558	4.650
2% uplift	0.017	0.021	0.014	0.013	0.012	0.005	0.011	0.093
EMRTS 24/7 Expansion Plan - NR	0.236	0.280	0.199	0.179	0.154	0.053	0.156	1.257
2021/22 EMRTS Requirement from LHBs to EASC	1.108	1.374	0.915	0.841	0.752	0.284	0.726	6.000
EMRTS Critical Care Ring Fenced Commissioner Allocation (NR)	0.355	-	0.291	0.241	0.235	0.041	0.258	1.420
2021/22 EMRTS Total Funding through EASC	1.462	1.374	1.205	1.082	0.987	0.325	0.983	7.420
EMRTS 24/7 Expansion Plan - Non Recurrent 2021/22	- 0.236	- 0.280	- 0.199	- 0.179	- 0.154	- 0.053	- 0.156	- 1.257
EMRTS 24/7 Expansion Plan - Recurrent Funding 2022/23	0.236	0.280	0.199	0.179	0.154	0.053	0.156	1.257
EMRTS Critical Care Ring Fenced Commissioner Allocation	- 0.355	-	- 0.291	- 0.241	- 0.235	- 0.041	- 0.258	- 1.420
EMRTS Critical Care Ring Fenced Commissioner Allocation	0.425	-	0.348	0.288	0.281	0.049	0.309	1.700
2.8% Uplift for 2022/23	0.043	0.038	0.035	0.032	0.029	0.009	0.029	0.216
2022/23 EMRTS Total Funding through EASC	1.575	1.412	1.298	1.161	1.063	0.343	1.063	7.915

Funding allocation by LHB per WHSSC tables

AB	BC	C&V	CTM	HD	Po	SB
18.75%	22.29%	15.83%	14.20%	12.29%	4.21%	12.42%

Figure 24- EMRTS Allocation

Note:

EMRTS 24/7 Expansion Plan - NR - Expansion plan - in year allocation reserve
EMRTS Critical Care Ring Fenced Commissioner Allocation (NR) - see allocation % split per commissioner allocations

COMMISSIONER ALLOCATION 2022/23

EASC: Commissioner Allocations 2022/23 Quality & Delivery Framework Agreement	Aneurin Bevan UHB	Betsi Cadwaladr	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	EASC Requirement
	£m	£m	£m	£m	£m	£m	£m	£m
2020/21 Ring-Fenced Commissioner Allocations Baseline	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
In year allocations								
Critical Care (Recurrent)	0.425	-	0.348	0.288	0.281	0.049	0.309	1.700
Major Trauma (NR)	0.305	-	0.249	0.207	0.202	0.017	0.221	1.201
Major Trauma Handback (NR)	- 0.038	-	- 0.031	- 0.026	- 0.025	- 0.002	- 0.028	- 0.150
2020/21 Commissioner Allocations Baseline	0.691	0.000	0.566	0.470	0.458	0.064	0.503	2.751
Adjustments for 2020/21 In Year Non Recurrent Funds:								
Major Trauma 2020/21 NR	- 0.305	-	- 0.249	- 0.207	- 0.202	- 0.017	- 0.221	- 1.201
Major Trauma Handback Reversal 2020/21 NR	0.038	-	0.031	0.026	0.025	0.002	0.028	0.150
Major Trauma (Recurrent)	0.162	-	0.133	0.110	0.108	0.009	0.118	0.640
2021/22 Requirement from LHBs to EASC	0.587	0.000	0.481	0.399	0.389	0.058	0.427	2.340
2022/23 Requirement from LHBs to EASC	0.587	0.000	0.481	0.399	0.389	0.058	0.427	2.340
Allocation to EMRTS (Critical Care)	*0.425*	-	*0.348*	*0.288*	*0.281*	*0.049*	*0.309*	*1.700*
Allocation to WAST (Major Trauma)	*0.162*	-	*0.133*	*0.110*	*0.108*	*0.009*	*0.118*	*0.640*
Allocation Remaining	-	-	-	-	-	-	-	-

Major Trauma % Split	*25.36%*	*0.00%*	*20.77%*	*17.23%*	*16.80%*	*1.40%*	*18.44%*	*100.00%*
Critical Care % Split	*24.98%*	*0.00%*	*20.46%*	*16.97%*	*16.55%*	*2.88%*	*18.16%*	*100.00%*

Figure 25- Commissioner Allocation

Note:

Critical Care (Recurrent) / Major Trauma (NR) / Major Trauma Hand back (NR) - Per WHSSC Income Expectations March 2021
Major Trauma (Recurrent) - As per 2021/22 Health Board Allocation Table A2

SPECIALIST COMMISSIONING 2022/23

EASC: Commissioner Allocations 2021/22 Quality & Delivery Framework Agreement	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	EASC Requirement
	£m	£m	£m	£m	£m	£m	£m	£m
2020/21 Commissioner Allocations Baseline	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
South-East Wales Regional Acute Coronary Syndrome Treat and Repatriate Service*	0.051	-	0.026	0.078	-	-	-	0.155
2021/22 Requirement from LHBs to EASC	0.051	0.000	0.026	0.078	0.000	0.000	0.000	0.155
2022/23 Requirement from LHBs to EASC	0.051	0.000	0.026	0.078	0.000	0.000	0.000	0.155
% split based on population usage of service	*33%*	*0%*	*17%*	*50%*	*0%*	*0%*	*0%*	*100%*

* Split per correspondence between C&V Clinical Board Director – Specialist Services and Chief Ambulance Services Commissioner, 20th November 2020
NB: Payments for this service to be made to Cardiff and Vale UHB

Figure 26- Specialist Allocation

EASC TEAM 2022/23

EASC Team 2021/22	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	EASC Requirement
	£m	£m	£m	£m	£m	£m	£m	£m
2021/22 EASC Team Baseline	0.101	0.156	0.072	0.078	0.083	0.045	0.062	0.598
2 % uplift	0.002	0.003	0.001	0.002	0.002	0.001	0.001	0.012
2021/22 EASC Team Requirement from LHBs to EASC	0.103	0.159	0.074	0.080	0.085	0.046	0.063	0.610
2.8% uplift	0.003	0.004	0.002	0.002	0.002	0.001	0.002	0.017
2021/22 EASC Team Requirement from LHBs to EASC	0.106	0.164	0.076	0.082	0.087	0.047	0.065	0.627

Figure 27- EASC Team

APPENDIX 9 - FINANCIAL PLAN 2022/23 ASSUMPTIONS

The 2022/23 Annual Planning Framework figures for EASC Commissioned Services will be consistent with the details set out in the Welsh Government (WG) allocation letter, which is expected to include specifically:

- An uplift for core cost growth assumed to be 2.8%, which includes funding to meet the first 1% of 2022/23 pay award costs
- Ring fenced funding to be provided in full to support the increasing cost profile of the Band 6 paramedic business case

The allocation does not include the following:

- Further funding to support the Agenda for Change (A4C) pay award or other pay award uplifts
- Funding for the ongoing NHS response to CoVID-19 in 2022/23

Major Trauma and Critical Care Transfer Service funding has been added to the EASC ring fenced allocation.

This is an initial allocation, and it is expected that any additional funding required to deliver key priorities will be allocated as appropriate when costs are confirmed, and source of funding agreed.

EAS ALLOCATION

DEMAND AND CAPACITY REVIEW: RECURRENT IMPACT OF ADDITIONAL FRONT-LINE RECRUITMENT

The Front Line In-Year Allocation Reserve was introduced in 2020/21 in order to provide a clearer link between provider programme delivery and commissioner payment. The Front Line In-Year Allocation Reserve process continued into 2021/22 following on from the successful delivery of an additional 136 whole time equivalent (WTE) front line staff as part of the Demand and Capacity Review.

The recurrent impact of phase 1 recruitment of the Demand and Capacity Review in 2020/21 was **£4.977m** in 2021/22 and has been included in the plan and allocated across the seven local health boards (LHBs) in line with the established risk share mechanism.

As part of phase 2 of the expansion of front-line resources Health Boards contributed **£2.0m** additional revenue on a non-recurrent basis for 2021/22. The draw down from this funding was made conditional on delivery of an additional 127 WTE front line staff in line with the plan and allocated only when expenditure has been incurred. At this stage of the planning cycle, WAST are forecasting to meet the recruitment target of an additional 127 WTE and the recurrent impact of this is expected to be **£5.640m** which has been included in the plan and allocated across the 7 LHBs in line with the established risk share mechanism.

This funding has been made available to support the recruitment of front line staff in line with the Commissioning Intentions and recommendations from the Demand and Capacity Review, which was jointly commissioned between EASC and WAST in 2019/20. This funding has been made available contingent on WAST contributing towards this resource by utilising their allocated 1% growth uplift and delivering efficiencies. Key drivers of efficiency for WAST will include:

- Reduction in the costs of overtime and an increase in the proportion of funding that is spent directly on front line resources

- Maximising the use of resources directed towards the front line with any slippages allocated to front line service development

NEPTS ALLOCATION

In addition to the assumptions set out in the WG allocation letter, the NEPTS funding position reflects the in-year 2021/22 transition of services. Historically, NEPTS funding flowed from LHBs to WAST directly but was included in the EASC annual financial plan for completeness as a commissioned service under EASC.

In 2022/23, NEPTS funding flow will change and be allocated to EASC directly from LHBs in order to become aligned with the Emergency Ambulance Service allocation and associated governance mechanisms.

In 2021/22, EASC secured a non-recurrent allocation from Welsh Government of **£2m** to support Health Boards with their Planned Care recovery programmes. For 2022/23, it is expected that LHBs will include non-emergency transport requirements within their Planned Care recovery programme plans and that funding for any additional requirements for NEPTS services will be provided to EASC in order to commission the service from WAST.

THE GRANGE UNIVERSITY HOSPITAL

The Grange University Hospital was opened in November 2020, with funding for the ambulance service being provided by Aneurin Bevan ABUHB to EASC in line with ambulance commissioning arrangements and the Service Level Agreement established for the Grange.

EMRTS ALLOCATION

In addition to the assumptions set out in the WG allocation letter, the EMRTS funding position is consistent with the approved development and expansion of the 24/7 service and the Critical Care Transfer Service. Funding for these initiatives will be released once the cost has been incurred. Funding for the Critical Care Transfer Service has been released by Welsh Government as a ring-fenced allocation (see note below on EASC Ring Fenced Commissioning Allocations).

As part of the expansion of the 24/7 service, Health Boards contributed **£1.257m** additional revenue on a non-recurrent basis for 2021/22. The draw down from this funding was made conditional on delivery of resources in line with the delivery plan and only when expenditure has been incurred. If expenditure is not incurred or the programme underspends, funding will be returned to LHBs. At this stage of the planning cycle, EMRTS are expecting to deliver the 24/7 service expansion in line with the plan and a recurrent allocation of **£1.257m** plus uplift will be required in 2022/23.

SOUTH-EAST WALES REGIONAL ACUTE CORONARY SYNDROME TREAT AND REPATRIATE SERVICE

In 2019/20, as part of 'A Healthier Wales' transformation initiative, EASC funded the development of a dedicated ambulance to transport patients between district general hospitals in south east Wales and the tertiary centre at the University Hospital Wales, Cardiff. The scheme was further funded by EASC on a non-recurrent basis in 2020/21 and has had a transformative impact both in terms of the reduction in access time to treatment for patients and the amount of time patients are in hospital. The scheme will therefore be funded on a recurrent basis from 2021/22 onwards, with funding being drawn down from Cardiff and Vale, Aneurin Bevan and Cwm Taf Morgannwg UHBs on a usage basis through the EASC brokerage system.

The cohort of patients benefiting from this service is broadly split 50% Cwm Taf Morgannwg CTMUHB (Prince Charles and Royal Glamorgan hospitals), 33% Aneurin Bevan UHB (Nevill Hall Hospital) and 17% Cardiff and Vale UHB (University Hospital Llandough).

RING-FENCED COMMISSIONING ALLOCATIONS

The Critical Care Transfer Service and Major Trauma service development allocations have been made available recurrently from Welsh Government on a ring-fenced basis. These have been reflected in the EASC Ring Fenced Commissioning Allocations values.

EASC TEAM RESOURCING

No assumption has been made for additional EASC Team resourcing other than the core cost growth uplift as set out in the Welsh Government allocation letter.

NON EASC ALLOCATIONS

In addition to the EASC revenue allocation, WAST and EMRTS services receive funding from other sources as outlined below. There are separate processes for negotiating and agreeing these amounts which are currently outside the remit of the EASC Joint Committee.

NHS 111 WALES PROGRAMME

Funding for the Welsh Ambulance Services NHS Trust's (WAST) 111 service delivery is included as Hospital, Community and Health Services Directed Expenditure in the Welsh Government allocation, which is passed through Aneurin Bevan University Health Board (ABUHB) as host organisation for the NHS 111 Wales programme and national roll out.

OTHER REVENUE

WAST receives revenue funding directly for the following services:

- Hazardous Area Response Team
- Health Board locally commissioned EMS services
- Major Trauma Units

CAPITAL FUNDING

Capital funding, and any associated revenue impacts for depreciation, for WAST and EMRTS is allocated directly to WAST and Swansea Bay LHB respectively from Welsh Government.

Emergency Ambulance Services Committee
Unit 1, Charnwood Court
Billingsley Road
Parc Nantgarw
Cardiff
CF15 7QZ

EMERGENCY AMBULANCE SERVICES
JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON
18 JANUARY 2022 AT 11:15HOURS
VIRTUALLY BY MICROSOFT TEAMS

PRESENT

Members:	
Chris Turner	Independent Chair
Glyn Jones	Interim Chief Executive, Aneurin Bevan ABUHB
Carol Shillabeer	Chief Executive, Powys Teaching Health Board PtHB
Stuart Walker	Interim Chief Executive, Cardiff and Vale CVUHB
Mark Hackett	Chief Executive, Swansea Bay SBUHB
Steve Moore	Chief Executive, Hywel Dda HDdUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB
In Attendance:	
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust (WAST)
Roshan Robati	Senior Programme Advisor for Unscheduled Care, Betsi Cadwaladr BCUHB
Stuart Davies	Director of Finance, Welsh Health Specialised Services Committee (WHSSC) and EASC Joint Committees
Ross Whitehead	Deputy Chief Ambulance Services Commissioner, EASC Team, National Collaborative Commissioning Unit (NCCU)
Ricky Thomas	Head of Informatics, National Collaborative Commissioning Unit (NCCU)
Matthew Edwards	Head of Commissioning and Performance, EASC Team, National Collaborative Commissioning Unit (NCCU)

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 22/01	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee and gave an overview of the arrangements for the meeting.	Chair

	Members were reminded that, following discussion with the Chairs of both EASC and the Welsh Health Specialised Services Committee (WHSSC), it had been agreed to hold a shortened meeting in light of the current severe operational pressures that Health Boards were facing. The Chair explained that an abbreviated agenda had been prepared with the meeting focussed on two main items, these were emergency ambulance capacity and the draft EASC Integrated Medium Term Plan (IMTP). It was stated that the performance report, Chief Ambulance Services Commissioner (CASC) report and the Welsh Ambulance Services NHS Trust (WAST) provider update had also been included for noting and information. Whilst the three items would not be considered during the meeting, the Chair confirmed that members could raise any related matters with the Chair or any member of the EASC Team. In light of operational pressures and the need for a shortened meeting, other routine reports were deferred to the next meeting of the Committee, due to be held on Tuesday 15 March 2022.	
EASC 22/02	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Tracey Cooper, Steve Ham, Stephen Harrhy, Gwenan Roberts and Jo Whitehead.	Chair
EASC 22/03	**DECLARATIONS OF INTERESTS** The Chair reminded those that had not yet responded to the request for Declarations of Interest to respond and suggested that the EASC Team could be contacted if there were any queries.	Chair
EASC 22/04	**MINUTES OF THE MEETING HELD ON 9 NOVEMBER** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 9 November 2021. Members **RESOLVED** to: • **APPROVE** the minutes of the meeting held 9 November 2021.	Chair
EASC 22/05	**ACTION LOG** Members **RECEIVED** the action log and **NOTED**:	

	EASC 21/64 Ambulance Handover Delays It was noted that discussions were ongoing with various sites and options being discussed regarding this matter. **EASC 21/65 Focus on session - Update on Demand & Capacity** It was agreed that a short paper would be prepared to include the assumptions used in the modelling. Members **RESOLVED** to: • **NOTE** the Action Log.	**EASC Team** **EASC Team**
EASC 22/06	**MATTERS ARISING** There were no matters arising.	
EASC 22/07	**CHAIR'S REPORT** The Chair's report was received. It was noted that the Chair had recently met with both Velindre University NHS Trust and Betsi Cadwaladr UHB. Each presentation had been tailored to suit local requirements and priorities and, again, this resulted in positive interactions and welcome feedback. The Chair advised that personal objectives had now been received from the Minister following the end of year appraisal. In addition to the core objectives, three additional targeted objectives had been included to reflect the specific role of the Committee. It was agreed that the inclusion of the specific Six Goals objective indicated the Minister's clear wish to formally extend the Committee's role in the urgent and emergency care arena. The Chair confirmed that the in-year review with the Minister would be held shortly. Members **RESOLVED** to: • **NOTE** the Chair's report	
Part 2. ITEMS FOR DISCUSSION		**ACTION**
EASC 22/08	**EMERGENCY AMBULANCE CAPACITY (2022-23)** Ross Whitehead presented the report relating to emergency ambulance capacity and the continuing challenge in ensuring the delivery of effective and responsive emergency ambulance services.	

	Members noted that changes in demand and lost capacity through handover, sickness and other areas had resulted in poor responses for patients, failure to achieve response targets and episodes of harm for some patients. The Welsh Ambulance Services NHS Trust (WAST) had recently provided a transition case to the Chief Ambulance Services Commissioner outlining their preferred option for additional capacity next year. This option included the recruitment and training of an additional 294 full time equivalents (FTEs) during 2022-23 to aid in reducing patient harm and system risk and supporting the move towards the strategic ambition previously presented to the Committee. Additional capacity would bolster operational resources and mitigate the impact of lost capacity through handover delays and workforce practices, whilst improvement plans to address these were being implemented. This capacity would predominantly come from recruiting and training additional Emergency Medical Technicians and would be unlikely to draw significantly on candidates that Health Boards would be seeking. Members noted that the case had been considered and agreed by the WAST Board during a closed board session and would be made available to Members on request. It was noted that the EASC Team were currently reviewing the case on behalf of the Committee. Whilst it has not been possible to fully appraise the case in the timescale between its submission and the meeting of the Joint Committee, it was clear from an operational delivery and patient safety perspective that the ambulance service would require additional capacity next year. The case presented as the WAST preferred option which included the £10m revenue during 2022-23 with an ongoing revenue tail of £16m plus an additional £16m capital requirement. It was noted that there were multiple risks associated with delivering the preferred model, particularly from a recruitment perspective, that would result in a significant underspend against this requirement if they materialised.	

There was currently no identified funding source from the committee or centrally to fund any uplifts in ambulance capacity on a recurrent basis. In addition, the committee does not have responsibility for capital funding for emergency ambulance services, but effective delivery of any additional capacity could require capital funding.

The paper presented aimed to seek the views of the Committee Members on the approach to increasing operational capacity within the emergency ambulance service during the financial year 2022-23, with a view to improving responsiveness of emergency ambulances for the population and supporting the wider health system.

The Chair thanked Ross Whitehead for the report adding that this would stimulate discussion among Members regarding their views around the approach to emergency ambulance capacity for the next financial year. The Chair requested that Members:

- considered the principle of recruiting additional frontline Ambulance staff in 2022-23
- note that the CASC and his team undertake a full assessment of the transitional plan recently received from WAST and provide clear recommendations to the committee via the EASC Management Group
- agree that reference would be made to the transition plan in the EASC IMTP.

It was confirmed that the 294 FTEs would be in addition to the additional resources funded in 2020-21 and 2021-22. It was also noted that during this time there had been a significant increase in activity and a material increase in lost capacity due to the increase in ambulance handover delays. Members were reminded that the modelling undertaken used an average of 6,000 lost handover hours per month; the current average was now 18,000 hours.

Members were advised that the modelling undertaken indicated that in excess of 300 FTEs were required, the 294 FTEs indicated the level that WAST feel that they were able to recruit and train.

It was agreed that this was a significant request and that, whilst this may address the pressure across the system in the short term, there should a robust effort to explore more sustainable opportunities to relieve the pressure across the system in the longer term.

	Members agreed that this request to increase emergency ambulance capacity reflected an inherently inefficient health and social care system. Equally, it was agreed that this was not just a case for additional resources due to capacity being held outside of our hospitals, but that there were key risks in terms of patient safety and experience. It was suggested that a process of scrutiny and assurance be undertaken. It was agreed that involving Health Board Directors of Finance, Directors of Planning and Chief Operating Officers, working with WAST colleagues, would ensure a robust process involving key stakeholders. The Chair thanked Members for their views and contribution to this important discussion. The EASC Team would coordinate the process, linking in with the EASC Management Group. This would ensure that appropriate EASC governance processes were followed and also that the risks, benefits and assumptions made within the case were fully understood. Members **RESOLVED** to: • **NOTE** the report and agreed actions.	**EASC Team**
EASC 22/09	**DRAFT EASC Integrated Medium Term Plan (IMTP) 2022-25** Ross Whitehead provided an update on the work to develop the EASC IMTP for 2022-25. It was suggested that Members would be familiar with many of the key principles adopted. The plan aimed to reflect and align with key strategic documents, Welsh Government policy, EASC Chair's objectives, plans for transformational change across Health Boards (HB) and Trusts and Commissioning Intentions (2022-23). The key priorities for EASC commissioned services were confirmed as: • **Emergency Medical Services (EMS)** Building upon the engagement undertaken with a wide range of stakeholders in relation to the vision for a modern ambulance service (initially presented, discussed and agreed at the EASC Committee in July 2021). Steps were already being taken on this journey and a case for additional emergency ambulance capacity and additional funding for Year 1 (2022-23) has been submitted.	

	Implementation of a new commissioning framework for EMS that started to reflect the progress made towards the vision for a modern ambulance service, would be a key part of this work around EMS. This new framework would be enacted on 1 April 2022. • **Non-Emergency Patient Transport Services (NEPTS)** Following completion of the transfers of work from HBs, NEPTS would focus on: – delivering the best patient transport model for Wales ensuring value and utilisation efficiency – strengthening the quality assurance process for providers – understanding the current and future needs of HBs and developing and implementing a responsive and adaptive NEPTS service – developing a robust forecasting and modelling framework – collaborating with the system to reduce system inefficacies. • **Emergency Medical Retrieval and Transfer Service (EMRTS) including the Adult Critical Care Transfer Service (ACCTS)** EASC will continue to work with EMRTS Cymru to: – consolidate the implementation of the ACCTS with a clear focus on improving patient outcomes, value, quality and safety – explore opportunities for an enhanced Critical Care Practitioner-led response – finalise and circulate EMRTS Service Evaluation – support the work of the Wales Air Ambulance Charity in the implementation of their new organisational strategy. In terms of wider system transformational work programmes, the key priorities included within the EASC IMTP were confirmed as: • **National Transfer and Discharge Service** Work will be undertaken to ensure a more effective and efficient approach to transfer and discharge services, ensuring reduced fragmentation and improving patient flow into and out of secondary care facilities. Next steps would include: – developing the service through collaborative working with partner organisations – developing and seeking agreement for the business case.	

- **NHS 111 Wales**
  It was confirmed that:
  - options for commissioning NHS 111 Wales were currently being considered
  - there were many cross-cutting themes
  - there was a need to realise opportunities to simplify the NHS 111 Wales approach and service as we transition to commissioning phase
  - further discussions are required to ensure close alignment between EMS and 111 services.

- **Emerging System Change**
  In response to plans for transformational change, it was confirmed that the EASC would:
  - act as a forum for discussing the plans that are being developed across HBs at the earliest opportunity
  - support the wider urgent and emergency care system, with transport as a key element of the work to improve patient flow within the wider health system
  - work with partners to improve service delivery and performance and to lead the commissioning of new transport models in response to system need.

In terms of the EASC financial plan it was confirmed that:

- Early sight of financial requirements has been provided with a draft financial plan presented at EASC in November
- Draft financial plan was then presented to the deputy directors of finance including timelines and assumptions
- Engagement undertaken with peer groups to ensure inclusion in HB IMTPs
- Final draft of the financial plan to be presented to EASC MG in February and EASC Joint Committee in March.

Members were advised of the timeline for submission of the approved EASC IMTP to Welsh Government in March.

A discussion was then held, key points raised included:

- non-emergency patient transport services - noting the completion of transfers of work from HBs, it was agreed that a position report would now be prepared to capture the issues, risks and opportunities in this area in light of the COVID-19 pandemic and the constraints of social distancing, the reported increase in virtual consultations and the development of alternative pathways

	• that, as commissioners, the Committee should take action to remove inefficiencies that exist within the system and should embrace the innovation and opportunities that exist including same day emergency care, palliative paramedics • that a comprehensive baseline analysis and scoping exercise would be undertaken as part of the work to develop the case for a national transfer and discharge service in order to remove duplication and to ensure an efficient and effective service. The Chair thanked Ross Whitehead for the presentation and thanked Members for their contribution and suggestions for the EASC IMTP. The EASC Team would now refine the plan in light of the helpful comments received and circulate in line with the timeline presented. Members **RESOLVED** to: • **NOTE** the presentation and agreed actions.	
Part 3. ITEMS FOR NOTING AND DISCUSSION		**ACTION**
EASC 22/10	**KEY REPORTS AND UPDATES** Due to the agreement for a shortened meeting and an abbreviated agenda to reflect the operational pressure being faced across the NHS system, the performance report, CASC report and WAST provider update were included for noting and information. Whilst these three items were not considered during the meeting, the Chair confirmed that members should raise any related matters with the Chair or any member of the EASC Team. It was agreed that the WAST Team would undertake work to develop a system that would capture and report on episodes where the ambulance services was not able to deploy a response vehicle or where the patient decided to find their own transport to hospital. Members **RESOLVED** to: • **NOTE** the performance report, CASC report and WAST provider update	**WAST Team**
Part 4. OTHER MATTERS		**ACTION**
EASC 22/11	**ANY OTHER BUSINESS** There was none.	

DATE AND TIME OF NEXT MEETING		
EASC 22/12	The next scheduled meeting of the Joint Committee would be held at 09:30 hrs, on Tuesday 15 March 2022 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……

Christopher Turner (Chair)

Date ……

Aneurin Bevan University Health Board

Finance Board Report – April (Month 1) 2022/23

Executive Summary

This report sets out the financial performance of Aneurin Bevan University Health Board, for the month of April 2022 (month 1) and the year-to-date performance position for 2022/23.

The 2022/23 financial performance is measured by comparing the expenditure with the budgets as delegated in the Budget Delegation papers agreed at the March 2022 Board meeting. 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.

Apr-22
Performance against key financial targets 2022/23
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Trend	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	1,673	1,673	↑	**0**
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the curent month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000 £41,712	1,370 3.3%	1,370 3.3%	↔	**0**
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)	%	96.8%	96.8%	↑	**>95%**

Performance against requirements 21/22		**19/20**	**20/21**	**21/22**	**3 Year Aggregate (19/20 to 21/22)**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	✓	**(32)**	**(245)**	**(249)**	**(526)**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	✓	**(28)**	**(13)**	**(50)**	**(91)**
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	✓				

Underlying Financial Position (Brought Forward ULP)	**19/20**	**20/21**	**21/22**
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	**£11.405m Deficit**	**£16.261m Deficit**	**£20.914m Deficit**

Note: The Health Board has submitted an IMTP for 2022/23 – 2024/25, the last approved 3 year IMTP was 2019/20-2021/22. The Health Board submitted an Annual Plan for 21/22 in place of a 3 year IMTP, as directed by WG.

Key points to note for month 1 include:

- A reported in-month and year to date position of **£1.673m deficit**, (the IMTP plan forecast a month 1 position of £1.58m deficit),
- Income - includes anticipated Covid-19 and exceptional cost pressure funding,
- Pay Spend – has decreased (by c.£2.8m), due to the annual leave provision in March 2022, medical and nursing variable pay costs have reduced but continue to be high due to elective recovery activity and on-going operational pressures such as enhanced care.
- Non–Pay Spend (excluding capital adjustments) - has decreased significantly in comparison to March due to ICF, PFI and other payments relating to national funded schemes.
- Savings – overall achievement is per plan for month 1.

At Month 1, the year to date reported revenue position is a £1.673m deficit; reported capital position is break-even. The forecast position for both is break-even, however, both have significant risks to be mitigated in order to achievement this forecast.

The underlying financial deficit coming into 2022/23 (£20.9m) will need to be addressed to support financial sustainability and recurrent balance in future years. The IMTP assumes recurrent savings opportunities will be achieved to reduce the underlying financial deficit for 2023/24 (to £8m).

The Board has approved the 2022/23 – 2024/25 IMTP and the Budget delegation plan for 2022/23.

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

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

Report Author: Suzanne Jones – Interim Assistant Director of Finance

Report Received consideration and supported by:

Executive Team		**Committee of the Board**	

Date of the Report: 13th May 2022

Supplementary Papers Attached:

1. Glossary
2. Appendices

Purpose of the Report

This report sets out the following:

- The financial performance at the end of April 2022 and forecast position – against the statutory revenue and capital resource limits,
- The savings position for 2022/23,
- The revenue reserve position at the 30th of April 2022,
- The Health Board's underlying financial position,
- The Health Board's cash position and compliance with the public sector payment policy, and
- The 2021/22 Draft position (subject to Audit).

Assessment & Conclusion

- **Revenue Performance**

  The month 1 position is reported as a **£1.673m deficit,** with a forecast **year-end out-turn reported as break-even**. A summary of the financial performance is provided in the following table.

Summary Reported position - April 2022 (M01)	Full Year Budget £000s	YTD Reported Variance £000s
Operational Divisions:-		
Primary Care and Community	257,037	854
Prescribing	99,190	463
Community CHC & FNC	63,411	469
Mental Health	101,461	1,298
Director of Primary Community and Mental Health	321	6
Total Primary Care, Community and Mental Health	**521,421**	**3,090**
Scheduled Care	219,692	2,499
Medicine	98,650	2,577
Urgent Care	34,952	1,138
Family & Therapies	117,027	56
Estates and Facilities	78,206	1,408
Director of Operations	3,950	143
Total Director of Operations	**552,477**	**7,820**
Total Operational Divisions	**1,073,898**	**10,911**
Corporate Divisions	112,652	(606)
Specialist Services	171,680	25
External Contracts	80,917	(12)
Capital Charges	64,465	(0)
Total Delegated Position	**1,503,611**	**10,318**
Total Reserves	87,029	(8,646)
Total Income	(1,590,641)	(0)
Total Reported Position	**0**	**1,673**

The month 1 overspend is £0.9m higher than forecast in the submitted IMTP. The position has been underpinned by appropriately releasing part of the annual leave accrual and assuming an increased level of funding for Covid to match increased costs. The position is aligned to the IMTP profile but the current service pressures being experienced are incredibly challenging, presenting a significant risk to the Health Board's ability to meet its statutory requirement to break-even. The Health Board reaching a break-even position in 2022/23 is predicated on:

- Achieving savings of at least £26m,
- Managing the £19m risks included in the IMTP through cost avoidance,
- Managing any new in year cost pressures,
- WG funding for Covid-19, exceptional cost pressures and wage award.

To ensure delivery of the IMTP service, workforce and financial plans, progress must be made to deliver transformational change to support value driven efficiency improvement and financial sustainability.

IMTP 2022/23-2024/25

The Integrated Medium-Term Plan was presented to the Board on the 23rd March and was subsequently signed off and submitted to WG, this included narrative and the detailed minimum data set.

Welsh Government and the Health Board have agreed to collectively manage significant financial risks in 2022/23 in respect of exceptional cost items and the on-going public health response (Covid). The expectation is that there is a return to business as normal, however, this will require a transitional period, and is subject to risks of further outbreaks. The Health Board continues to take action to mitigate these costs and to reduce the collective risk.

The IMTP is structured to demonstrate three distinct areas:

- The **CORE** plan of the Health Board, the Health Board developed a balanced core plan, acknowledging that savings need to be achieved and risks need to be managed to achieve balance.
- The **National Exceptional Pressures**, this includes the real living wage award, national insurance and energy. The Health Board will work with Welsh Government to manage / deal with these costs, and
- **Local Covid Response**, the Health Board will demonstrate the ongoing costs of covid safe working and areas that cannot immediately return to business as usual and work with Welsh Governement to manage these costs.

Opportunities have been identified of c.£26m, incuded in the core plan, and the Health Board is working to translate these into meaningful savings.

The over-riding objectives of the ABUHB IMTP financial plan are to improve financial sustainability for service delivery and use transformation as a vehicle for value based improvement and efficiency delivery.

Financial impact of service and workforce pressures

- During April 2022, pay expenditure decreased compared with March due to the impact of the annual leave provision accounted for in March. Variable pay costs decreased compared with service recovery plans paid in March. Significant operational pressures remain due to sickness, vacancies and enhanced care hours. Non-pay expenditure decreased in comparison to March due to funded 111 costs, PFI, as well as Regional Integration Fund (RIF formally ICF) costs. The expected energy price increases have resulted in an additional cost of £0.8m in month 1.

- The number of Covid-19 positive patients in hospital has decreased in April however the total number of patients is at a similar level to January. There remains a significant number of patients recovering from Covid-19 across several wards in the Health Board. The temporary staffing cost to operate these areas ranging from ICU through to community and rehabilitation wards remains significant. All services still need to operate in a Covid-19 safe environment leading to a workforce and financial pressure.

- Demand for emergency and urgent care across all services – including primary care, mental health, acute and community hospitals – has increased significantly and in many cases is above the levels seen pre-pandemic. There remain challenges in terms of demand, flow and discharges across the UHB. The challenge is now to reduce the requirement for this

capacity to achieve a safe and sustainable service, workforce and financial plan across the UHB.

- The operational factors above coupled with enhanced care predominantly within GUH, as well as increasing elective activity, result in significant financial pressures.

Additional Covid-19 transitional costs are being incurred due to the following:

- Additional services implemented to deal with exceptional emergency pressures across all sites,
- 'green' patient pathways to minimise infection,
- GUH ward A1 urgent care temporary ward,
- additional bed capacity across hospital sites,
- significantly increased number of patients requiring enhanced care,
- delayed discharges for patients waiting for social care support, and
- service models being flexed to respond to service pressures faced.

To mitigate, key areas of focus for the Health Board are:

- System level working,
- Urgent care and elective care re-design,
- Demand and flow management,
- Workforce efficiency and
- Other actions to underpin the operational management and leadership to support clinical teams.

Workforce

The Health Board spent £59.1m on workforce in month 1 22/23 (21/22 monthly average of £58.3m).

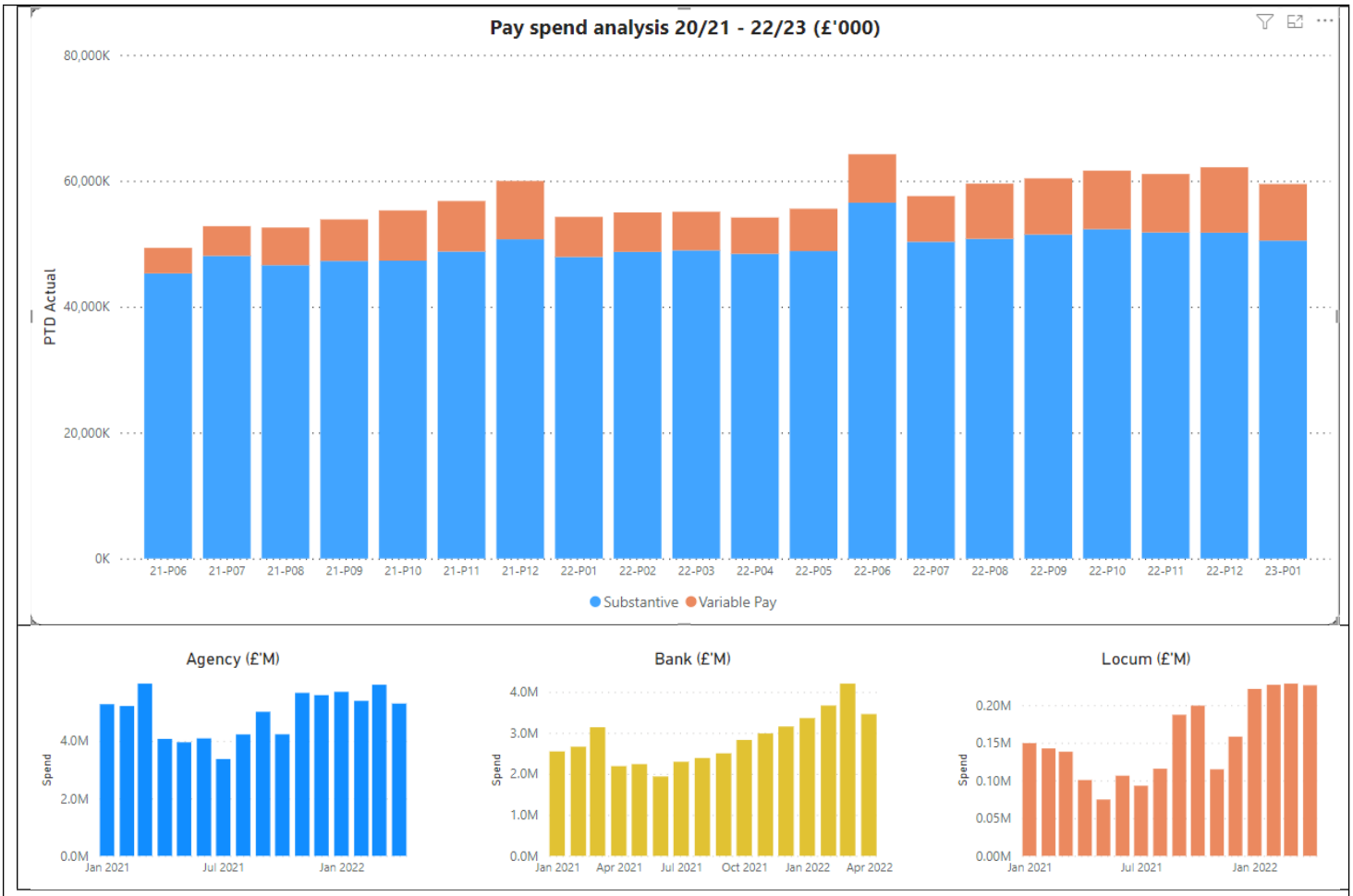
Substantive staffing costs (excluding the increased annual leave provision and notional 6.3% pension costs in March) have decreased by £1.6m (3.2%) compared to March. This is linked to payroll provisions made for the 21/22 financial year alongside reduced monthly enhancement payments.

There was a decrease in overtime in April however it remains higher than quarter 4 21/22 average costs. Compared with month 12 bank costs have decreased by £0.7m (17.7%) and agency costs have decreased by £0.66m (11%). The decrease is linked to international recruitment and service recovery costs paid in March, however these are offset by the on-going high levels of enhanced care provision across the UHB.

There is still a continued and significant reliance on the use of agency and bank staff.

Workforce expenditure is shown below differentiating between substantive and variable pay[1]:

[1] *To enable useful comparisons and trends all references to 21/22 pay expenditure exclude the month 12 expenditure for: Covid-19 annual leave provision (£2m), and Additional employer pension contributions (6.3%/£27m).*



Substantive staff
Substantive pay was £50.1m in April (exc. pension related adjustments) – a decrease of £1.6m compared to March. Substantive pay has decreased by £0.9m for medical staff, £0.3m for allied health professionals and £0.3m for additional clinical services, this is offset by an increase of £0.1m for registered nursing. The majority of these changes relate to specific forecast payroll adjustments and annual leave provision changes processed in March 2022.

Variable pay
Variable pay (agency, bank and locum) was £9m in April – a decrease of £1.4m compared with March.

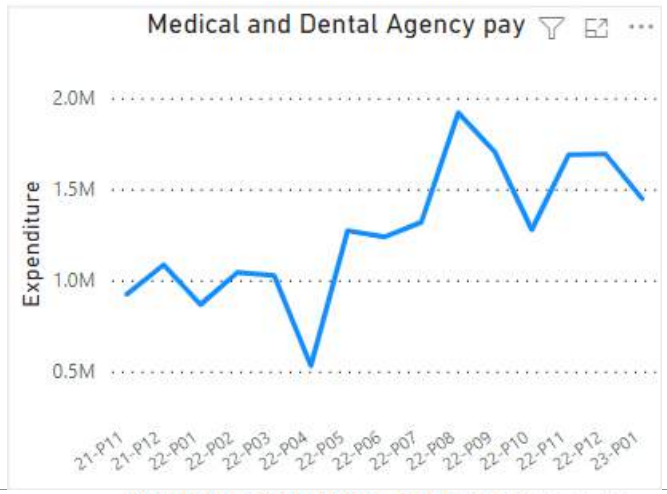
The Executive Team previously agreed the block booking of registered nurse (RN) agency and over recruitment of health care support workers (HCSW) to ensure safety of service provision. This will be reviewed to ensure the appropriate level for safe, sustainable services to be delivered across the Health Board.

It should be noted that the number of unfilled registered nursing shifts remains at a high level throughout the HB. If all these shifts were filled through variable pay the cost impact would be significant.

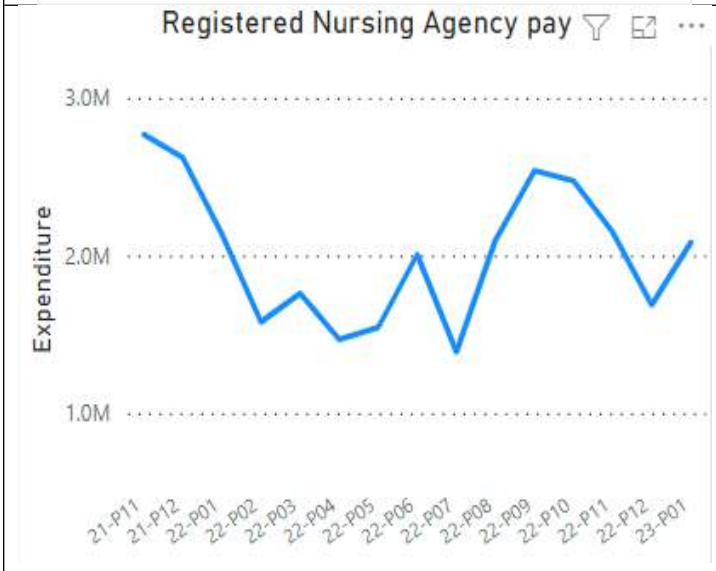
Bank staff
Total bank spend in April was £3.5m - a decrease of £0.7m compared with March, this is due to higher activity as part of recovery plans in March. There remain continued increases in enhanced care shifts. Areas where bank usage continues to be significant are GUH ED / Acute Medicine as well as wards with recovering Covid-19 patients and those with on-going Covid-19 additional support requirements.

Agency

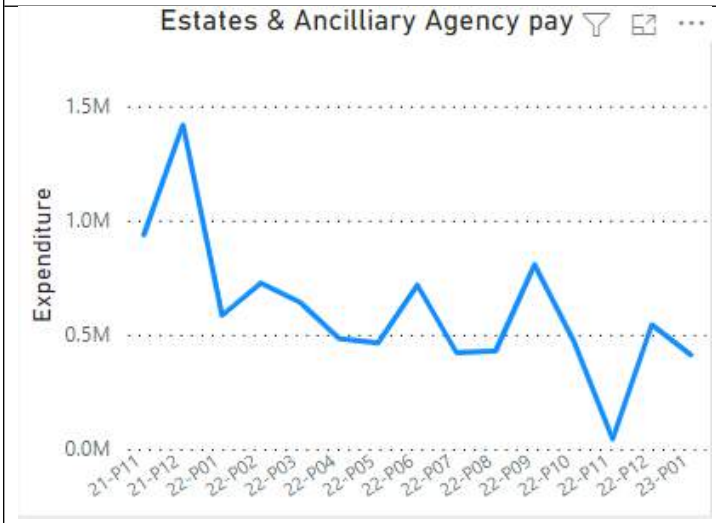
Total agency spend in April was £5.3m – a decrease of £0.7m compared to March. International recruitment costs as well as specific agency costs for recovery plans (e.g. audiology and cardiology) were paid in March, leading to the decrease in April.



- In-month spend of £1.5m, a £0.2m decrease compared to March.
  - Continued pressures in COTE and YYF medical staff backfilling a number of staff who are non-patient facing and numerous vacancies.
  - Ophthalmology and radiology costs linked to cover of vacancies.
  - Costs to provide additional elective work.
- Medical agency spend averaged c.£1.3m per month in 2021/22.



- In-month spend of £2.1m an increase of £0.4m compared to March.
- Reasons for use of registered nurse agency include:
  - Additional service demand including opening additional hospital beds,
  - Enhanced care and increased acuity of patients across all sites,
  - On-going sickness and international recruitment costs,
  - vacancies, and
  - enhanced pay rates.
- Registered Nursing agency spend averaged c.£1.9m per month in 2021/22.

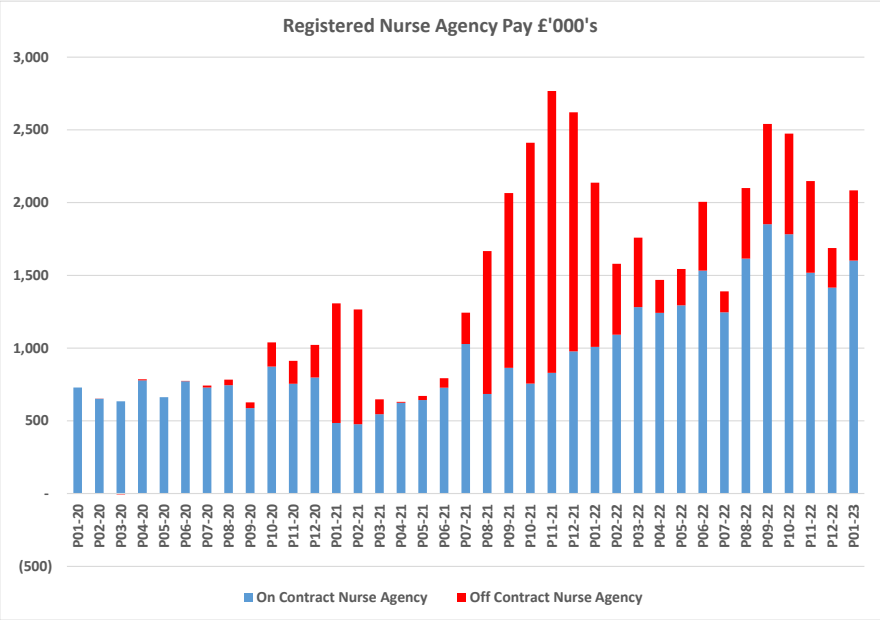


- In month spend of £0.5m on Estates & Ancillary, which is primarily within GUH and related to Covid.
- Reasons for use of agency include:
  - Meeting enhanced cleaning standards,
  - Enhanced care and increased acuity of patients,
  - Sickness,
  - Vacancies and
  - Supporting the Mass Vaccination Programme.
- Estates and Ancillary agency spend averaged c.£0.5m per month 2021/22.

Registered Nurse Agency

Registered nurse agency spend totalled £22.8m in 2021/22, £18.1m in 2020/21 and £10.2m in 2019/20.

Health Board spend in April 2022 is £2.1m on nurse agency; if this level of use continues throughout the financial year it would cost £25.2m in 2022/23. The use of "off-contract" agency – not via a supplier on an approved procurement framework – usually incurs higher rates of pay and remains significant in month.



The Health Board spent £0.48m on 'off' contract RN agency in April which is higher than March and reflects the increase vacancy hours used and an increase in enhanced care hours. The main reasons for its usage are:

- Enhanced care,
- Additional capacity,
- Nursing vacancies,
- Patient safety,
- Covid-19 responses, and
- Increased sickness and cover for staff in isolation.

As part of the new Variable Pay savings programme for 2022/23, the Nurse Agency Reduction Plan requires revision given the on-going service and workforce pressures coupled with an increase in unregistered nurse agency costs in 2021/22, this needs to be implemented in full for 2022/23.

Medical locum staff

Total locum spend in April was £0.23m which is at a similar level to March. Pathology and Anaesthetics remain areas of highest expenditure relating to on-going operational pressures and substantive vacancies.

Enhanced Care

Enhanced Care, also known as 'specialling', can include a spectrum of interventions ranging from the provision of assistance to help a patient mobilise, through to one-to-one patient monitoring. Enhanced care is designed to ensure a patient centred safe approach for patients with additional care needs.

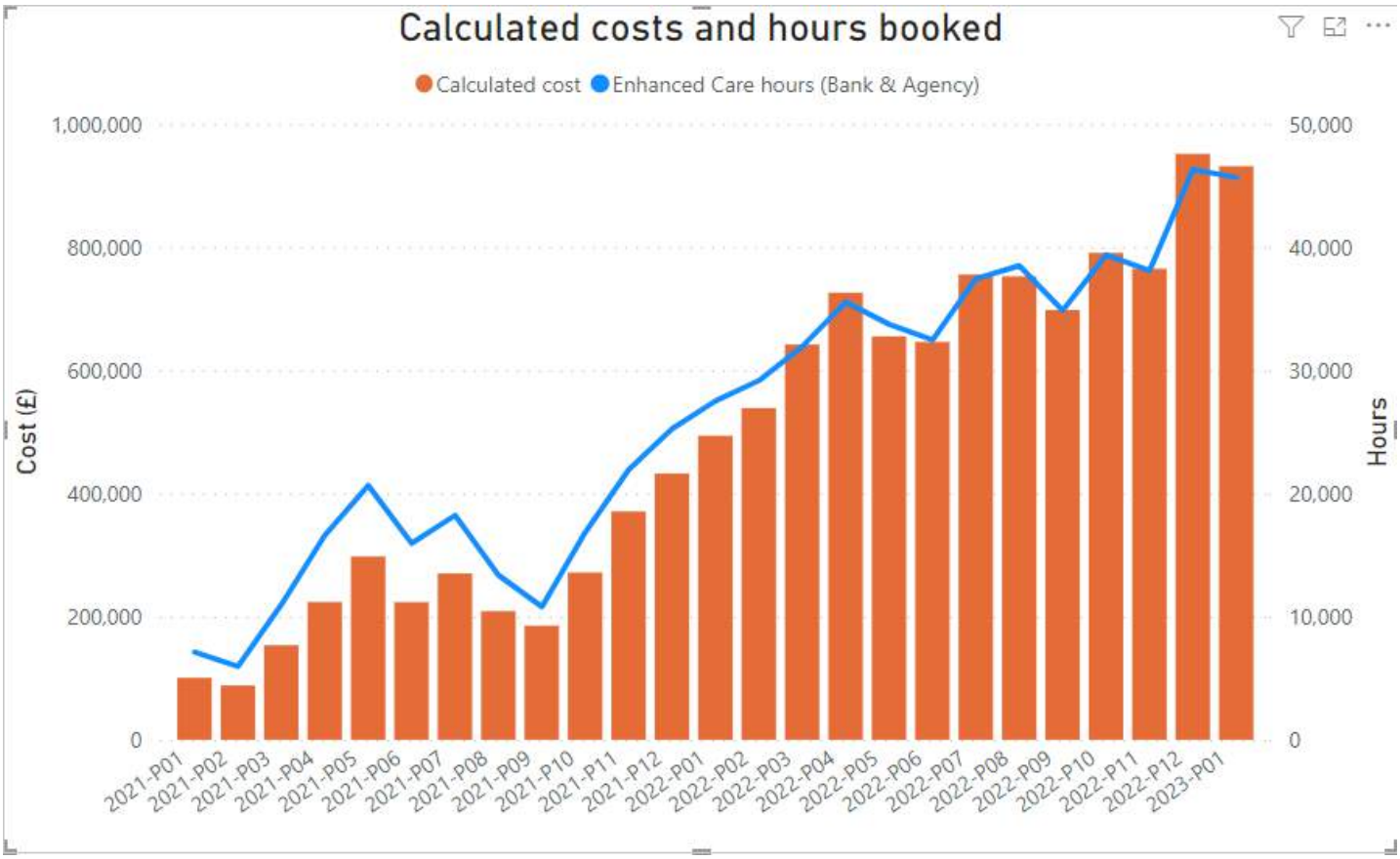
A review of the financial impact of 'enhanced care' – including the use of bank and agency staff – has identified the following use of nursing staff:

	2021/22	**2022/23**	**Increase**
Average number of hours used per month	35,446	45,658	29%
Increase in average notional cost per month compared to prior year			**£0.2m**
Estimated increase in the calculated annual cost based on average hours			**£2.8m**

The following graph highlights the increase in hours attributed to enhanced care for the period April 2020 (P01-2021) to April 2022 (P01-2023) using bank and agency registered nurse and health care support workers.

In April (P01-2023), enhanced care hours and associated notional costs remained high within the Medicine and Primary Care & Community Divisions. It should be noted that the hours quoted are the number of bank and agency hours worked using 'enhanced care' as the reason for booking, notional costs are calculated using average registered/unregistered hourly rates incurred.

There is a distinct increase in enhanced care hours (and associated costs) from February 2022 compared with March and April 2022. The monthly average from April 2021 to February 2022 is approx. 34,400 hours and £0.6m cost. The April cost of £0.9m is an increase of £0.3m above that average, indicating a step change which highlights the change in acuity of patients across the UHB.



Non-Pay

Profiled spend (excluding capital) was £78m in April which is a decrease of £30m compared with March due to the increased year-end costs in specific funded areas such as RIF, PFI, project 111 and partnership schemes expenditure. This is offset by the significant increase in energy prices, which is regarded by Welsh Government as an exceptional cost pressure. Additional funding has been anticipated for this pressure estimated in the region of £12.5m.

Other areas to note are:

- CHC Mental Health – the current patient numbers at the end of April was 406 which is a net increase of 6 MH patients in month with high cost packages.
- CHC Adult / Complex Care - 666 active CHC and D2A placements (decrease of 8 from March). There was a decrease of 4 D2A patients with a decrease of 6 placements on the 'Step Closer to Home' pathway (34 total) in April at a forecast cost of £0.7m for the financial year. The table below provides analysis of this:

Activity	March 2022	April 2022	Movement
D2A	76	72	-4
Step Closer to Home	40	34	-6
All Other CHC	558	560	+2
Total	674	666	-8

- For FNC - currently 838 active placements, which is a decrease of 9 from March.
- Primary Care medicines – the full year expenditure to date is £8.3m. The April 2022 forecast is based on growth in items of 0.8% with an average cost per item of £6.70, category M drugs prices continue to fluctuate. The pre Covid-19 baseline expenditure for prescribing assumed an average cost of closer to £6.50 per item presenting a financial pressure which requires mitigating actions and savings.

Service Pressures & Activity Performance

Bed Capacity

Additional medical beds have been opened as part of responding to the system pressures described previously. Additional capacity beds in Medicine were 48 in April as described in the table below:

No. of Additional Beds							
Site	**Ward**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**	**Description**
RGH	B3 Winter Ward	28	26	27	26	0	26 Additional Capacity
	C6E Med Additional Capacity from Oct					0	Old Resp Ward converted to Add Cap
	C5E	0	0	0	0	0	
NHH	3rd Floor	11	11	11	9	7	32 (flexed up from 28)
	4th Floor	5	4	3	2	6	28 (flexed up from 30)
	4/1 winter	32	32	27	28	0	Winter ward from 27th Dec (flexed up from 28)
GUH	C4	8	8	2	2	0	2 Covid beds in March
	B4					8	
	A4	2	2	2	2	1	Using Ringfenced beds
	Fox Pod					8	
YYF	Risca	30	30	0	0	0	30 Covid Ward (funded ward)
	Bargoed	0	0	0	0	0	30 Covid Ward (funded ward)
	Oakdale	0	30	15	22.5	0	50%->100% Covid Ward (funded ward). Return to Amber wef 14/2/22.
	Rhymney	14	28	28	0	0	Supporting 50% of SC ward for Winter capacity. Wef 7/1 100% Medicine additional capacity for Winter
	Penallta		28	28	28	0	100% of Ward (Red capacity under Dr Davies, Cons)
RGH AMU	D1W	23	21	12	0	18	15 Beds 2 additional RN 24/7
Total		**153**	**220**	**155**	**119.5**	**48**	

Oakdale and Penallta wards in YYF have now closed as surge capacity wards.

There was also a continued use of surge beds throughout the Community hospitals. These are described as follows:-

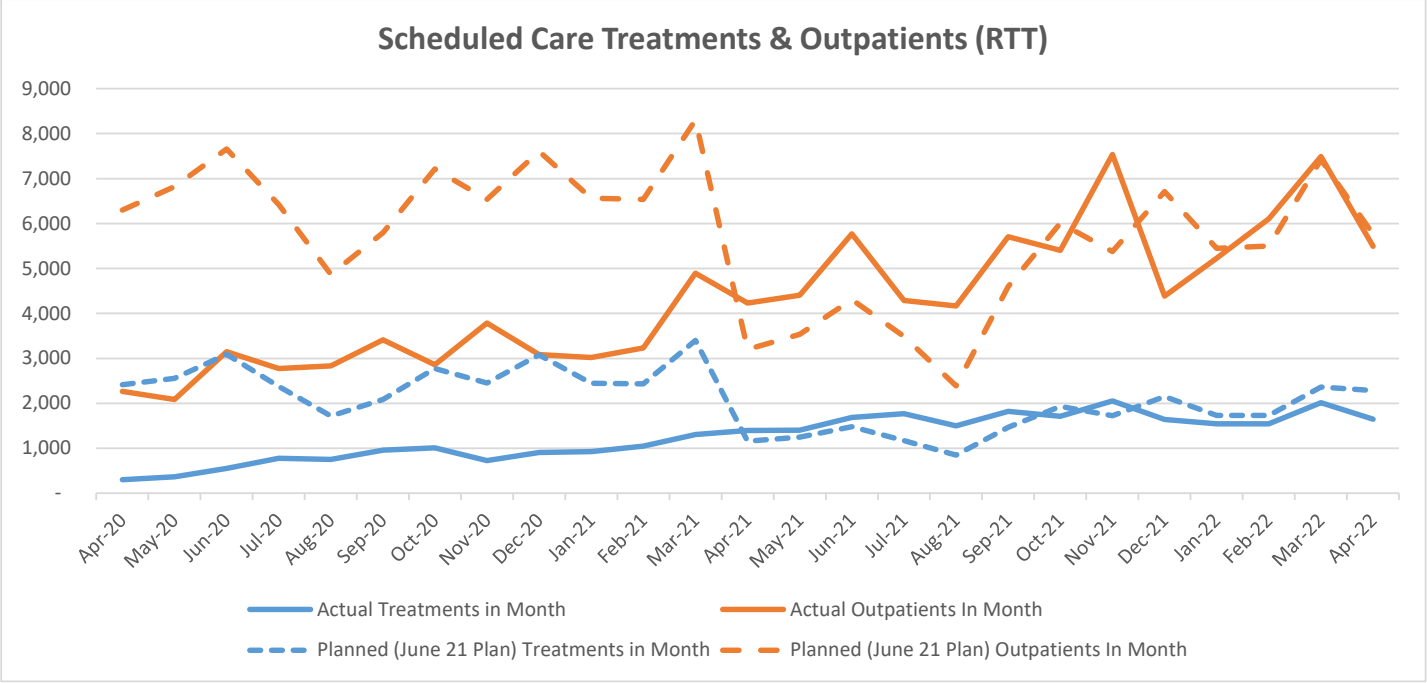
No. of Additional Beds						
Site	**Ward**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**
STW	Ruperra	24	24	24	24	24
	Holly		10	10	10	10
YAB	Tyleri	15	15	15	11	11
Total		**39**	**49**	**49**	**45**	**45**

It should be noted that Holly ward is the "Step Closer to Home" ward.

Scheduled Care treatments and outpatients

Elective activity has decreased in April given the March activity levels were greater than previous months. Outpatient activity is above plan in Dermatology due to virtual appointments using 'Telederm' but is variable across other specialities. Whilst most routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

Activity plans will need to be finalised linked to demand and capacity plans coupled with service, workforce and financial plans.



- Elective Treatments for April '22 was 1,647 with a 2021/22 total of 20,091 treatments.
- Outpatient appointments for April '22 was 5,491 with a 2021/22 total activity of 64,706.

Medicine Outpatient Activity

Medicine Outpatient activity for April '22 were 1,035 attendances (2021/22 activity 15,581) this is presented by specialty below:

Apr-22

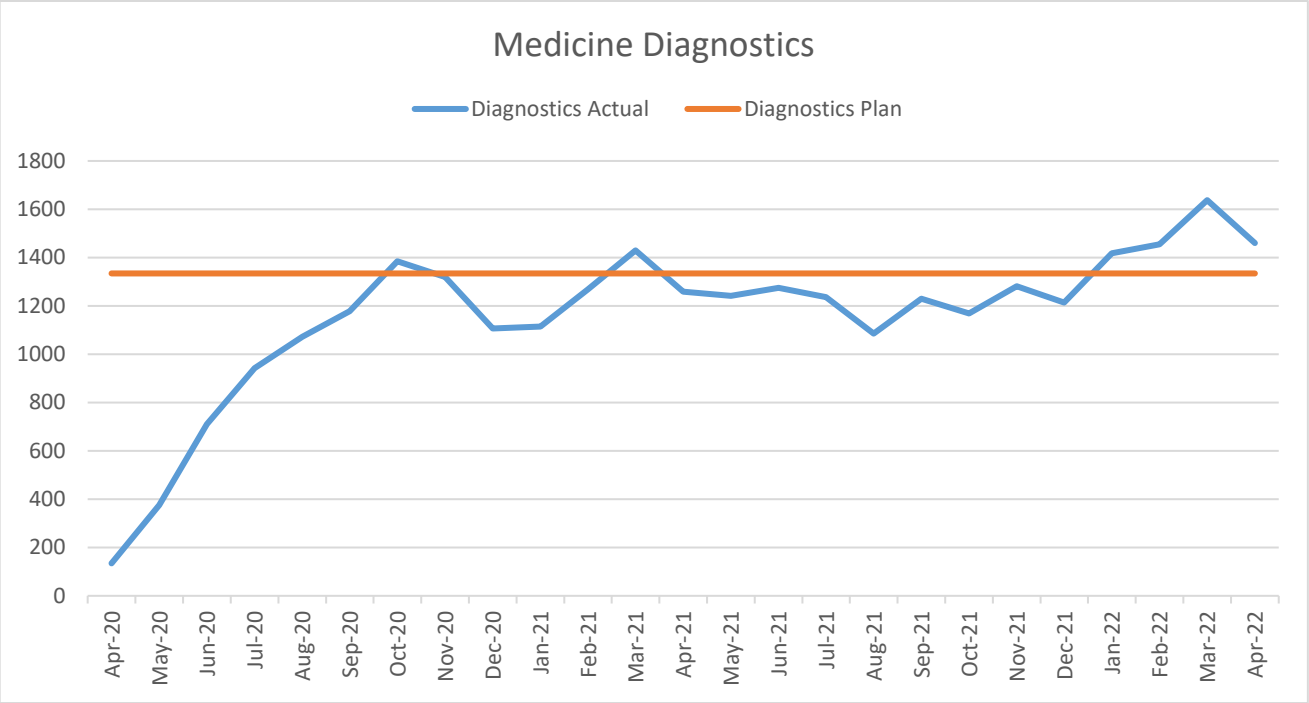
	Assumed monthly activity	Actual activity	Variance
Gastroenterology	510	198	-312
Cardiology	553	140	-413
Respiratory (inc Sleep)	606	232	-374
Neurology	259	193	-66
Endocrinology	242	121	-121
Geriatric Medicine	231	151	-80
Total	**2401**	**1035**	**-1366**

A year-to-date underperformance of 57% is presented.

Medicine Diagnostics (Endoscopy) Activity

Medicine endoscopy activity for April '22 was 1,460 procedures which is 126 cases less than plan.

The activity undertaken since April '20 is shown below;



Covid-19 – Revenue Financial Assessment

Total Covid-19 costs are shown as c.£74m and at this stage the Health Board is including expenditure and funding, these are full year forecasts unless otherwise stated:

- Testing - £6.5m
- Tracing - £6m
- Mass Vaccination - £9m
- PPE - £3.7m
- Extended Flu (estimate to be confirmed)
- Cleaning standards - £3.9m
- Long Covid - £0.8m
- Nosocomial investigation - £0.8m
- Other additional Covid-19 costs - £36m, and,
- Other additional Covid-19 costs relating to emergency and surge workforce pressures for *quarter 1 only* - £7.3m.

The cost impact of responding to Covid-19 and emergency system pressures along with increased patient acuity will be closely monitored and the implications for Q2 to Q4 will be appropriately reflected in future months returns.

The assumptions are in line with those used for the submitted IMTP, correspondence from WG and the IMTP financial assumptions letter sent in March 2022. Costs included in addition to the IMTP are related to on-going staffing issues because of covid, at this stage an amount is included for quarter 1 but, as stated above, this will be reviewed and updated.

The Health Board is reporting costs for additional capacity and maintaining Covid-19 safe and compliant operational service delivery across all sites, as part of the other additional Covid-19 costs section.

The Health Board is not including costs for Velindre Covid (recovery or outsourcing) within these figures, per the All Wales LTA agreement.

Type	Covid-19 Specific allocations - April 2022	£'000
HCHS	Testing (inc Community Testing)	6,508
HCHS	Tracing	6,000
HCHS	Mass COVID-19 Vaccination	9,000
HCHS	PPE	3,654
HCHS	Cleaning standards	3,900
HCHS	Long Covid	887
HCHS	Local transitional costs	43,276
HCHS	Nosocomial investigation and learning	753
	Total Covid-19 Allocations (anticipated)	**73,978**

Exceptional Cost Pressures

It is important to note the exceptional cost pressures recognised by Welsh Government for 22/23, these are energy prices, employers NI and the Real living wage award. It has been agreed that these be managed on a collective basis with funding assumed to cover costs, albeit the funding is not confirmed. The Health Board still has a duty to mitigate these costs within its financial plan to reduce the collective risk.

Type	Exceptional items allocations - April 2022	£'000
HCHS	Energy prices increase	12,500
HCHS	Employers NI increase	4,606
HCHS	Real living wage	2,812
	Total Exceptional items allocations (anticipated)	**19,918**

Budget Setting / Delegation

In line with Health Board SFI's budget delegation letters have been sent to Executive Directors, these clearly set out the expectations regarding managing within the delegated budget levels.

Executive Directors are now expected to issue delegation letters to Deputies and Divisional Directors, stating the level of budget and the expectations associated with managing that budget.

- **Revenue Reserves**

Health Board reserves are held by the Board, until such time as they agree their use or delegate this responsibility to the Chief Executive as Accountable Officer. Agreed funding delegations per the Board Budget Setting paper have been actioned, however, some funding allocations are held in reserves, where their use is directed by Welsh Government or funding is allocated for a specific purpose.

The following reserves, relating to WG Funding, were approved for delegation by the CEO.

£4m Mental Health – anticipate additional resources	£715k Strategic Programme for Primary Care fund
£200k Strategic Programme Primary Care Accelerated Cluster Development programme	£887k Adferiad (Long Covid) funding
£2.3m Dental – reduction in patient charges income target	£753k Nosocomial Covid-19 – Investigating and Learning from cases
£2.25m Covid 19 Tracing programme	£192k Substance misuse uplift
£8.9m delegation to Estates & facilities for additional Covid expenditure	£50k GMS Pay and expenses uplift
£62.5m Covid-19 response and exceptional costs	(£30k) Digital Priorities Investment Fund reduction
£222k VERS recovery	(£260k) TEC Cymru + Virtual Consultations
(£1.2m) Covid-19 mass vaccination programme adjustment	£1.5m Covid-19 Testing adjustment
£50k GMS Pay and expenses uplift	£2.9m Covid-19 PPE

Long Term Agreements (LTA's)

ABUHB have issued LTA commissioner documentation to providers in line with the All Wales DoF's agreed approach. Velindre NHS Trust have submitted a draft LTA to AB for consideration.

Draft agreements where AB is a provider of services have been sent to all commissioners of AB services in accordance with the DoF framework. LTA agreements have sent to C&VUHB, CTMUHB, PTHB, SBUHB and HDUHB.

Other providers are yet to submit 2022-23 LTAs for consideration.

Discussions are ongoing with WHSSC over the LTA where AB is a provider of specialised services.

All agreements are required to be signed before the 30th June 2022.

Underlying Financial Position (ULP)

The Underlying (U/L) forecast position is a brought forward value of £21m with a carry forward deficit into 23/24 of c.£8m in line with the IMTP submission.

Financial sustainability is an on-going priority and focus for the Health Board.

The IMTP identifies an improved forecast closing 2022/23 underlying deficit of **£8.1m.**

This is based on the current assessment of available recurrent funding, savings and the recurrent financial impact of existing service and workforce commitments. **It continues to exclude any potential recurrent impact of Covid-19 decisions.**

The Health Board's 2022-25 IMTP identifies several key priorities where the application of Value-Based Health Care principles – improving patient outcomes along with better use of resources – should result in delivering greater service, workforce and financial sustainability whilst improving the health of the population. The actions being taken to improve financial sustainability are integral to this approach.

The UHB Board approved approach to the refreshed 22/23 IMTP financial plan is to focus on making previous investment decisions sustainable before new investments are committed to. The WG allocation funding 22/23 provides the Health Board with the opportunity to help address its historic underlying financial position and prioritise current challenges and commitments as part of the 2022/23 IMTP.

Health Board savings schemes for 2022/23 need to be implemented in full and on a recurrent basis both to manage future cost pressures and reduce the underlying deficit. This position is assumed at present but will require constant management and implementation of new schemes. All investment and service developments should bear this position in mind, where appropriate.

Savings delivery

As part of the IMTP submitted by the Board to Welsh Government (March 2022), the financial plan for 2022/23 identifies a core savings requirement of £26.2m. As at Month 1 forecast achievement in 22/23 is £26.2m however this contains a high level of on-going risk to ensure full delivery.

Actual savings delivered to April amounted to £0.47m, compared with month 1 planned delivery of £0.25m. The profile of savings expected to be achieved is significantly increased from month 3 onwards.

The in month outturn profile as submitted as part of the IMTP for 2022/23 is presented below:

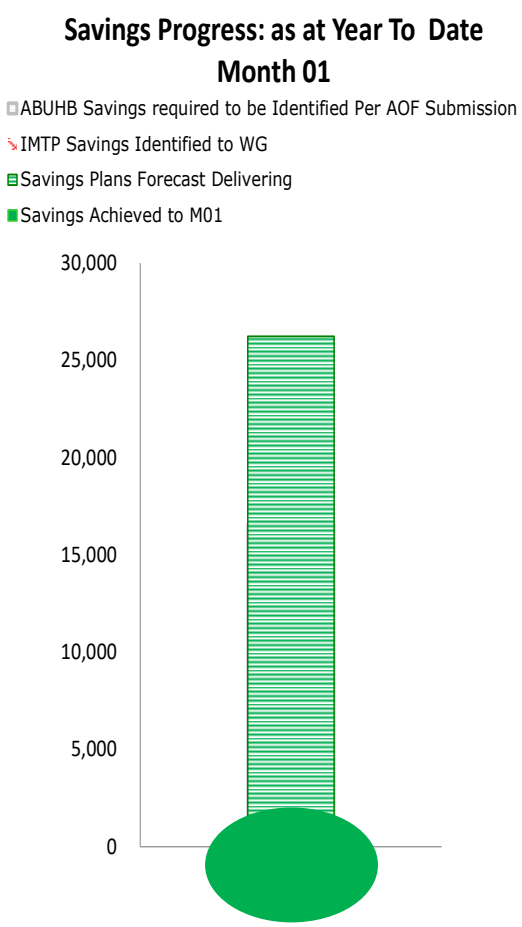
£m Deficit (Surplus)	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total Year End Position
Forecast Monthly Position	1.67	1.27	1.01	- 0.39	- 0.39	- 0.39	- 0.45	- 0.45	- 0.45	- 0.45	- 0.45	- 0.52	0.00

To achieve a balanced core financial plan, the Health Board needs to ensure that savings plans are achieved in line with plans. In addition, further cost avoidance plans are required to ensure that any other financial pressures are mitigated. The IMTP narrative notes potential risks that require mitigation either through additional savings plans or other solutions.

Savings schemes straddle transformational, transactional, and operational plans. Aligned to progressing the savings and mitigating actions a value focussed pathway approach is being employed. The Health Board has agreed nine priority areas for focussed support using a programme management approach with MDT support through an Executive lead, value, performance, workforce, service, planning and finance representation. In addition the Agile Working programme and Variable Pay Reduction project are priority areas for delivery during 2022/23.

The Value Based Health Care team as part of the "AB Connect" forum are working across programmes and divisions to support service improvement and outcomes capture. National schemes are being developed and the Health Board will be participating fully with these programmes.

Furthermore, the Health Board will continue to identify and implement transactional and operational savings including the reduction in agency spend, to leverage the benefits of digital investment and will fully utilise the ABUHB opportunities compendium and FDU 'VAULT' where appropriate.



Month 1 Forecast Savings Plans

	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
Medicines Management (Primary and Secondary Care)	3,331	0	3,331	3,331
Pay	9,897	194	9,703	9,709
Non Pay	13,010	7,942	5,068	5,063
Total	**26,238**	**8,136**	**18,102**	**18,102**

Further scheme detail is provided in the appendices

The Health Board will continue to pursue all available operational and transactional savings however this will no longer achieve the savings target.

To deliver greater levels of savings and to achieve better use of resources, which improves health outcomes – and doesn't adversely impact on safety and quality – a greater focus is required on savings and efficiency improvement related to:

- Eliminating unwarranted clinical variation
- Transformational service change

It is important to note at present that a number of Divisions are pursuing savings plans internally to mitigate local cost and underlying pressures.

Risks & Opportunities (2022/23)

There are risks to managing the 2022/23 financial position, which include:

- Ensuring full delivery of the savings plans identified in the IMTP
- Identifying savings to mitigate any further financial risks identified outside of the IMTP,
- Quarter 2-4 additional Covid cost pressures,
- Workforce absence / self-isolation / vacancies, availability of staff for priority areas,
- Responding to any specific Covid-19 impacts e.g., new variants, outbreaks,
- Unconfirmed levels of funding for exceptional cost pressures and the local covid responses, that the Health Board is currently assuming,
- Funding for any wage award or change in terms and conditions,
- Responding to the ongoing impact of Covid-19 and associated preventative services,
- Addressing backlogs in waiting times for services, due to the Covid-19 pandemic,
- Specific economic factors/Ukraine conflict issues such as energy costs, supply chain issues and non-pay inflation including travel expense costs, and
- Maximising the opportunity to change services resulting in improved health outcomes for the population.

Managing the financial risk is dependent on developing service and workforce plans that are sustainable during 2022/23 and in the future. Forecasting remains challenging given the level and variety of uncertainty linked to the issues listed above and the assumptions of delivery made in the IMTP.

Capital

The approved Capital Resource Limit (CRL) as at Month 1 totals £31.383m. In addition, the Health Board has received funding approval letters for Newport East H&WBC (£9.229m) and Grange University Additional works to Resus and CAEU (£1.1m). These approvals are in the process of being signed and will be added to the CRL in May. The current forecast outturn is breakeven.

The remaining works to the Same Day Emergency Care Unit, Resus, CAEU and Grange House are progressing from the remaining Grange University Hospital funding. All Laing O'Rourke works are due to complete by the middle of September. The additional works costs are being offset by the final VAT recovery claim due in the last quarter of 2022/23.

The YYF Breast Centralisation Unit approval was received in March 2022. Works are due to commence on site in the last week of May. The Full Business Case (FBC) for Newport East Health and Well-being Centre has been approved and a funding letter has been received. Preparations are underway to progress the land purchase from Newport City Council and commence construction works.

The Business Case for the proposed Endoscopy Unit at RGH was submitted to Welsh Government in March but final approval is still awaited. The FBC for the NHH Satellite Radiotherapy Centre is near conclusion and expected to be submitted to Board for approval in May. The Outline Business Case for the Mental Health SISU is on-going and expected to be submitted to Board for approval in July 2022.

The second year of the National Imaging Programme funding totals £4.7m for ABUHB. The spend in the current year includes the replacement of two CT Scanners (NHH / RGH) and the installation of three general rooms purchased during 2021/22.

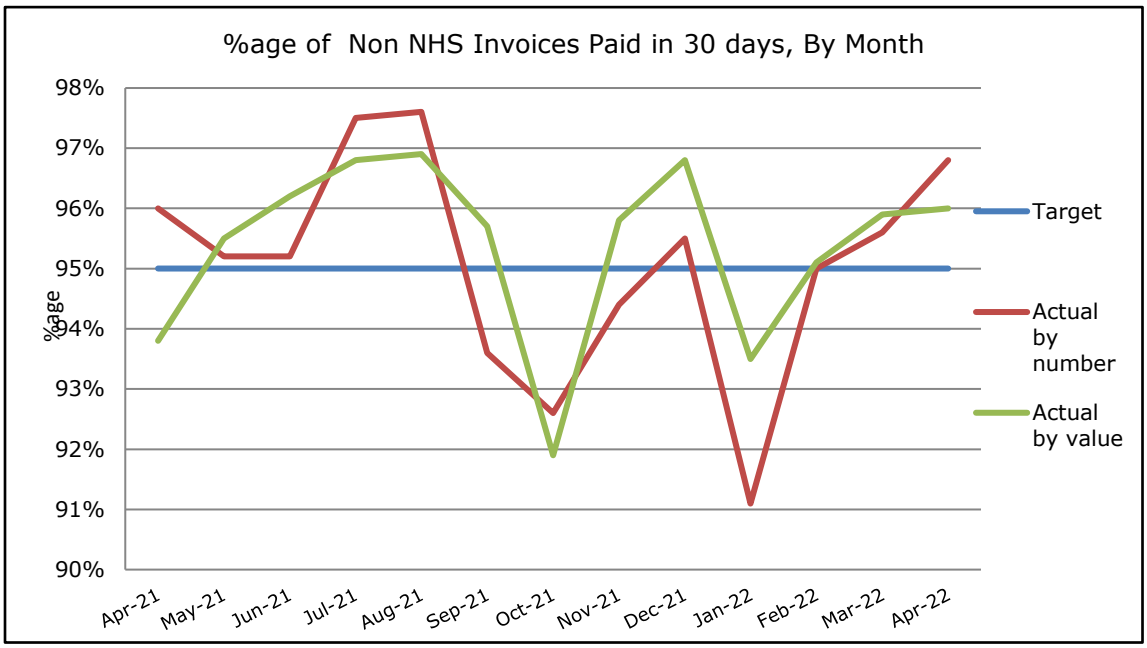
The Health Board Discretionary Capital Programme (DCP) allocation for 2022/23 is £8.227m (a reduction of 24% compared to 2021/22). Final All Wales Capital Programme scheme brokerage for 2021/22 slippage was £1.859m, leaving a balance of £6.638m to address spend in the current financial year. The opening 2022/23 DCP was approved at the March board meeting. Expenditure has now commenced against these schemes. The new approval of £1.1m for remaining works at the Grange University Hospital has reimbursed the Discretionary allocation, however, this has been partly offset by additional discretionary scheme slippage form 2021/22. The unallocated contingency budget as at the end of April is £739k.

Cash

The cash balance on the 30th of April is £2.45m, which is within the advisory figure set by Welsh Government of £6m.

PSPP

The HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods, both in month & on a cumulative basis.



Review of 2021/22 financial performance

ABUHB achieved its revenue and capital financial performance targets for 2021/22, following a year of significant uncertainty and challenge.

Non-recurrent Welsh Government Covid-19 funding supported the cost pressures coupled with delivery of savings to support the achievement of this position. Key financial highlights include:

- The Revenue out-turn position was a surplus of £249k (subject to audit) with a 3 year cumulative performance £526k surplus.
- The Capital outturn position was a surplus of £50k (3 year cumulative performance £91k surplus).
- Both Revenue & Capital outturns are both subject to Audit review.
- Savings achieved during the year were £16.6m.
- Covid-19 expenditure for the year was £172.1m, savings not delivered were £8.6m
- Welsh Government funding received for Covid-19 related issues was £180.7m.

- The Cash held at the year-end was £1.72m, within advisory limits.
- The 95% Public Sector Payment Policy target was achieved.

Recommendation

The Board is asked to note:

- The financial performance at the end of April 2022 and forecast position – against the statutory revenue and capital resource limits,
- The savings position for 2022/23,
- The revenue reserve position at the 30th of April 2022,
- The Health Board's underlying financial position,
- The Health Board's cash position and compliance with the public sector payment policy, and
- The 2021/22 Draft position (subject to Audit).

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risks of achieving the Health Board's statutory financial duties and other financial targets are detailed within this paper.
Financial Assessment, including Value for Money	This paper provides details of the year to date and forecast financial position of the Health Board for the 2022/23 financial year.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance. This paper provides a financial assessment of the Health Board's delivery of its AOF/IMTP priorities and opportunities to improve efficiency and effectiveness.
Equality and Diversity Impact Assessment (including child impact assessment)	The Assessment forms part of the AOF service plan.
Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides details of the financial position that supports the Health Board's 3 year plan. The Health Board has a statutory requirement to achieve financial balance over a rolling 3 year period.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Long-term financial linked to IMTP completion **Integration –** Regional partnership and integration with other NHS Wales organisations **Involvement –** use of environmental fund and specific investment as well as on-going links with services for engagement **Collaboration** – collaboration with external partners **Prevention** – long-term strategy to provide investment and savings through preventative measures across the UHB.

	The Health Board Financial Plan has been developed based on the approved AOF/IMTP, which includes an assessment of how the plan complies with the Act.
Glossary of New Terms	See Below
Public Interest	Circulated to board members and available as a public document.

Glossary

A		
A&C – Administration & Clerical	A&E – Accident & Emergency	A4C - Agenda for Change
AME – (WG) Annually Managed Expenditure	AQF – Annual Quality Framework	AWCP – All Wales Capital Programme
AP – Accounts Payable	AOF – Annual Operating Framework	ATMP – Advanced Therapeutic Medicinal Products
B		
B/F – Brought Forward	BH – Bank Holiday	
C		
C&V – Cardiff and Vale	CAMHS – Child & Adolescent Mental Health Services	CCG – Clinical Commissioning Group
C/F – Carried Forward	CHC – Continuing Health Care	Commissioned Services – Services purchased external to ABUHB both within and outside Wales
COTE – Care of the Elderly	CRL – Capital Resource Limit	Category M – category of drugs
CEO – Chief Executive Officer		
D		
DHR – Digital Health Record	DNA – Did Not Attend	DOSA – Day of Surgery Admission
D2A – Discharge to Assess	DoLS - Deprivation of Liberty Safeguards	DoF – Director(s) of Finance
E		
EASC – Emergency Ambulance Services Committee	EDCIMS – Emergency Department Clinical Information Management System	eLGH – Enhanced Local general Hospital
ENT – Ear, Nose and Throat specialty	EoY – End of Year	ETTF – Enabling Through Technology Fund
F		
F&T – Family & Therapies (Division)	FBC – Full Business Case	FNC – Funded Nursing Care
G		

GMS – General Medical Services	GP – General Practitioner	GWICES – Gwent Wide Integrated Community Equipment Service
GUH – Grange University Hospital	GIRFT – Getting it Right First Time	
H		
HCHS – Health Care & Hospital Services	HCSW – Health Care Support Worker	HIV – Human Immunodeficiency Virus
HSDU – Hospital Sterilisation and Disinfection Unit	H&WBC – Health and Well-Being Centre	
I	IMTP – Integrated Medium Term Plan	INNU – Interventions not normally undertaken
IPTR – Individual Patient Treatment Referral	I&E – Income & Expenditure	ICF – Integrated Care Fund
L		
LoS – Length of Stay	LTA – Long Term Agreement	LD – Learning Disabilities
M		
MH **–** Mental Health	MSK - Musculoskeletal	Med – Medicine (Division)
MCA – Mental Capacity Act		
N		
NCN – Neighbourhood Care Network	NCSO – No Cheaper Stock Obtainable	NICE – National Institute for Clinical Excellence
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
ODTC – Optometric Diagnostic and Treatment Centre		
P		
PAR – Prescribing Audit Report	PCN – Primary Care Networks (Primary Care Division)	PER – Prescribing Incentive Scheme
PICU – Psychiatric Intensive Care Unit	PrEP – Pre-exposure prophylaxis	PSNC –Pharmaceutical Services Negotiating Committee
PSPP – Public Sector Payment Policy	PCR – Patient Charges Revenue	PPE – Personal Protective Equipment
PFI – Private Finance Initiative		
R		

RGH – Royal Gwent Hospital	RN – Registered Nursing	RRL – Revenue Resource Limit
RTT – Referral to Treatment	RPB – Regional Partnership Board	RIF – Regional Integration Fund
S		
SCCC – Specialist Critical Care Centre	SCH – Scheduled Care Division	SCP – Service Change Plan (reference IMTP)
SLF – Straight Line Forecast	SpR – Specialist Registrar	
T		
TCS – Transforming Cancer Services (Velindre programme)	T&O – Trauma & Orthopaedics	TAG – Technical Accounting Group
U		
UHB / HB – University Health Board / Health Board	USC – Unscheduled Care (Division)	UC – Urgent Care (Division)
ULP – Underlying Financial Position		
V		
VCCC – Velindre Cancer Care Centre		
W		
WET AMD – Wet age-related macular degeneration	WG – Welsh Government	WHC – Welsh Health Circular
WHSSC – Welsh Health Specialised Services Committee	WLI – Waiting List Initiative	WLIMS – Welsh Laboratory Information Management System
WRP – Welsh Risk Pool		
Y		
YAB – Ysbyty Aneurin Bevan	YTD – Year to date	YYF – Ysbyty Ystrad Fawr

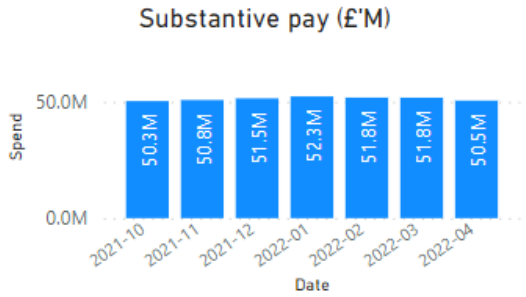
Aneurin Bevan University Health Board

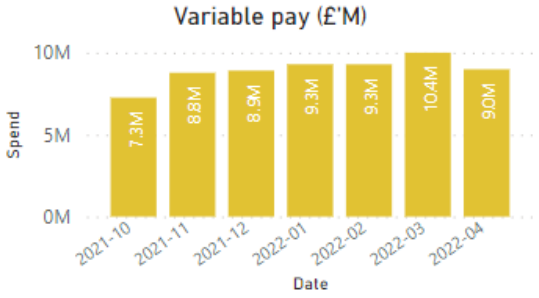
Finance Report – April (Month 1) 2022/23

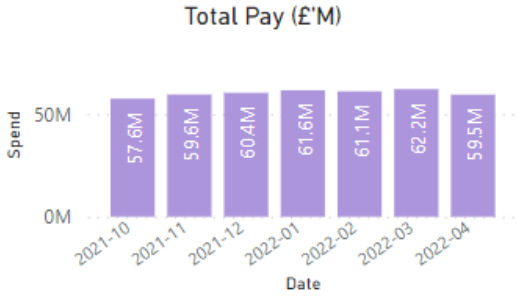
Appendices

Pay Summary 1
Pay Summary 2 Substantive Pay
Pay Summary 3 Variable Pay
Non Pay Summary
RTT & Waiting List Initiatives
Covid-19 Funding Assumptions & Delegation
Savings
Reserves
Cash / Public Sector Payment Policy
External Contracts – LTA's
External Contracts – Specialised Services
Balance Sheet
Health Board Income
Capital Planning & Performance

Pay Summary (1) (subject to change excluding annual leave and Pension employer costs):







Substantive (£'000)

Pay category	22-P07	22-P08	22-P09	22-P10	22-P11	22-P12	23-P01	Change	%	Avg 20/21
ADD PROF SCIENTIFIC AND TECHNICAL	2,191	2,226	2,253	2,258	2,497	2,267	1,916	-351	-15.5%	2,137
ADDITIONAL CLINICAL SERVICES	6,410	6,431	6,616	6,922	6,595	6,486	6,352	-134	-2.1%	5,946
ADMINISTRATIVE & CLERICAL	8,251	8,301	8,342	8,948	8,747	8,597	8,593	-5	-0.1%	7,412
ALLIED HEALTH PROFESSIONALS	3,205	3,339	3,287	3,284	3,350	3,311	3,558	247	7.5%	2,997
ESTATES AND ANCILLIARY	2,511	2,572	2,600	2,805	2,631	2,758	2,529	-228	-8.3%	2,516
HEALTHCARE SCIENTISTS	1,106	996	972	975	961	1,011	977	-35	-3.4%	956
MEDICAL AND DENTAL	11,817	11,845	11,866	11,801	11,879	12,910	12,059	-851	-6.6%	10,780
NURSING AND MIDWIFERY REGISTERED	14,827	15,075	15,538	15,329	15,143	14,426	14,523	97	0.7%	13,932
STUDENTS	2	2	2	2	3	6	6	0	6.2%	218
Total	**50,321**	**50,786**	**51,478**	**52,324**	**51,805**	**51,771**	**50,512**	**-1,259**	**-2.4%**	**46,894**

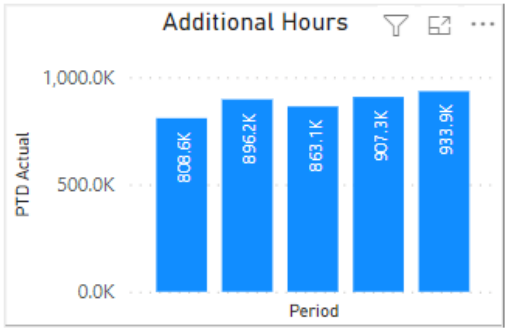
Variable pay (£'000)

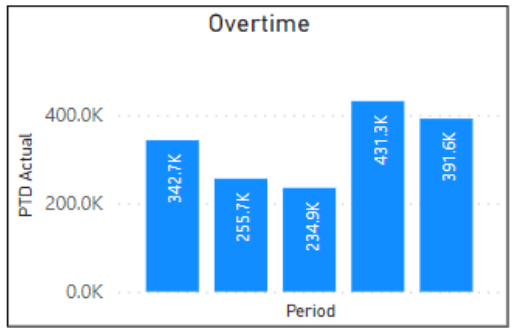
Pay category	22-P07	22-P08	22-P09	22-P10	22-P11	22-P12	23-P01	Change	%	Avg 20/21
Agency	4,232	5,674	5,594	5,711	5,395	5,958	5,301	-657	-11.0%	3,385
Bank	2,828	2,987	3,155	3,359	3,667	4,203	3,458	-744	-17.7%	2,072
Locum	199	115	158	221	227	229	226	-2	-1.0%	163
Total	**7,259**	**8,775**	**8,907**	**9,292**	**9,289**	**10,389**	**8,986**	**-1,404**	**-13.5%**	**5,620**

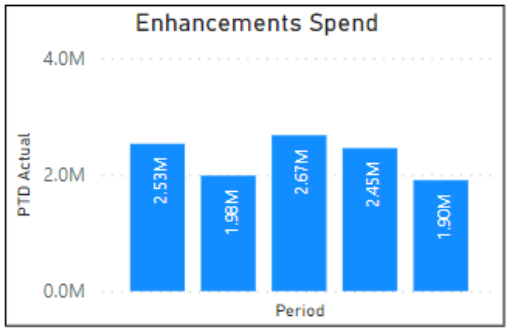
Total pay (£'000)

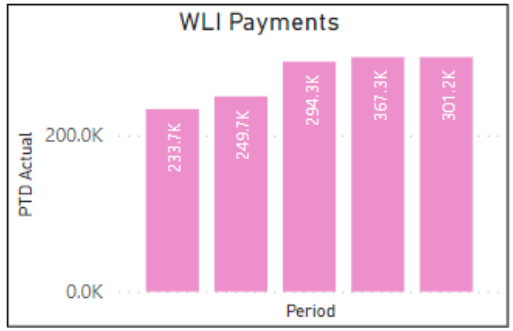
Pay category	22-P07	22-P08	22-P09	22-P10	22-P11	22-P12	23-P01	Change	%	Avg 20/21
Pay	57,580	59,561	60,385	61,616	61,093	62,160	59,498	-2,662	-4.3%	52,514

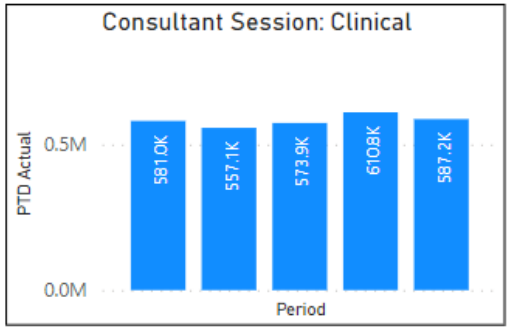
Pay Summary (2): Substantive Pay

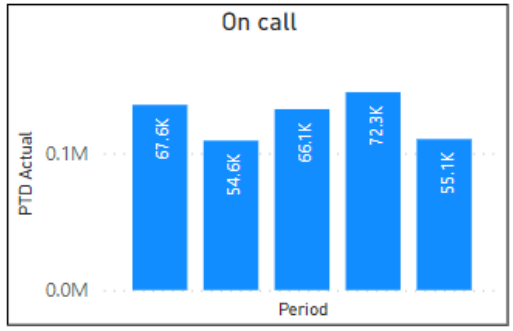










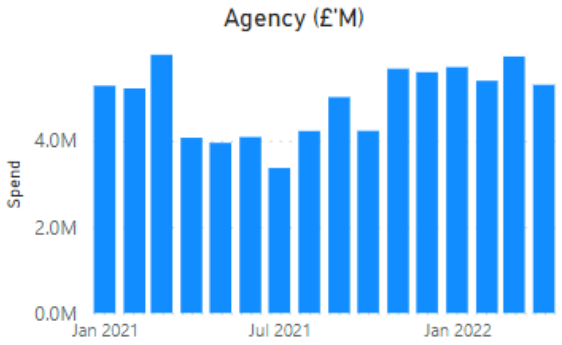


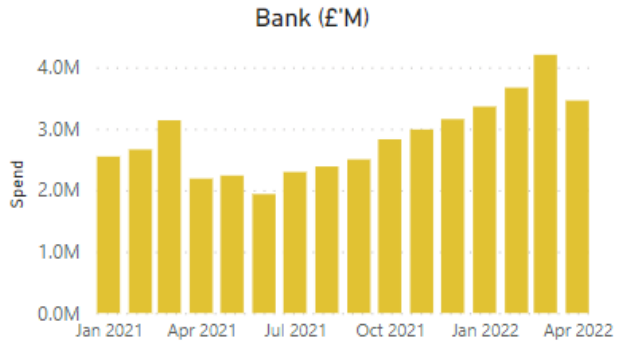
Analysis type by Division

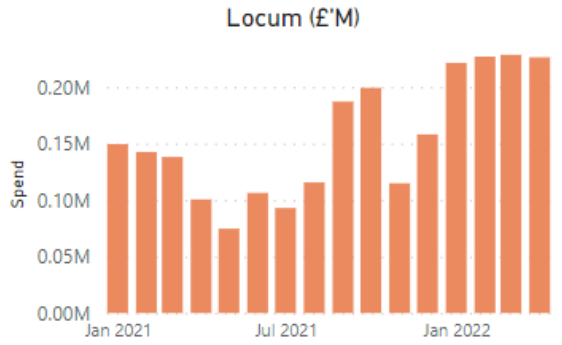
Analysis type	22-P09	22-P10	22-P11	22-P12	23-P01	Total
Enhancements						
Scheduled Care	512	388	511	491	373	**2,275**
Medicine	398	312	425	386	294	**1,814**
Estates and Facilities	352	289	381	358	284	**1,664**
Primary Care & Community	314	243	369	303	244	**1,473**
Family & Therapies	329	254	321	319	247	**1,470**
Mental Health	207	166	226	203	156	**958**
Urgent Care	201	157	225	190	152	**924**
CHC/FNC	116	89	116	111	82	**514**
Corporate	100	86	100	92	72	**450**
Total	**2,529**	**1,982**	**2,674**	**2,454**	**1,903**	**11,542**
ADDITIONAL HOURS						
Scheduled Care	284	313	273	376	306	**1,551**
Medicine	236	238	237	223	294	**1,227**
Urgent Care	138	196	196	150	216	**896**
Family & Therapies	115	116	138	133	121	**623**
Primary Care & Community	7	12	7	16	3	**45**
Mental Health	14	15	6	2	8	**44**
Corporate	15	7	6	7	-14	**22**
Total	**809**	**896**	**863**	**907**	**934**	**4,409**
CONSULTANTS SESSION: CLINICAL	**581**	**557**	**574**	**611**	**587**	**2,910**
Overtime	**343**	**256**	**235**	**431**	**392**	**1,656**
WAITING LIST PAYMENTS: CONSULTANTS	**234**	**250**	**294**	**367**	**301**	**1,446**
ON CALL	**68**	**55**	**66**	**72**	**55**	**316**
Total	**4,563**	**3,996**	**4,706**	**4,843**	**4,172**	**22,280**

Pay Summary (3): Variable Pay

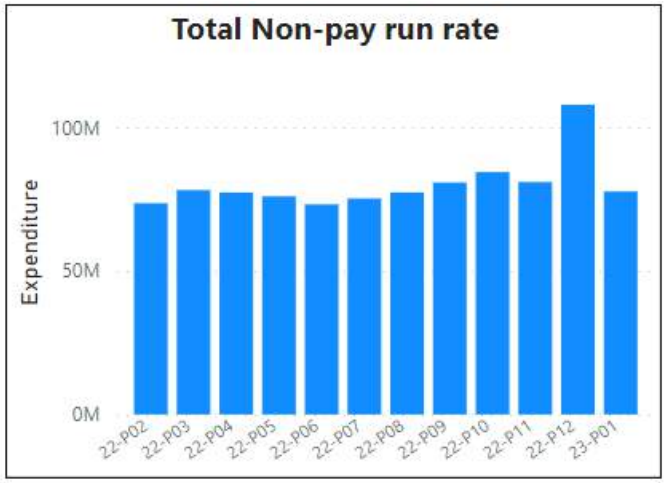
Pay category	21-P10	21-P11	21-P12	22-P01	22-P02	22-P03	22-P04	22-P05	22-P06	22-P07	22-P08	22-P09	22-P10	22-P11	22-P12	23-P01	Change	%
Agency																		
Admin & Clerical Agency	189	301	386	183	227	222	128	208	82	182	115	191	243	237	412	148	-264	-64.0%
Allied Health Prof Agency	104	108	186	45	3	-31	76	91	124	88	104	172	144	155	213	108	-105	-49.2%
Estates & Ancilliary Agency	1,160	937	1,417	585	726	643	483	465	717	422	428	807	474	44	544	413	-131	-24.1%
Medical Agency	1,093	923	1,085	866	1,043	1,027	531	1,272	1,238	1,318	1,920	1,704	1,278	1,688	1,693	1,448	-245	-14.5%
Nurse HCA/HCSW Agency	151	97	162	166	261	358	611	590	756	729	880	67	917	951	1,020	1,101	81	7.9%
Other Agency	170	84	142	89	114	110	71	59	92	103	128	114	180	170	390	-1	-390	-100.2%
Registered Nurse Agency	2,412	2,767	2,620	2,138	1,579	1,759	1,469	1,544	2,006	1,390	2,100	2,540	2,475	2,148	1,687	2,084	397	23.5%
Total	**5,279**	**5,217**	**5,998**	**4,070**	**3,953**	**4,088**	**3,369**	**4,228**	**5,015**	**4,232**	**5,674**	**5,594**	**5,711**	**5,395**	**5,958**	**5,301**	**-657**	**-11.0%**
Bank																		
Admin & Clerical Bank	116	121	166	98	97	132	129	120	111	134	111	108	131	102	117	104	-13	-10.8%
Estates & Ancilliary Bank	120	113	138	86	80	89	119	142	145	154	146	148	153	142	173	159	-14	-7.8%
Nurse HCA/HCSW Bank	1,058	1,064	1,250	972	1,013	812	1,005	1,079	1,102	1,185	1,114	1,193	1,217	1,397	1,427	1,276	-151	-10.6%
Other Bank	0	-1	2	1	1	0	-2	2	-1	0	0	0	0	0	0	0	0	-285.2%
Registered Nurse Bank	1,253	1,365	1,581	1,031	1,046	903	1,044	1,043	1,144	1,355	1,616	1,706	1,858	2,026	2,486	1,919	-567	-22.8%
Total	**2,547**	**2,661**	**3,137**	**2,188**	**2,238**	**1,936**	**2,295**	**2,386**	**2,500**	**2,828**	**2,987**	**3,155**	**3,359**	**3,667**	**4,203**	**3,458**	**-744**	**-17.7%**
Locum																		
Medical Locum	150	143	138	101	75	106	93	116	187	199	115	158	221	227	229	226	-2	-1.0%
Total	**150**	**143**	**138**	**101**	**75**	**106**	**93**	**116**	**187**	**199**	**115**	**158**	**221**	**227**	**229**	**226**	**-2**	**-1.0%**
Total	**7,976**	**8,021**	**9,273**	**6,359**	**6,265**	**6,130**	**5,757**	**6,729**	**7,702**	**7,259**	**8,775**	**8,907**	**9,292**	**9,289**	**10,389**	**8,986**	**-1,404**	**-13.5%**

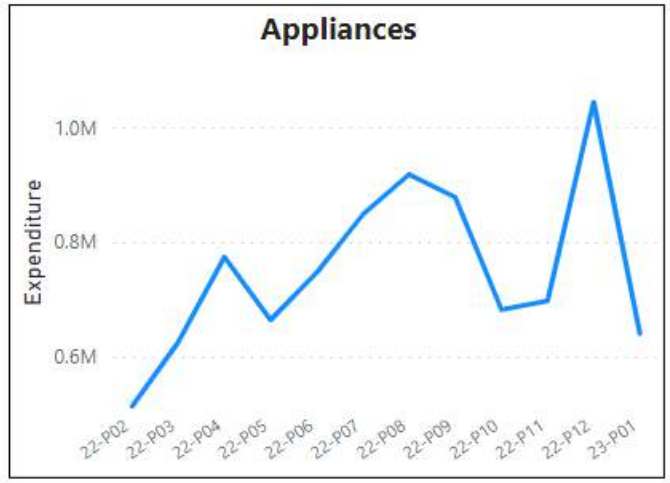


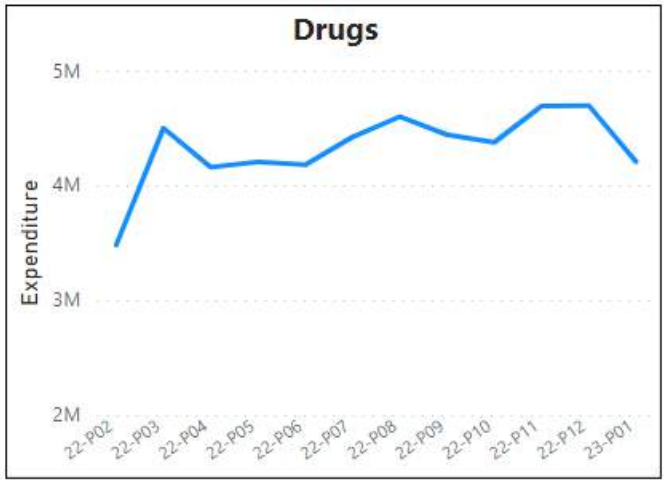


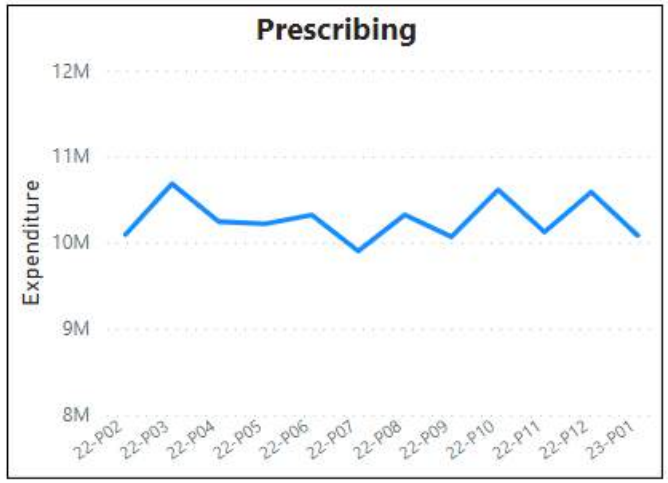


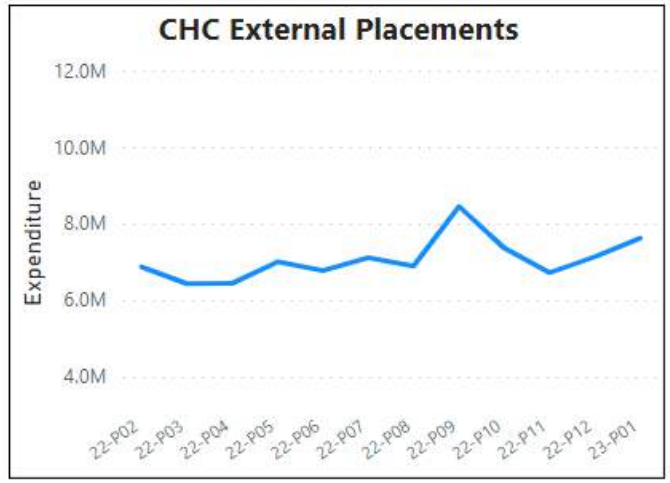
Non-Pay Summary:











Referral to Treatment (RTT):

Elective activity has significantly reduced as part of the Health Board's Covid-19 planned response. Whilst some routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

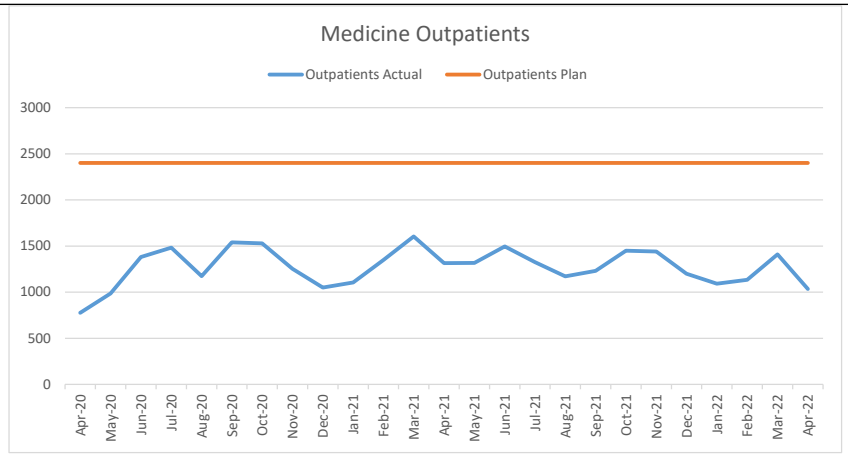
- Elective Treatments for April '22 were 1,647.

Directorates	Plan	Actual	Variance in Activity (Cases)				
			Core	Backfill	WLI	Other	Total
Derm	175	136	(49)	0	10	0	**(39)**
ENT	169	81	(50)	0	(38)	0	**(88)**
GS	363	306	(66)	13	(4)	0	**(57)**
Max Fax	187	151	0	(12)	(24)	0	**(36)**
Ophth	376	212	(147)	(11)	(6)	0	**(164)**
Rheum	0	0	0	0	0	0	**0**
T&O	506	368	2	(46)	(94)	0	**(138)**
Urology	511	393	(122)	(4)	8	0	**(118)**
Total	**2,287**	**1,647**	**(432)**	**(60)**	**(148)**	**0**	**(640)**

- Outpatient activity for March '22 was 5,491.

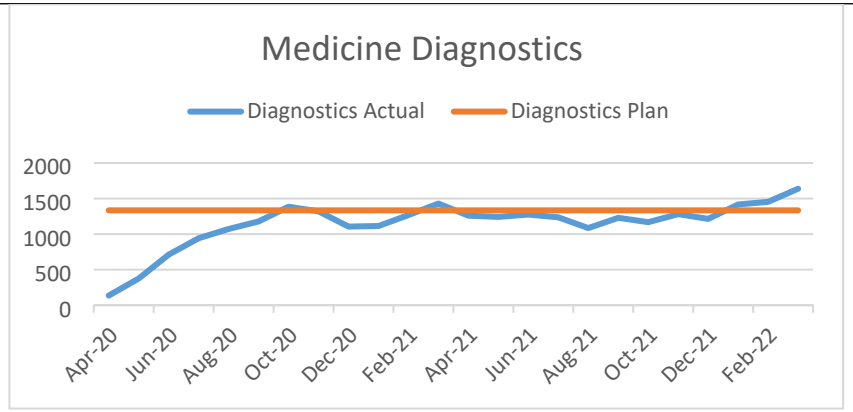
Plan	Actual	Variance in Activity (Cases)				
		Core	Backfill	WLI	Other	Total
1,123	1,551	464	0	(36)	0	**428**
423	397	(26)	0	0	0	**(26)**
1,277	1,240	16	(50)	(3)	0	**(37)**
241	344	113	0	(10)	0	**103**
1,080	491	(539)	10	(60)	0	**(589)**
136	106	(30)	0	0	0	**(30)**
1,002	988	(78)	(68)	132	0	**(14)**
483	374	(116)	0	7	0	**(109)**
5,765	**5,491**	**(196)**	**(108)**	**30**	**0**	**(274)**

- Medicine Outpatients activity for April '22 was 1,035:



	Assumed monthly activity	Actual activity	Variance	Variance
Gastroenterology	510	198	-312	61%
Cardiology	553	140	-413	75%
Respiratory (inc Sleep)	606	232	-374	62%
Neurology	259	193	-66	25%
Endocrinology	242	121	-121	50%
Geriatric Medicine	231	151	-80	35%
Total	**2401**	**1035**	**-1366**	**57%**

- Medicine Diagnostics activity for March '22 was 1,460:



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YTD April 22	Assumed monthly activity	Actual activity	Variance	Variance
Endoscopy	1334	1460	126	-9%
Total	**1334**	**1460**	**126**	**-9%**

Waiting List Initiatives:

Medicine have spent £81k in April 22:

- Gastroenterology (£60k)
- Cardiology (£21k)

Scheduled Care Division have spent £182k in April:

- Radiology (£94k)
- Pathology (£16k)
- Ophthalmology (£2k)
- Trauma & Orthopaedics (£46k)
- General Surgery (£10k)
- Urology (£8k)
- Dermatology (£4k)
- Oral Surgery (£2k)

Family & Therapies Division have spent £31k, Gynaecology Medical Staffing (£18k), CAHMS (£11k) and Sexual Health (2k).
Mental Health have spent £7k.

Covid-19 and Exceptional items Funding Assumptions

The Health Board has anticipated WG funding for Covid-19 as listed below;

Type	Covid-19 Specific allocations - April 2022	£'000
HCHS	Testing (inc Community Testing)	6,508
HCHS	Tracing	6,000
HCHS	Mass COVID-19 Vaccination	9,000
HCHS	PPE	3,654
HCHS	Cleaning standards	3,900
HCHS	Long Covid	887
HCHS	Local transitional costs	43,276
HCHS	Nosocomial investigation and learning	753
	Total Covid-19 Allocations (anticipated)	**73,978**

Type	Exceptional items allocations - April 2022	£'000
HCHS	Energy prices increase	12,500
HCHS	Employers NI increase	4,606
HCHS	Real living wage	2,812
	Total Exceptional items allocations (anticipated)	**19,918**

Covid-19 Funding & Delegation

The HB has anticipated Covid funding totalling £74m. The UHB has anticipated funding of £20m for exceptional items listed in the WG letter dated 14th March.

Only funding for National Programmes has been delegated at this stage.

Savings

Division	Scheme / Opportunity	Recurrent / Non Recurrent	Current Year Forecast	Forecast FYE
Commissioning	GUH OOA cost reduction	R	0	0
Complex Care	Reduction of RN Agency (RJ)	R	250	250
Corporate	Workforce and OD	NR	3,657	0
Corporate	Workforce variable pay	R	214	214
Corporate	R&D savings	R	200	200
Corporate	Non-recurrent opportunities	NR	2,047	0
Estates and Facilities	Minor works	NR	138	0
Estates and Facilities	Agency (non-contract)	NR	268	0
Estates and Facilities	Park Square car park	NR	94	0
Estates and Facilities	Agile working related opportunities	NR	100	0
Estates and Facilities	Workforce variable pay	R	347	347
Family & Therapies	Family & Therapies non-pay	NR	652	0
Family & Therapies	MSK	R	250	250
Family & Therapies	Workforce variable pay	R	300	300
Medicine	Medicine non-pay	NR	486	0
Medicine	Medical staffing roster	R	0	0
Medicine	LoS bed reduction - GUH plan	R	0	0
Medicine	Workforce variable pay	R	0	0
Medicine	Endoscopy Backfill Cost Reduction	R	100	100
Medicine	Retinue Savings	NR	8	0
Mental Health and Learning Disabilities	Workforce variable pay	R	378	378
Primary Care and Community	Workforce variable pay	R	646	646
Primary Care and Community	Prescribing support dieticians (Prescribing)	R	100	100
Primary Care and Community	Waste reduction scheme (Prescribing)	R	168	168
Primary Care and Community	Pharmacy led savings (Prescribing)	R	50	50
Primary Care and Community	Scriptswitch (acute) (Prescribing)	R	180	180
Primary Care and Community	Scriptswitch (repeat) (Prescribing)	R	390	390
Primary Care and Community	Darifenacin to Solifenacin switch	R	80	80
Primary Care and Community	Respiratory Inhaler Switches	R	349	349
Primary Care and Community	Rebate - total (Prescribing)	R	1,000	1,000
Scheduled Care	Anaesthetics-POCU temporary staffing	NR	180	0
Scheduled Care	Scheduled Care non-pay	NR	500	0
Scheduled Care	Vascular mitigation opportunity	R	1,150	1,150
Scheduled Care	Theatres overall opportunity	R	3,949	3,949
Scheduled Care	GUH Theatre establishment	R	419	419
Scheduled Care	Eye Care / Cataracts	R	500	500
Scheduled Care	Medical staffing roster	R	140	140
Scheduled Care	Enhanced Care	R	1,107	1,107
Scheduled Care	SACU / POCU	R	77	77
Scheduled Care	LoS bed reduction - Scheduled Care / Family	R	864	864
Scheduled Care	Outpatient transformation (DNA & Follow-up)	R	2,394	2,394
Scheduled Care	Workforce variable pay	R	571	571
Scheduled Care	Antibiotic savings	R	0	0
Scheduled Care	Lenalidomide Price Reduction	R	944	944
Scheduled Care	Bortezomib rationalisation	R	70	70
Urgent Care	Medical staffing roster	R	141	141
Urgent Care	SDEC / Ambulatory Care	R	774	774
Urgent Care	Retinue	NR	6	0
			26,238	18,102

Reserves

7769-ALLOCATIONS TO BE DELEGATED

Confirmed or Anticipated	R / NR	Description	22/23
Anticipated	NR	Mental Health Service Improvement funding 22-23	4,050,000
Anticipated	NR	C19 Response-Cleaning Standards	3,900,000
Anticipated	NR	C19 Response-Increased bed capacity	3,177,000
Anticipated	NR	C19 Response-Other Capacity & facilities costs	11,433,000
Anticipated	NR	C19 Response-Increased workforce costs	6,262,000
Anticipated	NR	C19 Response-Discharge Support	11,242,000
Anticipated	NR	C19 Response-Other Services that support the ongoing COVID response	9,581,000
Anticipated	NR	C19 Response-Other	1,581,000
Anticipated	NR	Exceptional-Incremental National Insurance	4,606,000
Anticipated	NR	Exceptional-Incremenntal Real Living Wage	2,812,000
Anticipated	NR	Exceptional-Increase in Energy Costs (net of baseline costs)	12,500,000
Anticipated	NR	C19 National-Covid PPE	3,654,000
Anticipated	NR	C19 National-Covid Testing	6,508,000
Anticipated	NR	Urgent Primary Care	1,400,000
Anticipated	NR	Primary Care 111 service	623,000
Anticipated	NR	End of Life Care Board	112,000
		Confirmed Allocations to be apportioned	**83,441,000**

7788-COMMITMENTS TO BE DELEGATED

Description	22/23
Wales Cancer Network support and SLAs	273,421
Lympedema Network SLAs	46,508
Value Based Recovery balance	1,083,000
Vascular Centralisation commitment	387,500
Neurology repatriation reserve	37,735
Powys income reduction commitment	972,000
Other (NCN provision/B1 and B2 enhancement alloc, VERS budget recovery)	788,237
Total Commitments	**3,588,401**

Reserves Delegation:

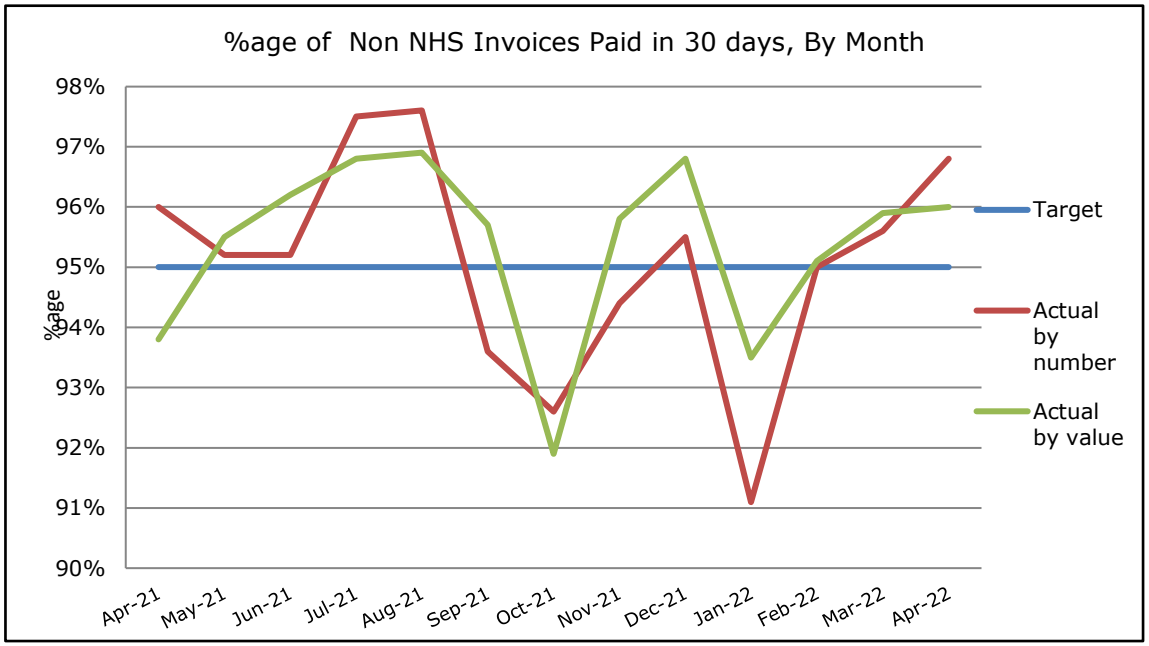
As at month 1, anticipated allocations are being held to be delegated namely for Covid-19, exceptional items, mental health and other primary care elements. Other commited reserves are held which are due to be delegated once values and plans are finalised.

Cash Position

- The year end cash balance at the 30th April is £2.447m, which is below the advisory figure set by Welsh Government of £6m.

Public Sector Payment Policy (PSPP)

- This month the HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods both in month & cumulatively for 2021/22. This achievement has continued into 2022/23.

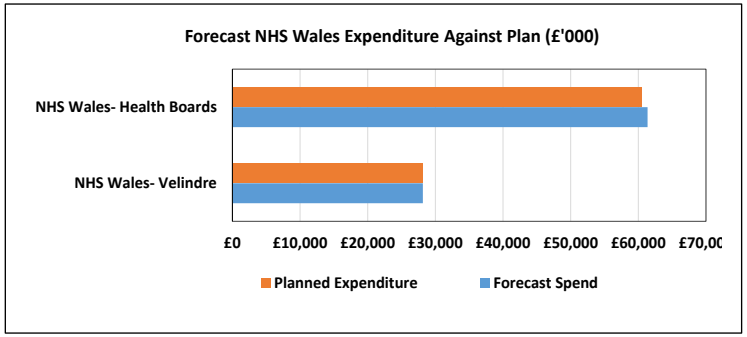


Contracting & Commissioning – LTA Spend & Income

Month/Financial Year:- Month 1 (April) 2022-23

At Month 1 the financial performance for Contracting and Commissioning is a YTD favourable variance of £12k.

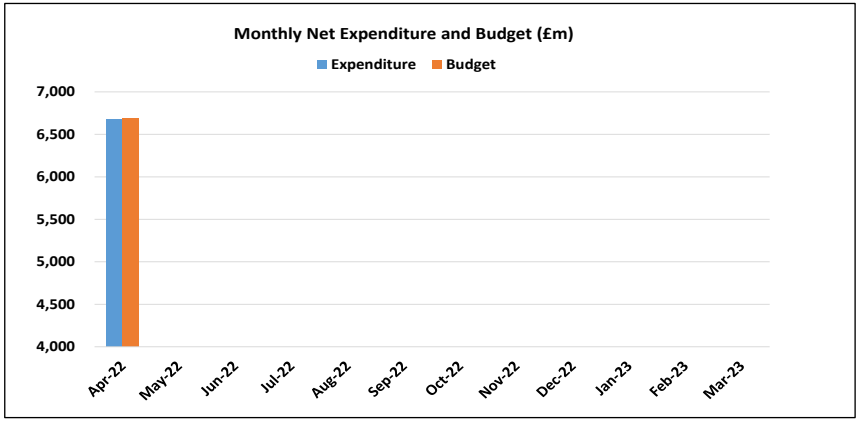
The key elements contributing to this position at Month 1 are as follows:

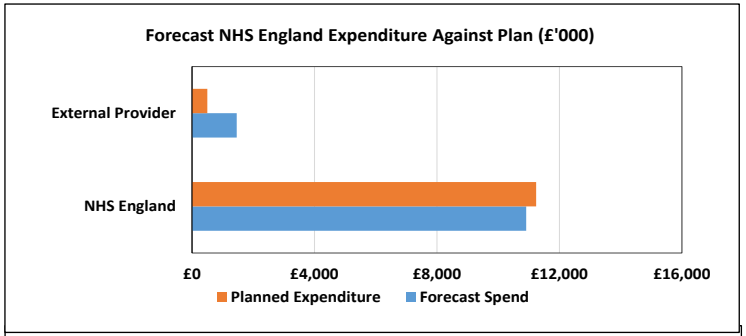


NHS Wales Expenditure

Contract Expenditure with NHS Wales has moved away from block agreements in 2022-23.

There is a cost pressure expected due to increased NICE drug expenditure

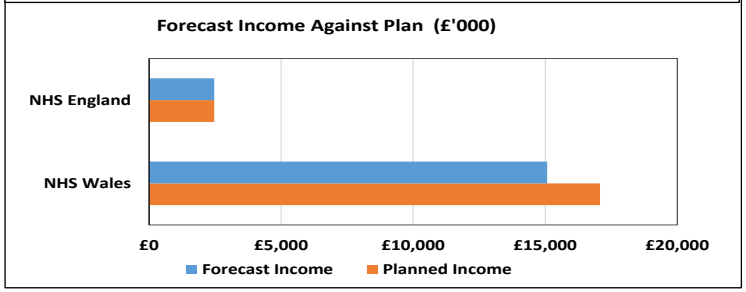




NHS England Expenditure

Contract Expenditure with NHS England organisations is expected to move away from Block agreements in 2022-23

There is a risk of increased expenditure if English providers deliver additional activity



Provider Income

There is a c£2m cost pressure expected from the reduced activity being delivered for Powys LHB following the opening of the GUH hospital.

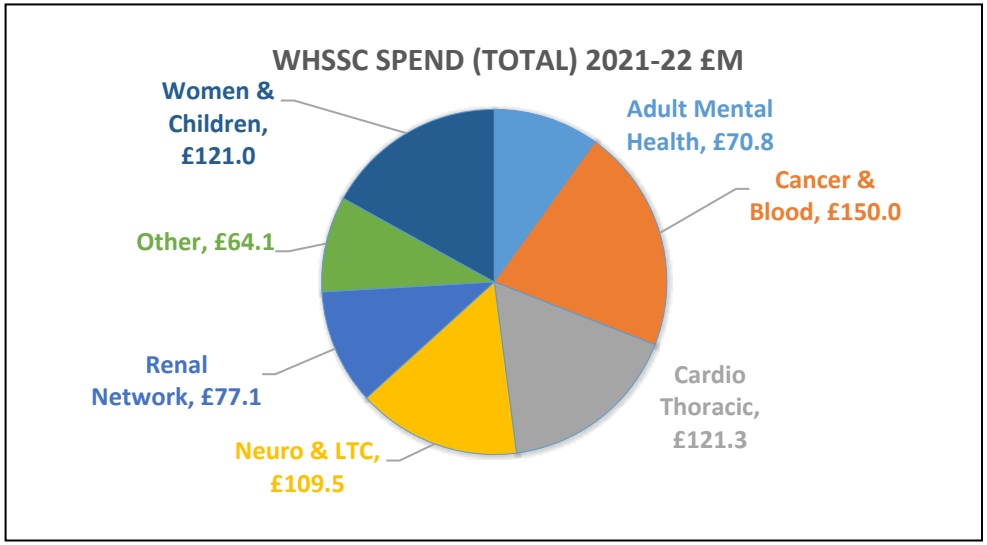
Key Issues 2022-23

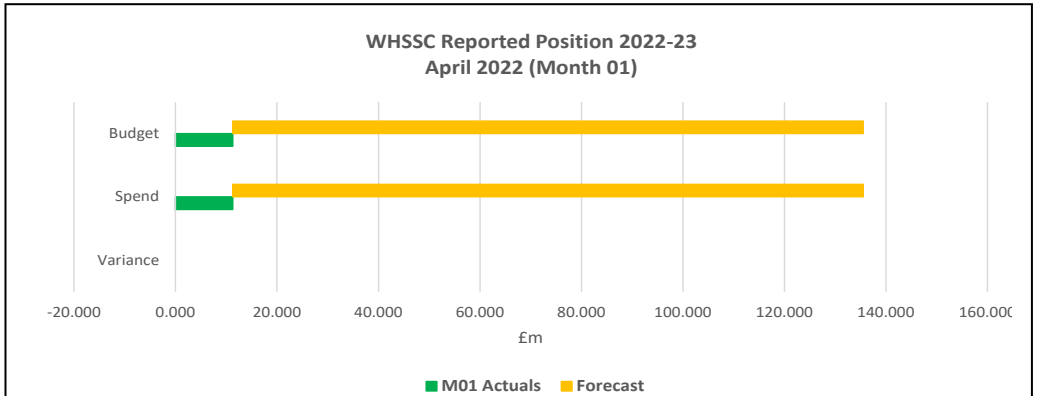
- All LTAs are required to be signed by the Welsh Government deadline of 30th June 2022. ABUHB have sent documents and updated schedules to all other Health Boards for review and agreement
- The nationally agreed inflationary uplift of 2.8% and the impact of the 21-22 NHS Pay Award has been funded and is reflected in the above position
- Directors of Finance have agreed a contract mechanism within Wales to 'block' non admitted patient care charges based on 2019/20 and to apply a 10% 'tolerance' to admitted patient care to reduce volatility in the contracting position. Enhanced rates will be available for recovery/increased activity.
- NICE costs continue to operate on a pass-through basis and there is a c£700k recurrent pressure vs budget for NICE and High-Cost Drug charges from Cardiff and Cwm Taf
- There is a **c£2m cost pressure** expected from the reduced activity being delivered for Powys LHB following the opening of the GUH hospital. There is a c£1m contract for activity with St Joseph's hospital to support endoscopy and MRI.

WHSSC & EASC Financial Position 2022-23

Period: Month 01 2022-23

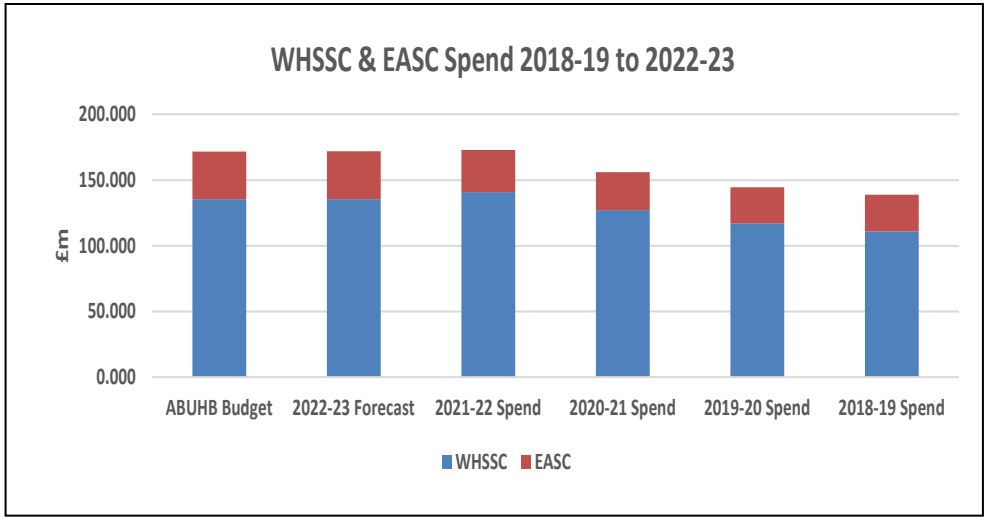
The Month 01 financial performance for WHSSC & EASC is a YTD overspend of £25k. The Month 01 position reflects the agreed IMTP & LTA agreements with providers.

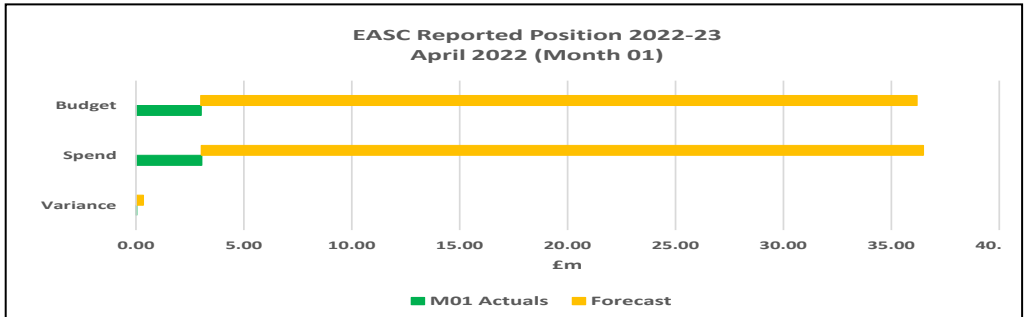




Key Variances

- The WHSSC outturn position reflects the 2022-23 WHSSC IMTP agreed by Chief Executives at the WHSSC Joint Committee





Key Variances

- The EASC outturn position reflects the 2022-23 EASC IMTP agreed by Chief Executives at the EASC Joint Committee.
- **The variance reflects the HB's contribution share of £1.8m non recurring support to Welsh Ambulance Services Trust in 2022-23 to support ongoing recruitment and service**

Balance Sheet

Balance sheet as at 30th April 2022	2022/23 Opening balance £000s	30th April 2022 £000s	Movement £000s
Fixed Assets	810,479	808,232	-2,247
Other Non current assets	131,429	132,897	1,468
Current Assets			
Inventories	8,726	8,376	-350
Trade and other receivables	133,826	131,170	-2,656
Cash	1,720	2,447	727
Non-current assets 'Held for Sale'	0	0	0
Total Current Assets	144,272	141,993	-2,279
Liabilities			
Trade and other payables	227,018	206,640	-20,378
Provisions	195,707	209,187	13,480
	422,725	415,827	-6,898
	663,455	**667,295**	**3,840**
Financed by:-			
General Fund	530,429	534,269	3,840
Revaluation Reserve	133,026	133,026	0
	663,455	**667,295**	**3,840**

Note:- The balance sheet is subject to change and audit review so is currently in draft only.

Other Non-Current Assets:
- This relates to an increase in Welsh Risk Pool claims due in more than one year £1.7m and a decrease in intangible assets £0.2m since the end of 2021/22.

Current Assets, Inventories:
- The decrease in year relates to changes in stock held within the divisions.

Current Assets, Trade & Other Receivables:
The main movements since the end of 2021/22 relate to:
- An increase in the value of debts outstanding on the Accounts Receivable system since 2021/22 to the end of April £5.7m. A decrease in the value of both NHS & Non-NHS accruals of £9.7m, of which £2.4m relates to an increase of Welsh Risk Pool claims due in less than one year and £12.1m relates to a decrease in NHS & Non-NHS accruals since the end of 2021/22.
- An increase in the value of prepayments held of £1.3m.

Cash:
- The cash balance held in month 1 is £2.447m.

Liabilities, Provisions:
- Due to the increase in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £13.5m.

General Fund:
- This represents the difference in the year-to-date resource allocation budget and actual cash draw down including capital.

Health Board Income
WG Funding Allocations: £1.6bn

Confirmed Allocations as at April 2022 (M1 2021/22)

	£'000
HCHS	1,253,991
GMS	102,026
Pharmacy	32,831
Dental	30,941
Total Confirmed Allocations - April 2022	**1,419,789**
Plus Anticipated Allocation - April 2022	**158,907**
Total Allocations - April 2022	**1,578,696**

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 £104m. The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Funding (allocations & income) for the UHB totalled £1.7bn for 22/23.

	RESOURCE LIMIT ITEMS				Resource Limit
	HCHS £'000	Pharmacy £'000	Dental £'000	GMS £'000	£'000
2. ANTICIPATED ALLOCATIONS					
DEL Non Cash Depreciation - Baseline Surplus / Shortfall	1,065				**1,065**
DEL Non Cash Depreciation - Strategic	20,892				**20,892**
DEL Non Cash Depreciation - Accelerated	400				**400**
DEL Non Cash Depreciation - Impairment	18,040				**18,040**
AME Non Cash Depreciation - Donated Assets	342				**342**
Total COVID-19 (see below analysis)	73,978	0	0	0	**73,978**
Energy (Price Increase)	12,500				**12,500**
Employers NI Increase (1.25%)	4,606				**4,606**
Real Living Wage	2,812				**2,812**
(Provider) Substance Misuse & increase	3,184				**3,184**
(Provider) SPR's	112				**112**
(Provider) Clinical Excellence Awards (CDA's)	298				**298**
CAMHS In Reach Funding	257				**257**
Technology Enabled Care National Programme (ETTF)	1,805				**1,805**
Informatics - Virtual Consultations	2,813				**2,813**
I2S DHR Phase 2 (£143k) & Omnicell (£425k)	(568)				**(568)**
Carers Funding	191				**191**
National Nursing Lead Community & Primary Care	53				**53**
National Clinical Lead for Falls & Frailty (£26k) & Primary & Comty Care (£113	139				**139**
National Allied Health Professional (AHP) Lead for Primary and Community Care	85				**85**
Accelerated cluster development programme	200				**200**
AHW:Prevention & Early Years allocation 20/21	1,171				**1,171**
Healthy Weight-Obesity Pathway funding 21-22	550				**550**
Community Infrastructure Programme	180				**180**
C19 Support for Post Anaesthetic Critical Care Units (PACU)	904				**904**
WHSSC - National Specialist CAMHS improvements	139				**139**
Same Day Emergency Care (SDEC)	1,500				**1,500**
PSA Self-management Programme (Phase 1 & 2)	114				**114**
OP Transformation-Dermatology Specialist Advice and study day	26				**26**
Digital Priority investment fund (DPIF)	500				**500**
Strategic Primary Care - additional posts	113				**113**
Learning Disabilities-Improving Lives	64				**64**
Nurse Operation lead pump-prime funding 22-23 (18mths)	68				**68**
WHSSC All Wales Traumatic Stress Quality Imprmt (ANEHFS 13 21/22)	159				**159**
Children & Young People MH & Emotional Wellbeing (ANEHFS 16 21/22)	200				**200**
CAMHS in-reach funding (ANEHFS 17 21/22)	521				**521**
Support all age Mental Health - Tier 0/1 provision (ANEHFS 22 21/22)	200				**200**
Memory Assessment Services - Gwent RPB (ANEHFS 37 21/22)	565				**565**
EASC/WAST Improvements in MH Emergency Calls (ANEHFS 54 21/22)	51				**51**
WHSSC - Impl of National Specialist CAMHS Improv. (ANEHFS 90 21/22)	131				**131**
Additional R&D pay uplift 1pct (ANEHFS 98 21/22) & NHS Pay enhancement Band 1 t	168				**168**
Mental Health - additional resources 22-23	4,050				**4,050**
GMS Refresh				1,603	**1,603**
Primary Care Improvement Grant				142	**142**
Agreement for Pay and Expenses 21-22 (not in Alloc letter - ANEHFS 10 21/22)				2,208	**2,208**
GMS - Pay and expenses updated for changes to list sizes				50	**50**
Dental patient charges target reduction 22-23			2,308		**2,308**
Welsh Risk Pool	(4,118)				**(4,118)**
Other – see separate table in commentary	2,135				**2,135**
Total Anticipated Funding	**152,596**	**0**	**2,308**	**4,003**	**158,907**

Capital Planning & Performance

The approved Capital Resource Limit (CRL) as at Month 1 totals £31.383m. In addition, the Health Board has received funding approval letters for Newport East H&WBC (£9.229m) and Grange University Additional works to Resus and CAEU (£1.1m). These approvals are in the process of being signed and will be added to the CRL in May. The current forecast outturn is breakeven.

The remaining works to the Same Day Emergency Care Unit, Resus, CAEU and Grange House are progressing from the remaining Grange University Hospital funding. All Laing O'Rourke works are due to complete by the middle of September. The additional works costs are being offset by the final VAT recovery claim due in the last quarter of 2022/23.

The YYF Breast Centralisation Unit approval was received in March 2022. Works are due to commence on site in the last week of May. The Full Business Case (FBC) for Newport East Health and Well-being Centre has been approved and a funding letter has been received. Preparations are underway to progress the land purchase from Newport City Council and commence construction works.

The Business Case for the proposed Endoscopy Unit at RGH was submitted to Welsh Government in March but final approval is still awaited. The FBC for the NHH Satellite Radiotherapy Centre is near conclusion and expected to be submitted to Board for approval in May. The Outline Business Case for the Mental Health SISU is on-going and expected to be submitted to Board for approval in July 2022.

Summary Capital Plan Month 1 2022/23	2022/23			
	Original Plan £000	Revised Plan £000	Spend to Date £000	Forecast Outturn £000
Source:				
Discretionary Capital:-				
Approved Discretionary Capital Funding Allocation	8,227	8,227		8,227
Less AWCP Brokerage	-1,534	-1,859		-1,859
NBV of Assets Disposed	0	0		0
Total Approved Discretionary Funding	6,693	6,368		6,368
All Wales Capital Programme Funding: -				
AWCP Approved Funding	24,615	25,015		25,015
AWCP Anticipated Funding (GUH ED Works & Newport East H&WBC)	0	10,329		10,329
Total Approved & Anticipated AWCP Funding	24,615	35,344		35,344
Total Capital Funding / Capital Resource Limit (CRL)	**31,308**	**41,712**		**41,712**
Applications:				
Discretionary Capital:-				
Commitments B/f From 2021/22	1,317	1,492	-29	1,492
Statutory Allocations	576	576	13	576
Divisional Priorities	587	618	0	618
Corporate Priorities	2,182	1,144	44	1,144
Informatics National Priority & Sustainability	1,800	1,800	46	1,800
Remaining DCP Contingency	231	738	0	739
Total Discretionary Capital	**6,693**	**6,368**	**74**	**6,368**
All Wales Capital Programme:-				
Grange University Hospital Remaining works	-1,408	-394	118	-394
Tredegar Health & Wellbeing Centre Development	10,023	9,934	592	9,934
Fees for NHH Satellite Radiotherapy Centre Development	198	257	-28	257
YYF Breast Centralisation Unit	8,989	8,978	-6	8,978
Newport East Health & Wellbeing Centre Development	0	9,287	15	9,287
Fees for MH SISU	258	263	13	263
Covid Recovery Funding	1,400	1,620	467	1,620
National Programme - Imaging	4,700	4,686	0	4,686
Digital Eyecare	0	66	2	66
National Programme - Infrastructure	12	12	0	12
NHH SRU Enabling Works	400	403	112	403
SDEC Equipment	0	79	11	79
ICF Discretionary Fund Schemes	43	153	0	153
Total AWCP Capital	**24,615**	**35,344**	**1,296**	**35,344**
Total Programme Allocation and Expenditure	**31,308**	**41,712**	**1,370**	**41,712**
Forecast Overspend / (Underspend) against Overall Capital Resource Limit				**0**

The second year of the National Imaging Programme funding totals £4.7m for ABUHB. The spend in the current year includes the replacement of two CT Scanners (NHH / RGH) and the installation of three general rooms purchased during 2021/22.

The Health Board Discretionary Capital Programme (DCP) allocation for 2022/23 is £8.227m (a reduction of 24% compared to 2021/22). Final All Wales Capital Programme scheme brokerage for 2021/22 slippage was £1.859m, leaving a balance of £6.638m to address spend in the current financial year. The opening 2022/23 DCP was approved at the March board meeting. Expenditure has now commenced against these schemes. The new approval of £1.1m for remaining works at the Grange University Hospital has reimbursed the Discretionary allocation, however, this has been partly offset by additional discretionary scheme slippage form 2021/22. The unallocated contingency budget as at the end of April is £739k.

Aneurin Bevan University Health Board

Performance Report

Executive Summary

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

Executive Sponsor: Nicola Prygodzicz**,** Director of Planning, Digital and IT and interim Performance

Report Author: Lloyd Bishop, Assistant Director of Performance and Information

Report Received consideration and supported by:

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

Date of the Report: 25th May 2022

Supplementary Papers Attached: Dashboard attached and supplementary graphs

Purpose of the Report

This report provides a high level overview of activity and performance at the end of January 2022, with a focus on delivery against key national targets included in the performance dashboard. The report focuses on the areas of RTT, Diagnostics, Unscheduled care access, Cancer, Stroke care and Mental Health.

Report Narrative

Background and context

The Annual Plan for 2021/22 set out the ambitions and priorities for the organisation and has delivered improvement across the breadth of the agenda despite another challenging 12 months for the organisation.

In 2021/22 the organisation delivered:

✓ Improvements in Urgent Care performance in a challenging climate

✓ Safe surgical zones created to maintain urgent and essential services

✓ Significant improvement for Referral to Treatment Times in context of pandemic challenges across Wales

✓ By February 2022, 95% of over fifty-year-olds had their first dose of the Covid vaccination, 94% their second dose and 86% have had their booster for Covid vaccinations

✓ Urgent Primary Care services established in all Enhanced Local General Hospital (ELGH) sites

✓ New ambulatory services established

✓ Reduced nurse vacancies by 85%

✓ Implemented the Mental Wellbeing Foundation Tier programme including Connect 5, SPACE (development of single point of access for children and young adults) and Melo.

The Annual Plan took a life course approach to setting the organisations priorities and there has been achievements in all areas:

Priority 1- Every Child Has the Best Start in Life
Through the opening of the Grange University Hospital the organisation has achieved greater resilience and sustainability in women and children's services. Despite the challenges of the pandemic preventative programmes in smoking and weight management were continued and vaccination programmes continued to deliver.

Priority 2- Getting it Right for Children and Young Adults
The innovative NEST programme continued building new support programme for young adults. A single point of access (SPACE) has been developed for children and young adult mental health services

Priority 3- Adults in Gwent Live Healthy and Age Well
This report sets out the progress being made in urgent care and planned care to maximise individuals time in the face of continuing demand. New models of care and practice to support individuals waiting have been delivered, such as the new MDT triage model in orthopaedics which has seen 28% of patients referred triaged away from consultant led pathways, getting the right care first time. In Cancer care rapid diagnostic clinics were established to speed up diagnosis of suspected cancer and the further development of Acute Oncology has progressed to the delivery stage.

Priority 4- Older Adults are Supported to Live Well and Independently
Much has been achieved in redesigning services for this age group, new models such as direct access to Community Beds and the piloting of an integrated care ward has supported timelier care. Home First and Discharge to Assess models are in place and greater integrated working in happening across the organisation.

Priority 5- Dying Well as a Part of Life
The Care After Death team have delivered an extraordinary programme of work to ensure the dignity of patients and family members during an extremely challenging year. Innovations such as memory boxes, hand printing and personal journals have been introduced by the team.

These give a flavour of the achievements against the Annual Plan and as the final quarters work and performance is validated a formal report on delivery against the Annual Plan will be provided in July. There is still much to achieve and progress was challenges by further waves of the pandemic but the organisation can be proud of the achievements to date.

This report therefore focuses on the key areas of focus from a performance perspective consistent with the approach taken in 2021/22.

Elective care

The Health Board continues to monitor closely the implementation of the prioritisation framework. Elective activity undertaken is defined by the clinical prioritisation of the patient, rather than a time based approach; this enables timely care for the most urgent patients and clinically led decision making. This will have an impact on RTT waits in some services.

The services continue to embrace new ways of working due to COVID-19, especially within outpatient services, where the focus has been on virtual clinics and reviews and office-based decisions. New outpatient activity increased again in March from January and February but was still below pre-pandemic levels. However, face to face attendances have been more evident over virtual

activity as services are still dealing with the backlog of long wait referrals received before and during the pandemic and are having to ensure the most appropriate use of virtual attendances. Overall, new outpatient activity is now at 90% of pre-pandemic levels with face-to-face new outpatient activity at 80% of pre-pandemic levels. The challenge for the services is to ensure that there is sufficient accommodation across the Health Board to undertake these clinics and to ensure that the clinic capacity is used for face-to-face attendances only and for all virtual activity to be undertaken in non-clinic settings.

The Outpatients Improvement Programme continues to build on the new ways of working and modernisation which was established through necessity after surge 1 of the pandemic. This includes the outpatient improvement measures outlined by the National Planned Care Programme Board, with key targets regarding risk-management of long waiting follow-up patients.

The outpatient programme focuses on driving improvement and change. The key to 'outpatient' sustainability is the ability to modernise its delivery through for example, maximising non- face to face consultations via telephone, video, group consultations, attend anywhere, virtual consultations or assessments and advice only. Embedding new processes such as See on Symptom (SoS) and Patient Initiated Follow-ups (PIFU), streamlining pathways and use of technology. The focus has been on the 52+ week new Outpatient waiting list clinical assessment process which will establish whether long waiting patients still require their appointment along with a clinical assessment. There is a robust process in place which has been underpinned by Welsh Government and which ensures that the patient and referrer are notified if a patient has indicated that they wish to be removed from the waiting list. This process is being rolled out to contact those patients who have been waiting over 36 to 51 weeks. Some other initiatives include determining where future services can be delivered, a communication strategy to keep in touch with patients who are on Health Board waiting lists, exploring new ways of working through technology, for example, a specialist advice system and roll out of video group consultations and the use of alternate staff groups whilst ensuring that there are close working links between Primary, Community and Secondary Care. The benefits of the programme will be an outpatient service that is designed around the needs of the patient, that access to services is timely and that patients are fully engaged in their treatment, promoting a culture of self-help.

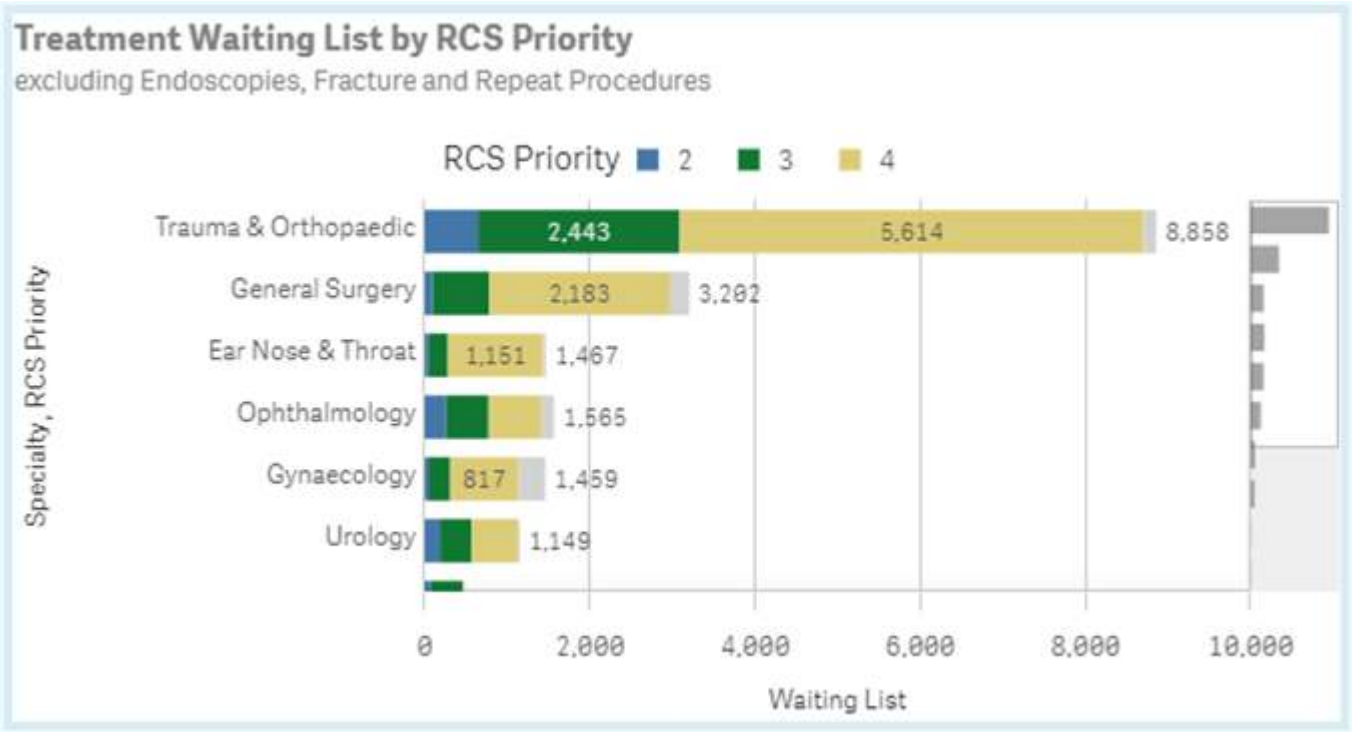
Operational divisions and support teams have worked collaboratively to restart services wherever possible, embracing new ways of working to maximise capacity and treat those at greatest risk. The Elective treatment plans are evolving with capacity continuing to improve..

Elective inpatient admissions had been increasing but remain at a lower level than pre-COVID-19. The steady increase in elective inpatient admissions stalled slightly in January and February due to the impact of the Omicron variant of COVID-19 The number of elective inpatient admissions have since increased in March to the highest level since the pandemic began, elective inpatient admission activity for March represented 72% of pre-pandemic levels. Daycase activity also increased in March to 89% of pre-pandemic levels. Plans are expected to improve further over the next few months, however, any additional work that will need to be undertaken to deal with the significant backlog may also still be affected by the implications of the current pension/tax issues for some of the Health Board's medical staff.

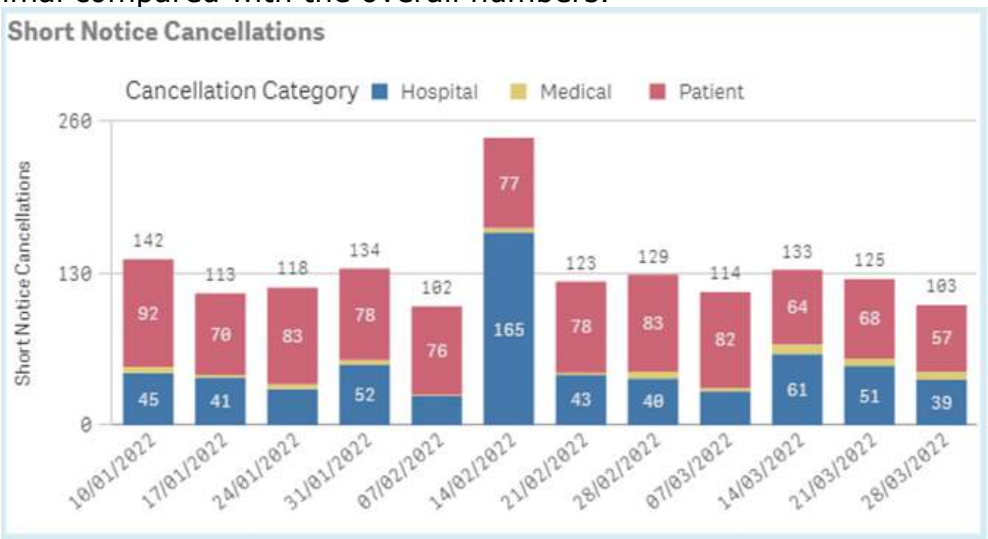
The Royal College of Surgeons (RCS) introduced guidance on how and what pathways should be prioritised. Changes to incorporate the agreed RCS risk prioritisation on the national Welsh Patient Administration System (WPAS) has enabled services to apply a risk code of P2, P3 or P4 to those patients waiting for treatment on an inpatient or daycase waiting list with P2 being the highest risk.

Capacity is planned and focused on treating those patients where they have been prioritised most at risk from harm. As part of the risk stratification process, patients must be re-assessed when they reach the priority target date. Current overall compliance of a risk priority applied to the inpatient

and daycase waiting lists is 95% with 9% being prioritised as P2. The graph below show the waiting list for the top six surgical specialties with a priority level and the number of P2 priorities that are within each specialty.

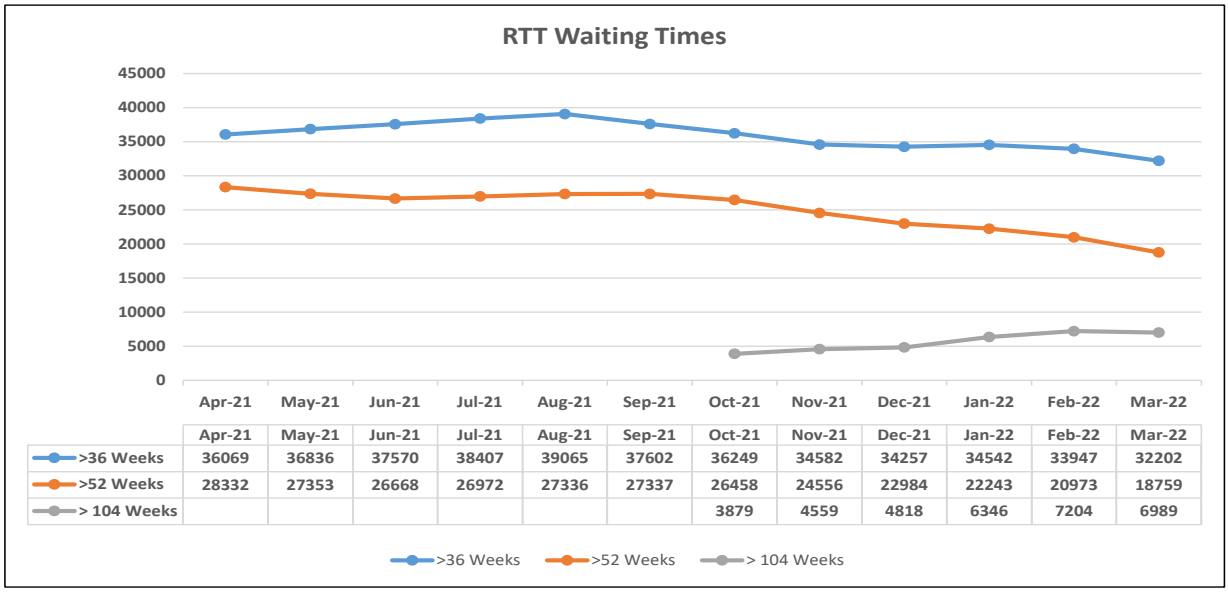


P2 patients are prioritised for admission, there are however, a number of patients who decline the offer of treatment due to the pandemic or pre-admission Covid isolation requirements and prefer to remain on the waiting list. The breakdown of cancellations is shown below with patient cancellations making up the majority of cancellations each week. The actual numbers of cancellations each week are less than pre-pandemic levels which were approximately 160 per week, but as a rate compared to activity, the numbers are similar. The number of short notice cancellations attributed to Covid-19 issues is minimal compared with the overall numbers.



The most complex elective patients will be treated at the Grange University Hospital where some patients have been cancelled due to emergency pressures. The volume of elective patients waiting beyond 36 weeks decreased in March 2022 with 32,202 compared with 33,947 in February 22. This reduction in the number of patients waiting over 36 weeks is the sixth reduction in seven months and is a clear indication that the Health Board is treating the longest waiting patients as well as

treating those with the highest clinical priority. The chart below illustrates the decrease in the 36+ week breach patients which reflects the incremental increase overall, in the number of patients the Health Board has treated each month:



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
>36 Weeks	36069	36836	37570	38407	39065	37602	36249	34582	34257	34542	33947	32202
>52 Weeks	28332	27353	26668	26972	27336	27337	26458	24556	22984	22243	20973	18759
> 104 Weeks							3879	4559	4818	6346	7204	6989

Of the 32,202 patients waiting over 36 weeks at the end of March, the table below shows that approximately 18,000 of those are at the new outpatient waiting list stage. There are also 18,759 waiting over 52 weeks with 8,390 of those at the new outpatient waiting list stage. Of the 18,759 patients waiting over 52 weeks, 6,989 of those patients have been waiting over 104 weeks with 1,606 of those at the new outpatient waiting list stage.

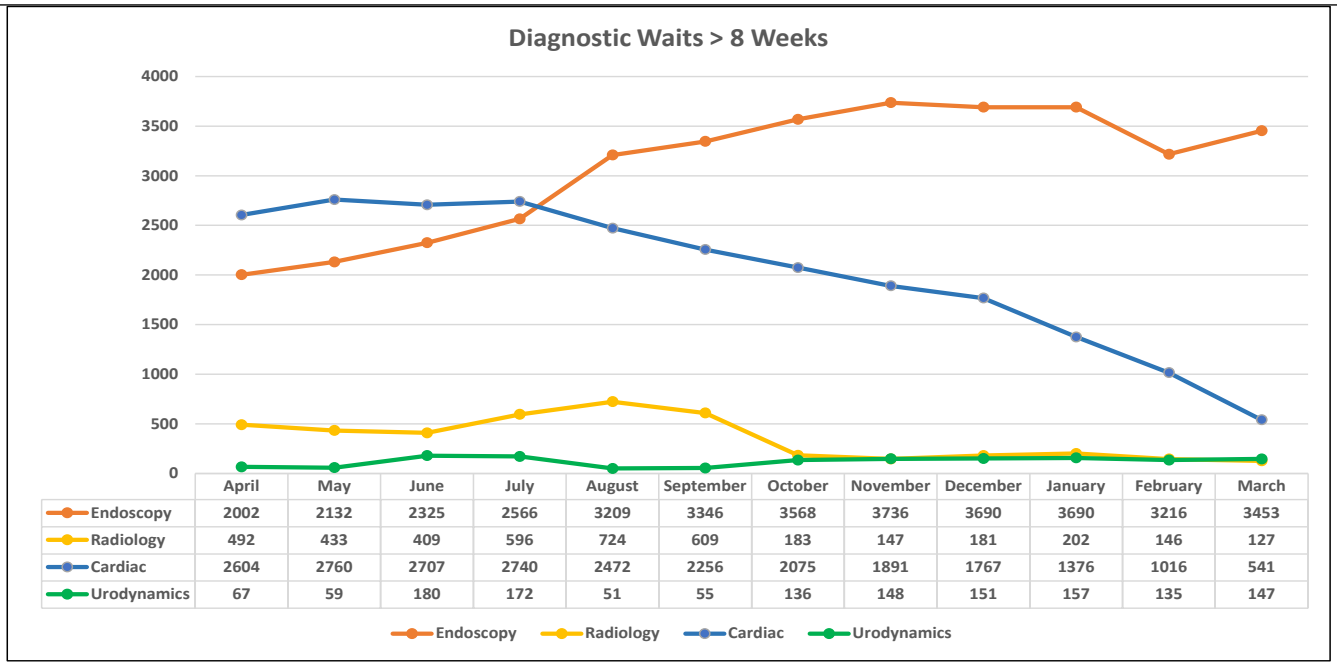
Week Bands	1 Outpatient WL	2 Diagnostic	2 Therapy	3 Follow Up	4 Daycase WL	4 Inpatient WL	Grand Total
0 to 25	47,528	2,589	190	4,512	8,437	2,405	65,661
26 to 35	9,585	713	37	761	1,907	648	13,651
36 to 51	9,566	575	33	486	1,672	1,111	13,443
52 to 103	6,762	450	51	612	2,055	1,840	11,770
104 +	1,606	393	42	260	2,547	2,141	6,989
Total	**75,047**	**4,720**	**353**	**6,631**	**16,618**	**8,145**	**111,514**

The Health Board continues to commission elective treatments and outpatients with St. Joseph's Hospital and ophthalmology treatments with Care UK. Opportunities continue to be explored with for additional capacity, along with other outsourcing / insourcing opportunities and regional working. This will be key in ensuring that the Health Board will be able to respond to the programme of revised Ministerial Priorities that have been introduced to tackle the backlog for the new financial year and longer term.

Diagnostic access

Services are gradually increasing capacity for all patients, although the backlog in patients needing to be seen and consequently requiring diagnostics is putting pressure on the services. However, the overall over 8 week position decreased in March 2022, with 4,300 waiting over 8 weeks compared with 4,574 in February and 5,495 in January.

The chart below illustrates the trend in the 8 week diagnostic waiting times since April 2021, Endoscopy is the main area of concern and plans to address the backlog are being implemented and further developed by the division.



	April	May	June	July	August	September	October	November	December	January	February	March
Endoscopy	2002	2132	2325	2566	3209	3346	3568	3736	3690	3690	3216	3453
Radiology	492	433	409	596	724	609	183	147	181	202	146	127
Cardiac	2604	2760	2707	2740	2472	2256	2075	1891	1767	1376	1016	541
Urodynamics	67	59	180	172	51	55	136	148	151	157	135	147

The following areas are noted as high risk in this month's report:

- The increase in the number of colorectal cancer referrals has increased the wait for more routine diagnostics. The FIT10 test was rolled out with a new pathway for lower GI USC and clinically assessed urgent referrals as part of demand management. The service continues to insource additional capacity and the above graph indicates a slight increase in the 8-week backlog. Despite further pressures with availability of staff which is affecting delivery through core theatres, the service anticipates that with service improvement and the additional insourcing capacity, the 8 week breach position will improve over the next few months.

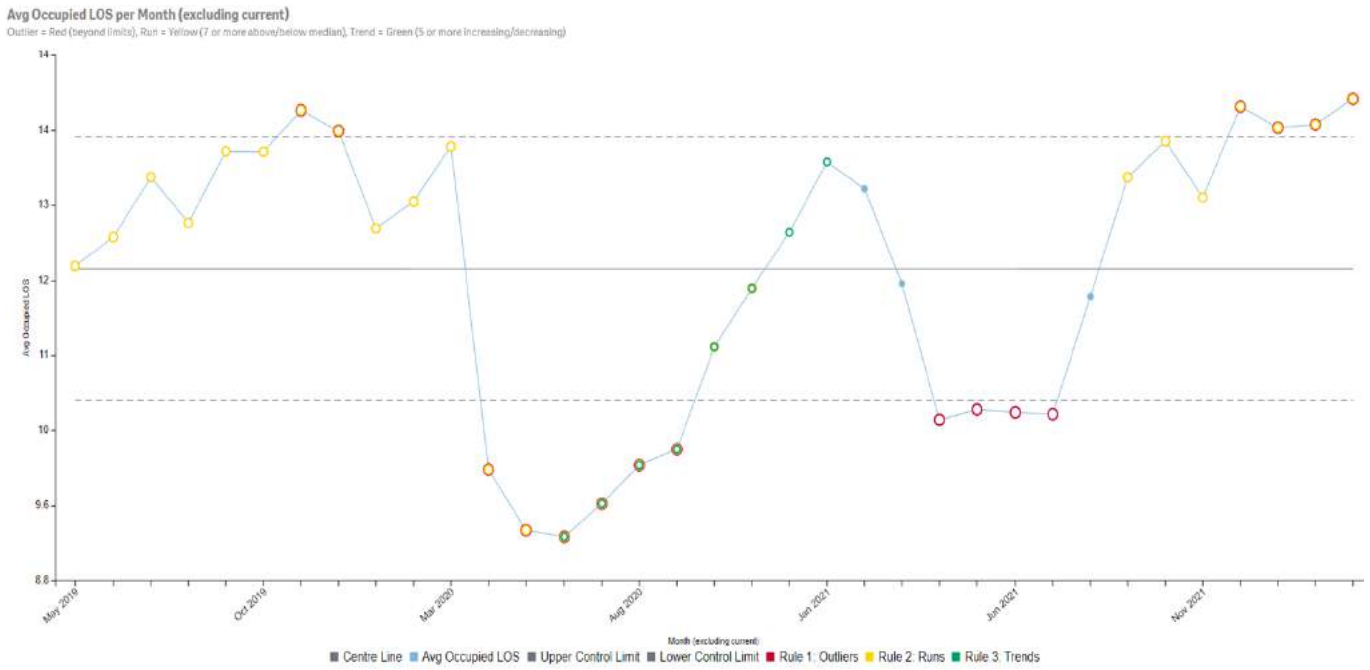
- Cardiology diagnostics have also been a concern as numbers over 8 weeks particularly for Echocardiograms had increased month on month. However, with the procurement of an insourcing company to deliver additional echo capacity, there has been a reduction in the number of 8 week breach patients in February and March, the impact of which is evident in the graph above. This improvement is likely to continue particularly with the approval to continue the insourcing capacity next year.

- Radiology diagnostics continue to recover well, with a few areas of exception. The main backlog is in MSK ultrasound although performance continues to higher than other parts of Wales. Some areas where there have been some longer waits are with those patients who require a general anaesthetic and a dedicated session to proceed with the diagnostic. Cardiac Mibi remains an issue nationally and has been for a few years particularly with the isotope availability.

Unscheduled Care access

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

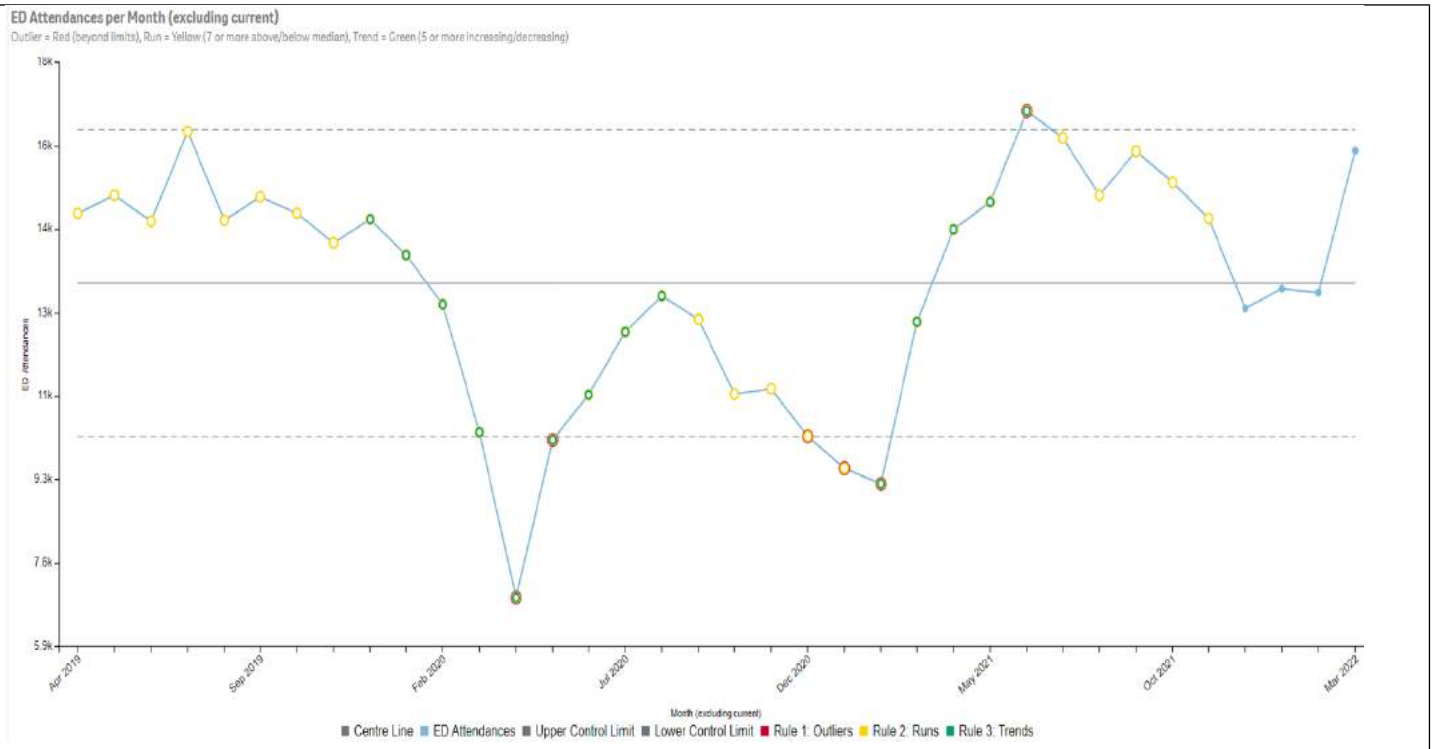
This pressure on the urgent care system has resulted in patients staying in hospital for longer. The average length of stay for patients admitted as an emergency is at its highest point since the previous high in November 2019. The chart below illustrates the monthly average length of stay for patients admitted as an emergency:



Emergency Demand

Attendance at the Health Board's Emergency Departments (ED) had been increasing since the start of February 2021. This increasing trend changed in December, January and February as it does every year, but a sharp increase in attendances was seen in March with 15,909 attendances compared to 13,051 in February and 13,132 in January.

The graph below provides an overview of the overall monthly ED attendances across the Health Board since April 2019. Attendances are expected to follow the typical seasonal trends in the coming months with increasing numbers of attendances through June, July and August in particular.



The Grange University Hospital continues to see a higher rate of patients being admitted than is the case for other emergency departments. The typical rate is 20% compared to 25% at the Grange University Hospital. This higher admission rate reflects the higher acuity of patients attending The Grange University Hospital Emergency Department which consequently results in more patients staying longer than 12 and 24 hours.

The ambulance handovers over 60 minutes has decreased compared with previous months. In March 2022, 737 patients waited over 60 minutes compared to the February position, where 850 were reported and 787 in January. The challenge in meeting this target is one that is experienced nationally and when compared with other Health Boards in Wales, Aneurin Bevan ranks higher than many other Health Boards in March 2022

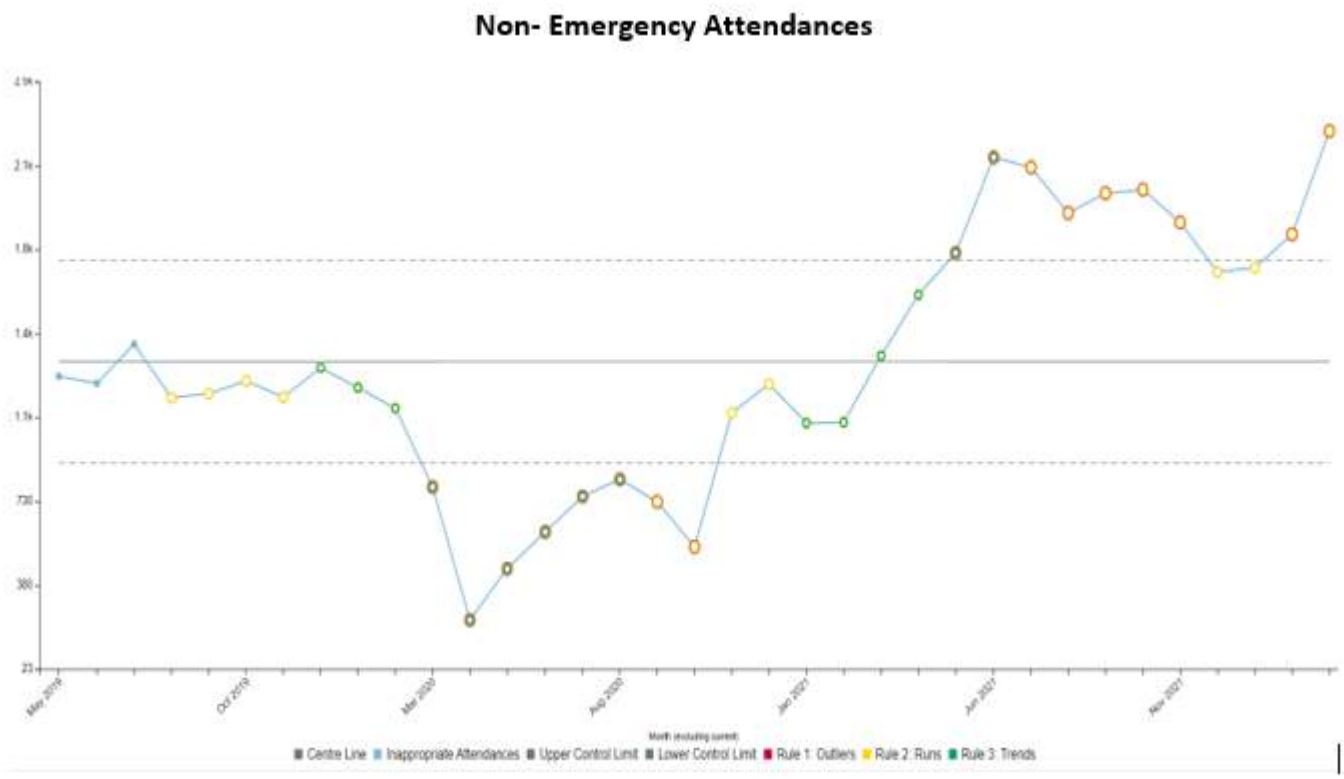
Proactive steps have been taken to deliver improvement plans to support timely ambulance crew handovers. The range of measures and actions continue to be implemented to support our ability to achieve the above:

4 and 12 Hour Performance

The 4 hour compliance target deteriorated slightly in March 2022 with performance at 73.7% compared with 74.9% for February 2022. For December, January and February, the Health Board achieved the highest 4 hour performance for all Welsh Health Boards with a major Emergency Department.

The performance measures are taken across all of the ED and Minor Injuries Units in the Health Board and it is performance at the Grange University Hospital that has been the most challenging. Performance against the number of 12 hour breaches has deteriorated slightly with 1509 waiting over 12 hours in March 2022 compared with 1355 in February 22. This increase is reflective of the significant increase in attendances for the month and the acuity of a high proportion of those patients.

Performance at other sites in relation to the 4 hour wait are consistently in the high ninety percent. There are a number of factors that impact on the flow of patients within the Grange University Hospital (GUH) and therefore, on the performance. The type of patients attending at the Grange ED department are those with more serious conditions. Consequently, these patients tend to flow through the system at a much slower pace, depending on the number and type of diagnostics required and working within Covid-19 guidelines. Given the clinical condition of patients, they are more likely to be admitted to the GUH or may require step down to e-LGH sites. However, as already referred to above, there may be a number of patients attending who could be seen more appropriately in other health settings. The graph below illustrates that the number of patients attending the Health Boards Emergency Departments (including MIU's) each month who are deemed as appropriate by the clinical team to be seen in a setting other than the Emergency Department or MIU. March saw 2,287 patients in this category, this number has increased significantly from the typical monthly median of 1250 prior to April 2021 to approximately between 1800 and 2300 each month since April 2021.



Other factors that can delay patients in ED are the turnaround times for Covid-19 testing, bed capacity and conveyance of patients to other sites. However, the level of focus will provide assurance that the Health Board is fully committed to ensuring the delivery of safe and effective urgent and emergency care services.

The community health and social care system is under intense pressure with a significant gap in the availability of domiciliary care provision and rehabilitation placements.

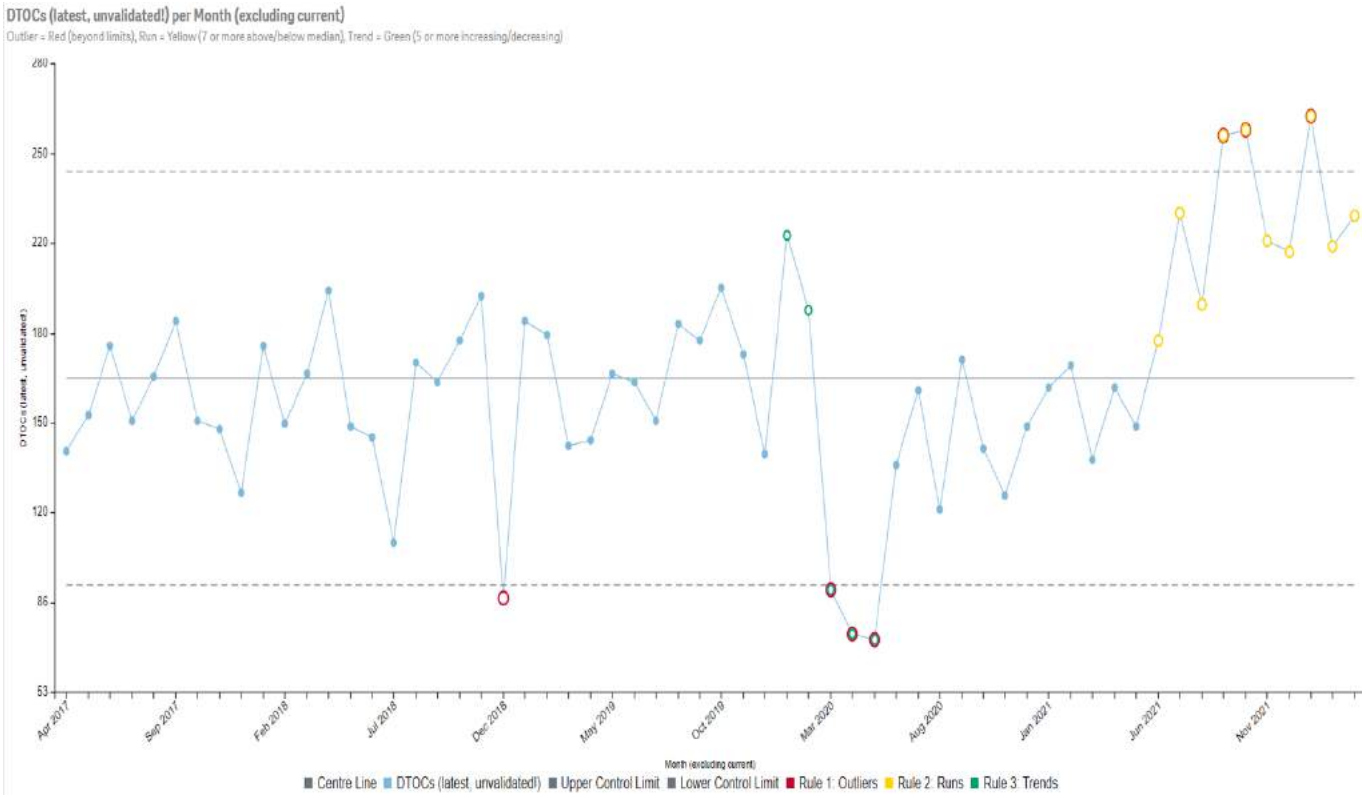
Continued pressures on bed capacity and staffing levels across the hospital system is a significant issue which ultimately impacts on flow and capacity available in the emergency departments and assessment units to support new presentations both in terms of self-presenters and ambulance handovers.

The Urgent Care Plan is a fundamental component of the Health Board's Winter Plan and is overseen by The Urgent Care Transformation Board which meets regularly to review the plan.

Delayed Transfers of Care (DToC)
Timely patient discharge or transfer of care to another provider is essential to ensure the timely admission of patients from the Health Board's Emergency Department, or the transfer of patients from one site to another within the Health Board.

The number of these patients was a formal reporting measure prior to the COVID-19 pandemic but was suspended by Welsh Government at the start of the pandemic in March 2020. The Health Board still monitors the number of these patients for internal use however the actual number is unvalidated and may be higher or lower.

Prior to the COVID-19 pandemic, there were typically 160 patients who had their discharge or transfer of care delayed. Since July 2021, this number has only been below 200 once and on 3 occasions has been in excess of 250. The position at the end of March is 230 and with the pressure across the health system this number may increase in the coming months. The chart below illustrates the pre-pandemic numbers and the increases since July 2021.

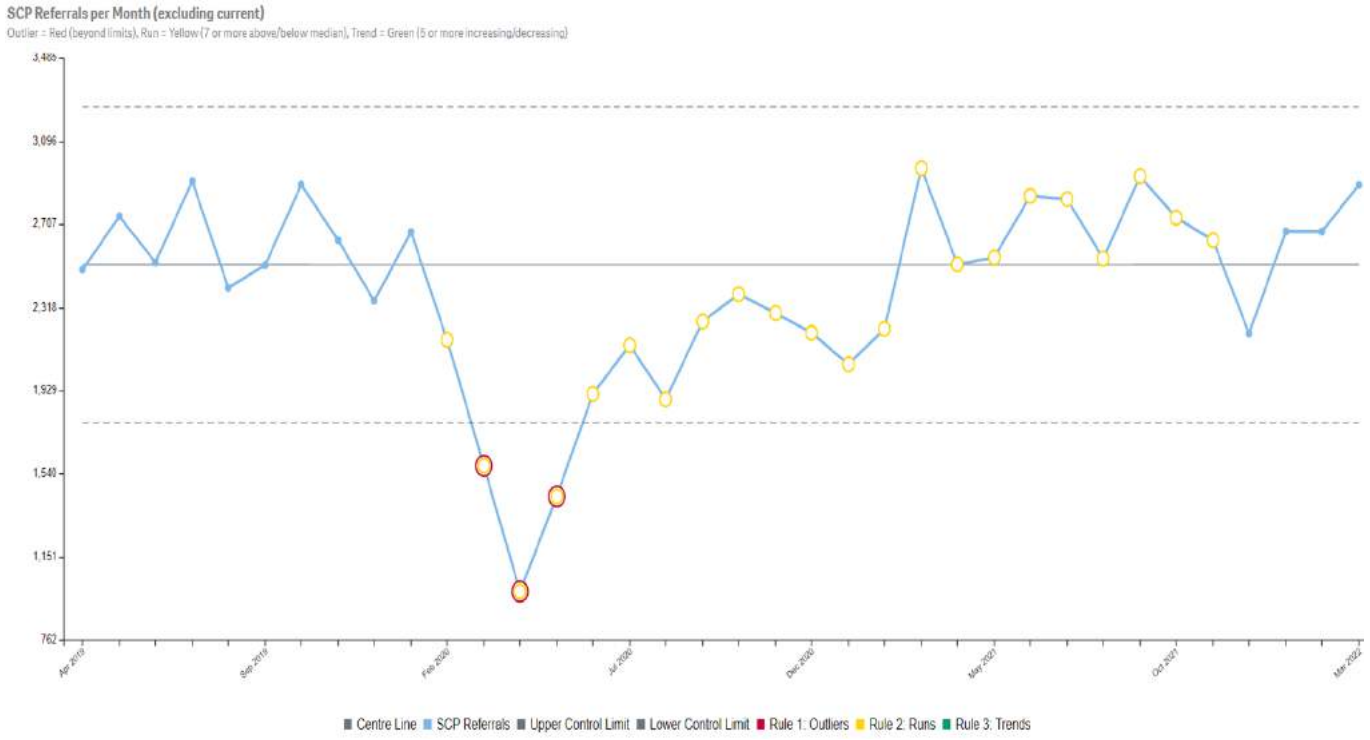


Six Goals for Urgent and Emergency Care
In May 2022, Welsh Government will launch the Six Goals for Urgent and Emergency care programme. The programme sets out the expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health.

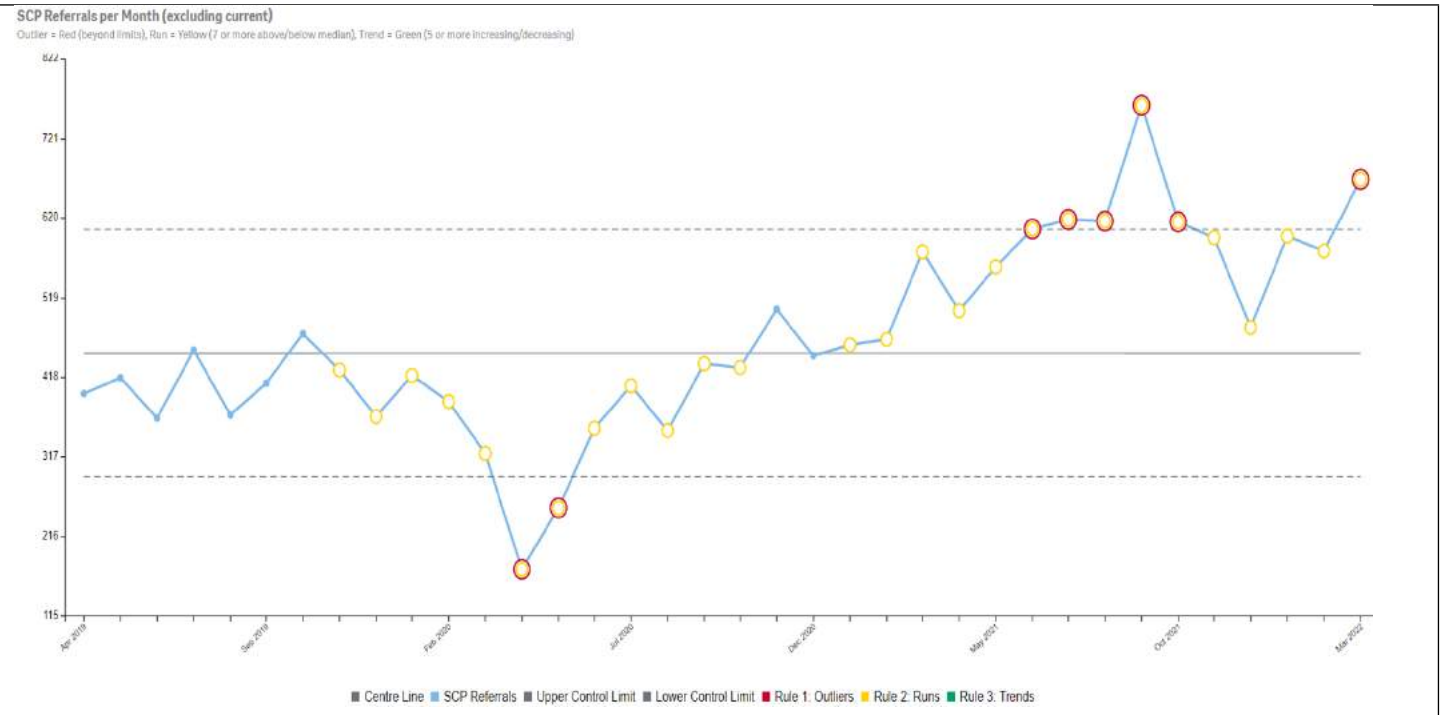
To ensure that the Health Board is able to deliver the expectations that the Six Goals for Urgent and Emergency care programme expects, the Health Boards existing Urgent Care transformation programme will evolve to align with the requirements and structure of the new national programme.

Cancer Access, including Single Cancer Pathway

Suspected cancer referrals in February and March have continued to exceed 2,500 referrals per month. The rapid sustained demand this year is continuing to have an onward impact on performance creating capacity challenges throughout the pathway both in the Health Board and for those patients requiring surgery at tertiary centres



The variance that we have seen in referral rates between tumour sites has continued into February and March's referral numbers. The demand for Colorectal in particular is challenging, there had been a drop off in demand in previous months, but this has now increased again in March. The chart below illustrates the significant increase in demand for Colorectal since March 2021.



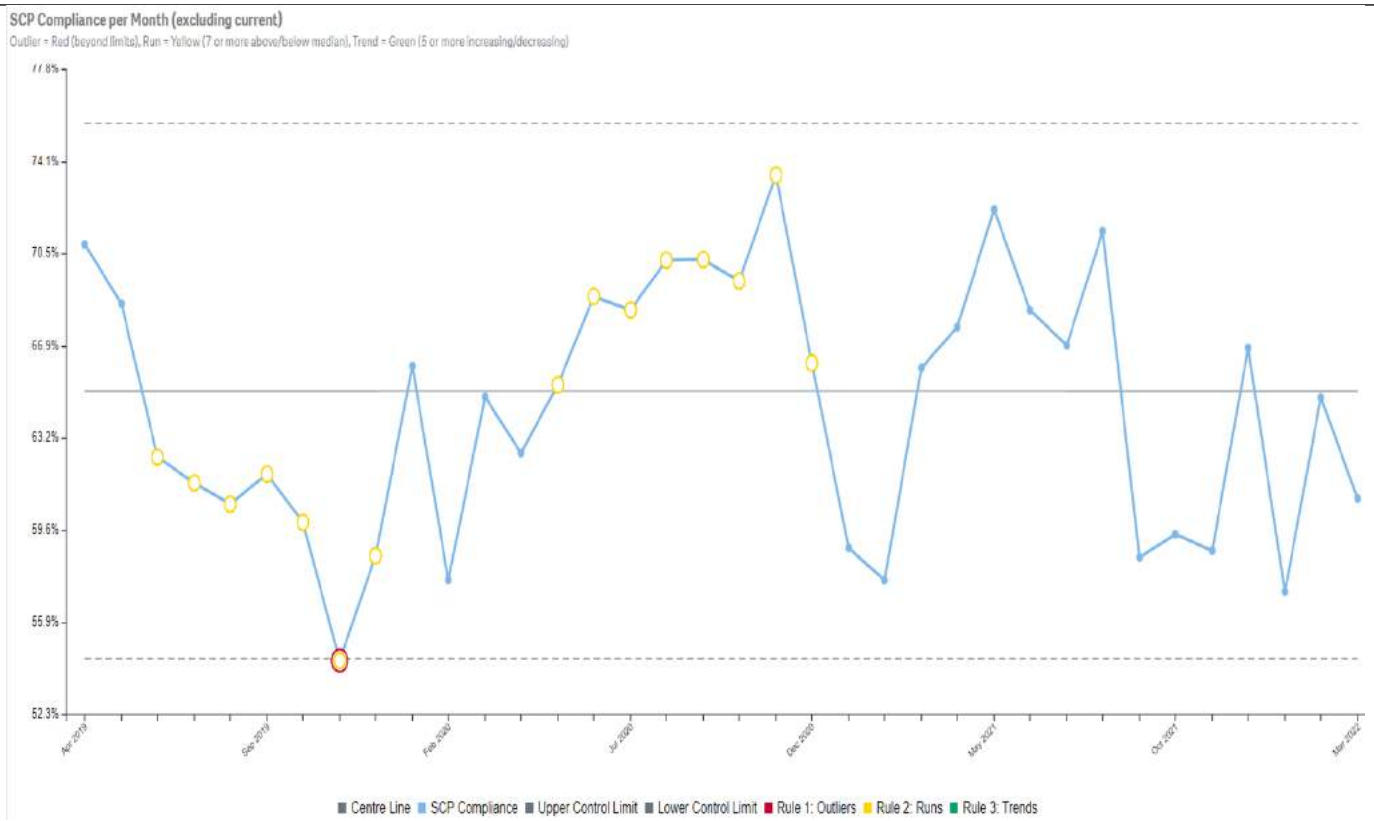
The Health Board's 62-day compliance position has, for the last 4 months been variable, performance has been between the high 50% and mid 60%. This variation is a demonstration of the fragility of the Single Cancer Pathway and the need for sustained and consistent deliverable capacity.

The most recent March performance figure has been reported as a disappointing 59.7%, a drop of 5% from February. This deterioration has been primarily driven by a considerable reduction in skin treatments whose high volumes have historically helped in increasing the performance denominator. The reasons behind the fall in skin treatments (from an average of 81 to 49 per month) is not entirely clear, however has been influenced by the current pathology pressures, and reduced cancer activity in order to recover waiting lists.

It should be noted that the breast service recorded a 31% improvement in performance in March, up to 70%.

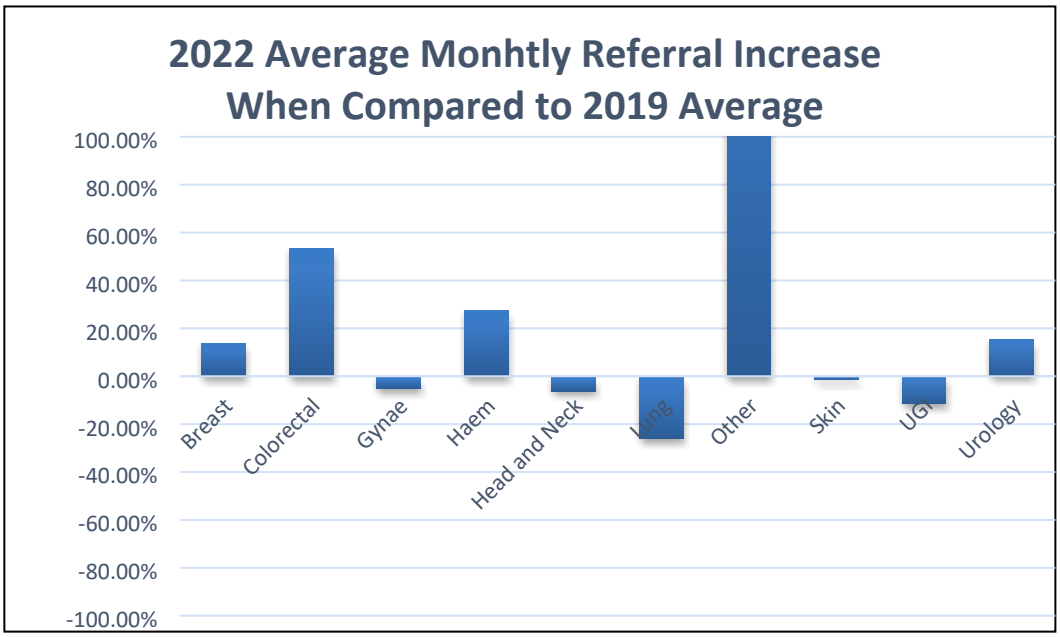
The reliance on skin treatments to maintain the cancer performance position clarifies the need for improvement across all tumour sites in improving the 62-day compliance. In order to meet the current 62-day pass thresholds, a reduction of 50 breaching patients, or 39% is required.

The recovery of cancer performance is multifactorial, with capacity issues and delays throughout the pathway. To turn the position around in the face of sustained high demand will require a concerted effort to create additional capacity, with an initial surge to recover the current backlogs. A strategy to approach this piece of work is to be presented at the May Cancer Board for approval.



The 2021/22 financial year closed having seen a 14% increase in suspected cancer referrals when compared with the 2019/20 financial year which was largely unaffected by COVID-19. Furthermore, the first 3 months of 2022 have seen a further 12.4% increase. These high referral numbers are welcomed as good news, suggesting the disruption to patients accessing primary care for concerning symptoms has mostly passed. The huge demand is however challenging the Health Board's capacity to diagnose and treat patients in a timely way.

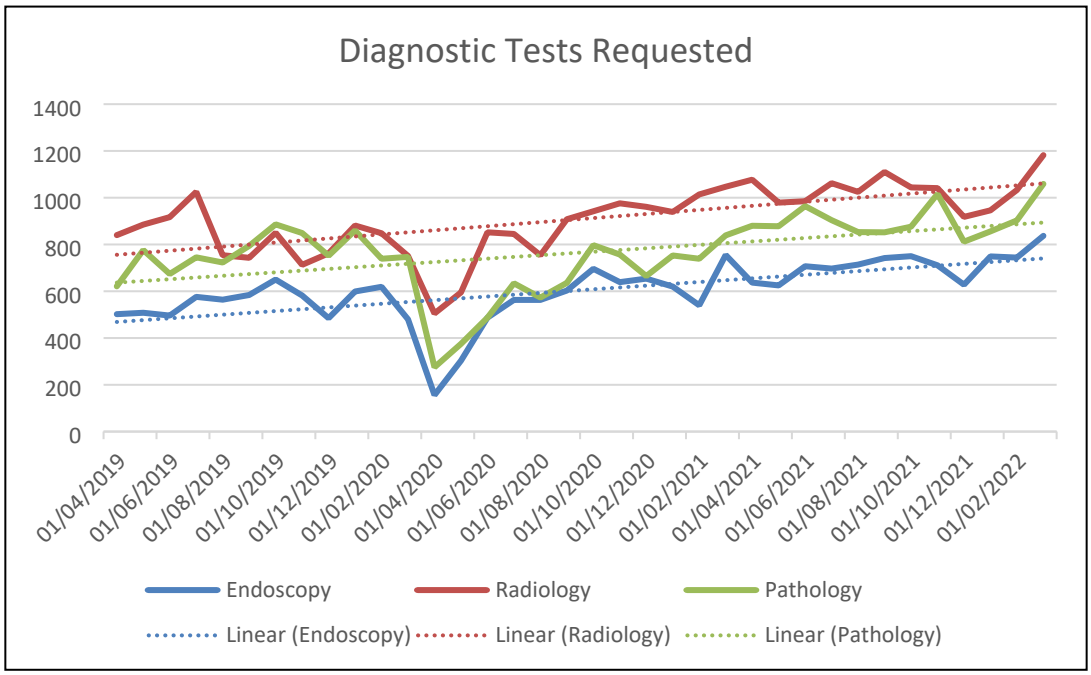
This high demand is not evenly distributed across tumour sites. Those tumour sites that have seen the biggest increases have subsequently struggled to achieve against the 62-day pathway target. Most notably, the huge Lower GI demand seen throughout the year has been sustained. Urology is also seeing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



- Large increase in "Other" is the result of the implementation of the Rapid Diagnostics Center. This has resulted in a demand increase of over 400%.

The high demand, coupled with increased use of straight to test services within pathways has consequently resulted in high demand within diagnostic services. This high demand has not consistently been met with comparative capacity increases which is leading to inflated waiting times within these services, most notable in pathology and endoscopy.

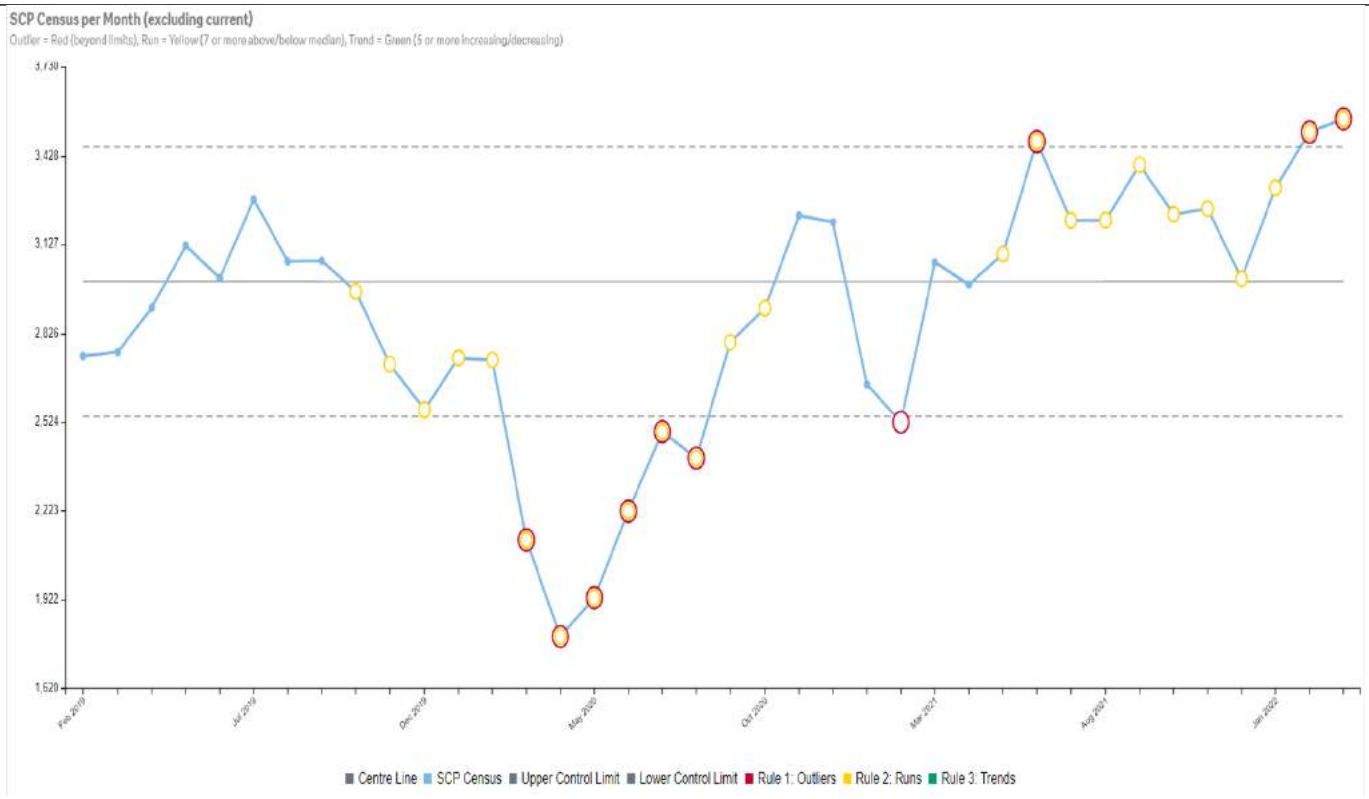
The recovery of pathology waiting times is of the highest priority. The movement of laboratories from the Royal Gwent site to a more suitable off site location is in progress, with the business case being presented to the Health Board's Pre Investment Panel (PIP) in early May. Ongoing plans are in place to try and reduce the level of unnecessary USC demand coming through the system. The turnaround time for pathology samples is having a noticeable impact on performance and is contributing to the reduced numbers of reported skin treatments. Endoscopy demand mirrors the high referral rates within the Lower GI pathway. Cancer Services are actively engaging with the Gastroenterology service to improve administrative processes which are currently struggling to schedule the increasing number of requests for endoscopy.



The combined effect of the sustained high demand coupled with capacity limitations and high demand for annual leave at the end of the year has resulted in considerable growth of both the cancer waiting lists and cancer backlog. It is likely that the numbers will plateau over the coming month, however the recovery of the position is unlikely without the provision of additional capacity and resource to address the backlog.

Whilst there is growth in the waiting lists across many of the tumour sites, Gynaecology and dermatology are having the most significant impact on growth due to the turnaround times of pathology samples needed to progress to diagnosis.

The growing backlog is an indication that performance over the coming months is unlikely to demonstrate significant improvement without operational intervention to increase cancer capacity and reduce waiting times. The below chart illustrates that the current backlog is now larger than at any previous time either post or pre-pandemic.



Treatment rates remain consistent across all tumour sites with the exception of skin for reasons given above, however there has been a small decrease in overall rates due to Easter with the bank holiday period and increased leave of treating clinicians.

Local wait times for treatments vary across tumour sites. The biggest challenge remains in Lower GI where the high demand and long theatre times are resulting in long wait times for patients to access surgery. Pre-operative assessment combined with the preparatory anaesthetic assessments are causing delays to pathways across a number of tumour sites due to nursing capacity.

Pressures within tertiary providers continue to add significant delays to some pathways, most notably Gynaecology surgery within the University Hospital of Wales and plastics and pancreatic within Swansea Bay. Although these waits are lengthening treatment pathways, the Health Board are not consistently referring patients within a reasonable time frame to meet the target because of the diagnostic pressures discussed.

Stroke Care

As an unscheduled, urgent care pathway, the Health Board's stroke pathways are directly impacted by the continued urgent care system wide pressure that is being seen nationally, regionally and locally; this is especially evident with regard to the access related stroke quality metrics.

The Health Board benefits from having a modern, purpose designed Hyper Acute Stroke Unit (HASU) at the Grange University Hospital (GUH) which provides urgent intervention at the most acute stage of the stroke. Since opening the GUH, and in the context of the continued urgent care system pressures, the Health Board has been unable to fully protect this HASU capacity to maintain access and timely flow. Similarly, when a patient with a stroke is ready to move on from the HASU, to the sub-acute rehabilitation facilities (currently at the Royal Gwent, Nevill Hall and Ystrad Mynach hospitals), the transfer can be delayed due to lack of capacity at those sites, again directly related

to system wide pressures in all parts of the urgent care pathway (including community social care that supports discharge for patients with increased dependency). Flow through the pathway is effectively stalled as a result of the pressurised and congested system, which has been further restricted by repeated COVID-19 outbreaks that can cause ward closures and delayed discharges to closed settings.

The Health Board monitors a number of key quality metrics for urgent intervention in stroke that determines whether a patient was able to have a CT scan within 1 hour and be admitted to the HASU within 4 hours of arriving at the hospital. Whilst stroke patients will receive necessary care interventions in the Emergency Department, and often pre-hospital by the paramedics, a timely scan and HASU care are critical for optimal outcomes.

Over the past 6 months, the proportion of patients with a suspected stroke who have a CT within 1 hour of arriving at the Emergency Department has been in region of 50% (52.9% in March 2022) which reflects a similar performance across Wales. This can be partly explained by the very congested Emergency Departments that lead to logistic and processing delays.

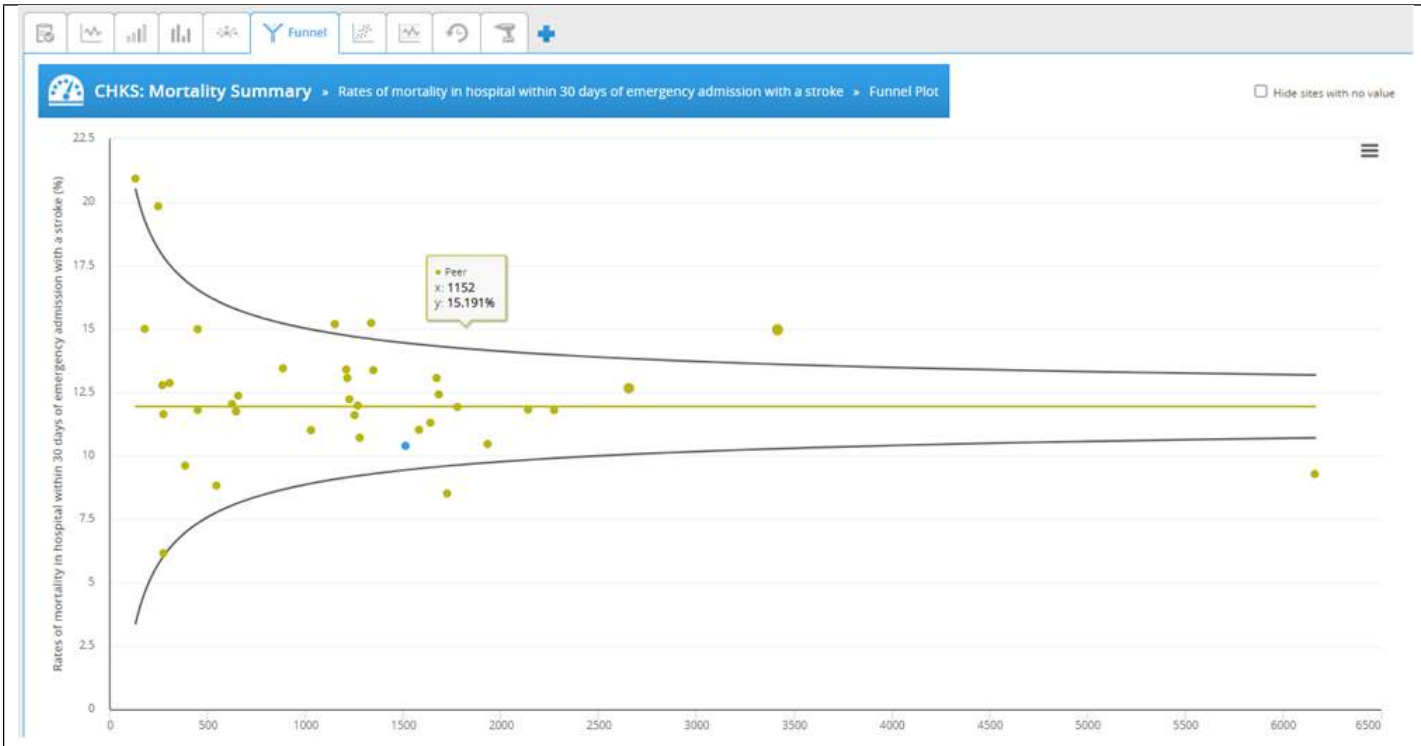
The proportion of patients with a confirmed stroke directly admitted within 4 hours has remained low over the past 6 months (14.5% in March 2022) which also reflects a similar performance across Wales (14.7%).

In March 2022, the Health Board recovered its previously good and best in Wales performance for the percentage of patients assessed by a stroke consultant within 24 hours at 94.3% in March 2022.

The proportion of applicable patients assessed by at least one therapist within 24 hrs of clock start improved with 44.3% in March 2022, up from 29.3% in January 2022, though still low in comparison to previous best performance of over 75%. The impact of the urgent care system pressures has resulted in decisions being taken to use the HASU therapy assessment room as additional bed capacity; whilst this assessment facility is unavailable then it is not possible to undertake the required level of therapy assessment for stroke patients during the critical acute phase.

Thrombolysis rates (proportion of stroke patients given thrombolysis) was 10% in March 2022. The thrombolysis audit is ongoing to identify any opportunities to improve thrombolysis performance. An earlier review of the data identified that patients have not arrived at the Grange University Hospital in a timely basis, and in some cases, there have been delays in referral to the HASU and stroke team. It is important to note that 100% of all clinically eligible stroke patients are given thrombolysis.

Notwithstanding concerns about timely access to stroke care, the reported mortality summary (comparison with top peers in the UK from Jan 2020 to March 2022) as shown in the funnel plot below, indicates that the Health Board is not an outlier for rates of mortality in hospital within 30 days of emergency admission with a stroke.



Whilst the urgent care system pressures are a major contributing factor to the access performance with the stroke care, there are also workforce factors (medical, nursing and AHPs) that must be considered. In recent years, the service has struggled to recruit into Stroke Consultant vacancies. However, it has been agreed for the service to develop a joint post to cover Acute Medicine and Stroke with the view to attracting a wider interest from applicants and will support both the Stroke service and the Medical Assessment unit.

The service has now successfully recruited into the Acute Medicine and Stroke post and is hopeful that the new consultant will commence in August 22.

An external review of therapy services across the stroke pathway has been undertaken to map the existing therapy workforce across the Health Board against clinically recommended levels in each setting. The report highlighted that gaps in specialist stroke therapy cover varied between professions and between sites, which is further complicated by those staff having to travel between sites. The review will form part of the stroke recovery plan and the focus will be to ensure that there is equitable therapy provision and determination of the best use of limited resources and the requirement for future stroke therapy provision.

As part of the stroke recovery plan and ongoing improvement work the Stroke Directorate has engaged with an external provider called "Getting it Right First Time" (GIRFT) for a specialty review. The specialty review will involve a local data pack being produced detailing ABUHB's stroke performance data, followed by a series of meetings with members of the Stroke MDT including Senior Operational Managers and Divisional Leads. The review will examine a wide range of factors, from length of stay, access to the HASU and rehabilitation sites, patient mortality, sharing of best practice, and areas for improvement and individual service costs through to overall budgets.

The GIRFT first meeting happened at the end of January 2022 and included representatives from all of the Stroke Multidisciplinary Team and the peer review will be conducted in May 2022. The findings / recommendations of the review will be fed into and be taken forward as part of the stroke

recovery plan, with a planning task & finish group being established and progress monitored through the Stroke Delivery Board reporting to the Executive Team.

In summary, a range of action is being taken forward to address performance issues with stroke quality metrics as part of the recovery plan:

- Utilising public communication opportunities to promote the importance of seeking immediate help at the signs of stroke (F.A.S.T.) by working in partnership with the CHC and the Stroke Association;
- Continued work with Emergency Department to ensure timely identification of stroke patients and expedite CT scans and transfer to the HASU;
- Work with the Director of Operations to put in place protection of the critical stroke pathway capacity as part of the Health Board's escalation procedures;
- Address workforce sustainability (medical, nursing and AHPs), aligned to a review of the entire stroke pathway, considering rehabilitation capacity and configuration, innovative roles, and most prudent use of limited resources;
- Support the GIRFT review process and establish a task & finish structure to respond to any recommendations as part of the recovery plan, with oversight by the Stroke Delivery Board;

Mental Health
The Health Board is currently experiencing a technical issue with the ePex system and are unable to report against several of the Mental Health measures. The issue has been escalated as a matter of urgency and is being investigated. Where data is not available, February 2022 has been included as the latest reporting period.

CAMHS
Sustained performance of the CAMHS measure of 80% is reported, with 97.2% of patients waiting less than 28 days for a first appointment at the end of February 2022. The implementation of the SPACE wellbeing (development of single point of access, multi-agency panels) which is operational in all five local authority areas has continued to have a positive impact on access to services.
Access to services on the CAMHS Neurodevelopmental (ND) pathway of children waiting less than 26 weeks to start an ADHD or ASD neurodevelopmental assessment has unfortunately seen a further deterioration in March 2022 to 56% compared with 66.7% in January 2022 against the target of 80%. It has been evidenced that there has been an increase in service demand, the level of acceptance of ND referrals by 103% since the relaunch in April 2021 and the team have been operating additional evenings and weekend clinics, in addition to using both telephone and video consultation to meet the demand. This increase in demand and also the impact of the easing of COVID19 lockdown and the restarting of face to face appointments resulted in a backlog of follow up appointments for the children undergoing a neuro-developmental assessment and has inevitably delayed the conclusion of the assessments.

The service is still applying the September 2021 initiated model, streamlining the booking of ND assessments i.e., booking the initial appointment and clinical observation appointment within 8 weeks. All children and young people undergoing an ADHD assessment will automatically have a school observation rather than a 1:1 clinical observation. The aim is to be able to keep the waiting list moving more fluidly acknowledging that there will be more complex cases that require school observations to gather more evidence and additional ADOS (Autism Diagnostic Observation Schedule assessments).

Primary Care Mental Health
Performance against the 80% target for Primary Care Mental Health Measures for assessment significantly improved in February 2022 to 83.7% compared with 48.2% in the previous month.

However, the position for intervention remains below the target with position deteriorating from 14.1% to 13.1% between January and February 2022.

The continued deterioration in intervention performance is in part due to the service focusing on the assessment in line with Welsh Government guidance, to ensure that all patients receive the initial assessment with a registered mental health practitioner. This is an approach which aims to minimise the number of interactions with different practitioners and to direct patients to the most appropriate care and support first time. Where therapy is indicated, the aim has been to maintain care interventions with the same practitioner. As these longer waiting patients have started their intervention, this has consequently had a negative impact on performance. The recovery plan continues to be aimed at reducing waiting lists for therapeutic. Though waiting lists for counselling and low intensity intervention have reduced to some extent, it is unlikely that that the target can be achieved in the short term, whilst we await additional funding for therapists and commissioned counselling services.

The MELO website which offers free, self-help resources in looking after mental wellbeing, is fully up and running, offering a strong Foundation Tier. This has been co-developed with Public Health Wales, with funding for continued revision, development and marketing. Virtual stress control classes have also been running and are promoted through the MELO social media platform and practitioners to improve take-up.

Where face to face appointments have resumed, issues remain with available, suitable accommodation to hold clinics which allow for appropriate social distancing. Room availability to provide face to face therapy has remained an issue with more services competing for the same accommodation with a lack of rooms available in GP surgeries and many community premises remaining closed. This is a recurring theme across directorates within the Mental Health and Learning Disability Division and with Family and Therapies for CYP. Transforming the service to provide therapy remotely required significant changes to clinician practice.

A recovery plan is being implemented which focuses on reducing waiting list volumes and reducing waiting times in both measures and arrangements are already in place for approximately two thirds of the PCMHSS waiting list to be addressed. However, commissioned services continue to struggle to employ therapists in the numbers required. Any recovery will be later than planned due to provider being unable to implement the contract. This is still being looked at with procurement with the intention of setting up a framework. In addition, recruitment to the vacant posts is key in being able to provide a sustainable service. This will support continuation of service delivery in line with contracts that have been awarded but these would need to continue at least for the first nine months of the new financial year to ensure that waiting lists do not increase further.

Despite the many challenges described, and loss of some staff, the service is focussed on improving performance, although it is anticipated that the position will not start to improve until later in the financial year.

Psychological Therapy

A sustained improvement in performance since April is reported for psychological therapy in Specialist Mental Health Services, with 74.6% of patients waiting less than 26 weeks for treatment at the end of February 2022, compared with 61.4% in April 2021, against a target of 80%.

Performance is calculated based on combined compliance for Adult, Older Adult and Learning Disabilities (LD) services. However, the Older Adult service has consistently achieved performance levels above 80% with 94% in February. This has been the case following the re-introduction of face-to-face contacts. However, the Older Adult group has similar rates of mental health challenges as working age adults yet referrals to primary and secondary care mental health services are at a

much lower rate. The challenge ahead is to identify the factors that influence this situation and to ensure that the plans address this.

With regards to Adult Services, the service has plans to continue to improve performance and reduce long waiters. The service has introduced new procedures to see service users whilst at the same time making better use of clinical resource. Going forward, an important part of the service strategy is to continue to increase access to proportionate interventions in a timely way through the provision of interventions in a group format. The work includes piloting a centralised group quality improvement program which will aim to pool resources for delivering group interventions and increase service user involvement in design and delivery. This has the potential to free resource within the Community Mental Health Teams (CMHT) therefore improving access to person-centred individual tailored approaches for those that need it. In addition to general improvement plans, each area is currently working on developing improvement plans relevant to local need. This initiative has also ensured easier access to group interventions by offering service provision in the evenings. Furthermore, the provision of evidence-based psychological intervention outside of CMHTs (within Part one of the Mental Health Measure) has facilitated some flow through internal waiting lists.

The service has benefitted from increased provision of highly specialist practitioner psychologist sessions providing assessment and intervention for those with more complex and enduring psychological needs and guiding intervention plans for those with moderate needs. The provision of these extra sessions has ensured that the service can maintain quality assurance through clinical supervision and outcomes monitoring and is an approach that is being considered to continue into the next financial year and, if possible, on a permanent basis.

It is widely anticipated that there will continue to be significant mental health consequences of the COVID-19 pandemic and public health control measures. Isolation, loneliness, and disconnection are commonly reported. Many people within the community have suffered significant loss and trauma. Psychological therapies are the indicated intervention in such circumstances and the service still anticipate a significant rise in referrals once services return to a more normal state. However, long-term, the aim is to aspire towards providing and promoting accessible and preventative mental health care. An action plan is under development, which may require increased workforce and financial support.

Care and Treatment Plan Compliance

An improvement in performance in the overall percentage compliance of valid care treatment plans completed has been reported over the last six months, with 85.7% of patients having a care treatment plan in January 2022 against the target of 90%. Since January overall compliance has reduced to 78.3% but with significant staff absence in January in the Adult Directorate this is to be expected. However, OAMH compliance increased from 63.1% in January to 79.5% in February; recruitment of a new Business Development role has provided increased insight and management of CTP compliance within the Older Adult Directorate. Learning Disabilities services are showing consistent compliance above the 90% target. There has been a significant amount of work undertaken over the past couple of months to clear the backlog of care treatment plans to improve compliance; it is anticipated that improvements in compliance will be realised and continue to improve.

Service Recovery Plans

In addition to restarting many routine services, the Health Board is implementing a range of recovery plans – further details are set out in the finance report. These include increasing acute, community based and mental health services, along with investing in alternative services – such as

weight management, alcohol care services – based on greater preventative support and improving health outcomes.

Outcome measures

In the Health Board's Annual Plan 2021-2022, focus is placed on the patient first so that every individual using the services whether at home, in the community or in hospital, has a positive experience. To do this the quality and safety of the care and services is core throughout all of the Health Board's plans which will have a focus on enabling a safety culture that minimises preventable harm, improves outcomes and experience and eliminates variation and waste.

There is a time lag to the data but to introduce this approach, 2 outcome measures have been included in the attached graphs:

- Emergency readmission within 28 days following hip fracture
- Heart failure readmissions within 30 days

It is anticipated that future reports will include an update from relevant services to provide some context

This provides a summary of the actions being undertaken to deliver and/or improve performance against the range of organisational and national targets.

Recommendation

The Board is asked to:

- Note the current Health Board performance, trends against the national performance measures and targets and progress on service recovery.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The report highlights key risks for target delivery.
Financial Assessment	The delivery of key performance targets and risk management is a key part of the Health Board's service and financial plans.
Quality, Safety and Patient Experience Assessment	There are no adverse implications for QPS.
Equality and Diversity Impact Assessment (including child impact assessment)	There are no implications for Equality and Diversity impact.
Health and Care Standards	This proposal supports the delivery of Standards 1, 6 and 22.
Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides a progress report on delivery of the key operational targets
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	An implementation programme, specific to ABUHB has been established to support the long term sustainable change needed to achieve the ambitions of the Act. The programme, will support the Health Board to adopt the five ways of working and self-assessment tool has been developed, and working with corporate divisions through a phased approach sets our ambition statements for each of the five ways of working specific to the Division and the action plan required to achieve the ambitions.

	Long Term – *can you evidence that the long term needs of the population and organisation have been considered in this work?*
	Integration – *can you evidence that this work supports the objectives and goals of either internal or external partners?*
	Involvement – *can you evidence involvement of people with an interest in the service change/development and this reflects the diversity of our population?*
	Collaboration – *can you evidence working with internal or external partners to produce and deliver this piece of work?*
	Prevention – *can you evidence that this work will prevent issues or challenges within, for example, service delivery, finance, workforce, and/or population health?*
Glossary of New Terms	

Integrated Performance Dashboard — March 22

Appendix 1

Domain	Sub Domain	Measure	Report Period	National Target	Current Performance	Previous Period Performance	In Month Trend	Performance Trend (13 Months)	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement	RTT	Patients waiting less than 26 weeks for treatment	Mar-22	95%	61.9%	59.8%	↑		56.2%	56.6%	55.9%	57.5%	59.0%	59.0%	58.5%	58.5%	59.4%	58.4%	58.3%	59.8%	61.9%
		Patients waiting more than 36 weeks for treatment	Mar-22	0	32202	33947	↑		35367	36047	36815	37564	38402	39063	37602	36247	34582	34254	34542	33947	32202
		Patients waiting more than 8 weeks for a specified diagnostic	Mar-22	0	4300	4574	↑		5707	5375	5581	5675	6128	6605	6406	6015	5979	6120	5495	4574	4300
		Patients waiting more than 14 weeks for a specified therapy	Mar-22	0	866	997	↑		838	366	245	256	311	460	506	526	629	891	1111	997	866
	Follow Up	Number of patients waiting for a follow-up outpatient appointment	Mar-22	69268	113107	112359	↓		104511	105936	107248	107236	108392	109467	111078	112419	112915	113705	112312	112359	113107
		Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Mar-22	3903	17939	18032	↑		12739	14047	14583	15338	16153	16691	17449	18293	17805	18504	18604	18032	17939
	HRF	% of R1 patients who are waiting within 25% in excess of their clinical target date	Mar-22	95%	59.5%	59.0%	↑		43.4%	46.3%	46.8%	49.4%	54.7%	56.2%	58.3%	57.3%	60.0%	59.4%	58.6%	59.0%	59.5%
	STROKE	% stroke patients directly admitted to acute stroke unit ≤4 hours	Mar-22	50%	14.5%	14.0%	↑		40.0%	49.2%	32.7%	31.7%	26.5%	26.8%	24.6%	19.3%	8.2%	18.5%	12.5%	14.0%	14.5%
		% of stroke patients assessed by a stroke consultant ≤24 hours	Mar-22	85%	94.3%	93.0%	↑		97.2%	100.0%	94.6%	96.7%	94.2%	93.1%	96.8%	91.5%	87.1%	77.8%	78.9%	93.0%	94.3%
		% of stroke patients receiving the required minutes for speech and language therapy	Mar-22	57%	13.6%	53.5%	↓		50.8%	45.2%	41.5%	25.8%	33.0%	30.4%	27.9%	27.8%	15.5%	13.1%	28.1%	53.5%	13.6%
	ED	Category A ambulance response times within 8 minutes.	Mar-22	65%	57.4%	58.1%	↓		62.0%	60.3%	56.6%	60.1%	61.5%	64.4%	55.1%	56.3%	57.2%	57.6%	56.5%	58.1%	57.4%
		Number of ambulance handovers over one hour	Mar-22	0	737	853	↑		853	880	925	744	698	711	674	694	804	720	791	853	737
		% patients waiting < 4 hrs in A&E figures inc. YAB & YYF	Mar-22	95%	73.7%	74.9%	↓		76.8%	78.3%	74.5%	76.0%	73.1%	70.0%	68.4%	66.9%	71.9%	74.1%	76.3%	74.9%	73.7%
		Number patients waiting > 12 hrs in ABUHB A&E departments	Mar-22	0	1509	1354	↓		963	933	1055	1101	1339	1303	1499	1724	1413	1270	1241	1354	1509
	Cancer	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	Mar-22	75%	59.7%	64.4%	↓		65.9%	67.4%	71.9%	67.7%	65.8%	71.1%	58.4%	59.1%	58.1%	66.7%	56.6%	64.4%	59.7%
	MENTAL HEALTH	Assessment by LPMHSS within 28 days of referral.	Feb-22	80%	83.7%	48.2%	↑		88.3%	86.3%	83.1%	92.2%	88.1%	82.5%	84.4%	89.9%	88.9%	86.3%	48.2%	83.7%	
		Interventions ≤ 28 days following assessment by LPMHSS.	Feb-22	80%	13.1%	14.1%	↓		62.6%	47.6%	57.8%	58.7%	50.4%	37.5%	29.3%	20.7%	22.6%	22.3%	14.1%	13.1%	
		Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Feb-22	80%	74.6%	77.2%	↓		64.6%	61.4%	62.7%	66.7%	70.0%	71.6%	68.8%	74.6%	77.5%	75.7%	77.2%	74.6%	
	CAMHS	4+ Weeks Waiting List	Feb-22	80%	97.2%	96.2%	↑		100.0%	100.0%	100.0%	98.7%	98.7%	92.6%	100.0%	98.2%	100.0%	94.7%	96.2%	97.2%	
		Neurodevelopmental (ISCAN) Waiting List	Mar-22	80%	56.2%	60.1%	↓		90.4%	87.9%	80.0%	80.9%	94.8%	76.3%	71.5%	77.2%	76.8%	68.1%	65.7%	60.1%	56.2%
	HCAIS	Cases of e coli per 100k population (rolling 12m)	Mar-22	67	58.01	57.17	↓		49.65	52.34	52.68	54.03	53.66	52.66	51.99	54.16	54.66	55.5	56.34	57.17	58.01
		Cases of staph aureus per 100k pop (rolling 12m)	Mar-22	20	22.4	22.74	↑		26.42	26.76	27.27	27.43	24.74	24.24	24.91	24.57	24.24	23.91	22.57	22.74	22.4
		Clostridium difficile cases per 100k pop (rolling 12m)	Mar-22	25	34.27	32.93	↓		24.6	25.08	24.74	27.27	28.42	29.6	29.9	29.92	31.43	32.26	31.76	32.93	34.27
		Cases of klebsiella per 100k population (rolling 12m)	Mar-22		15.55	16.22	↑		19.5	18.85	18.85	19.86	19.56	17.7	16.55	17.22	17.55	17.55	16.38	16.22	15.55
		Cases of aeruginosa per 100k population (rolling 12m)	Mar-22		5.18	5.18	↑		4	4.54	4.21	4.7	4.68	4.9	5.18	5.18	5.52	5.18	5.02	5.18	5.18
	HIP FRACTURE	Percentage of survival within 30 days of emergency admission for a hip fracture	Jan-22	94.57%	98.3%	95.7%	↑		89.4%	100.0%	96.3%	95.6%	94.1%	97.9%	87.5%	91.8%	93.7%	95.7%	98.3%		
Aim 1: People in Wales have improved health and well-being with better prevention and self-management	SMOKING CESSATION	Percentage of adult smokers who make a quit attempt via smoking cessation services	Dec-21	1.25%	3.2%	NA	↓		3.3%			1.1%			2.2%			3.2%			
	CHILDHOOD IMMUNISATION	Percentage of children who received 2 doses of the MMR vaccine by age 5	Dec-21	95%	90%	NA	↓		93%			91%			91%			90%			
		Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	Dec-21	95%	97%	na	↓		96%			96%			96%			97%			
	MENTAL HEALTH	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (under 18)	Feb-22	90%	91%	98%	↓		64%	74%	90%	92%	95%	98%	93%	98%	98%	94%	98%	91%	
		Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)	Feb-22	90%	78%	82%	↓		64%	72%	76%	77%	83%	85%	84%	88%	87%	83%	82%	78%	
Aim 3:The health and social care workforce is motivated and sustainable	COMP	Timely (30 day) handling of concerns and complaints	Sep-21	75%	76%	77%	↓		74%	78%	78%	75%	70%	77%	76%						
	W&D	% PADR / medical appraisal in the previous 12 months	Dec-21	85%	59%	59%	↓		58%	60%	60%	60%	58%	57%	58%	58%	59%	59%			
		Monthly % hours lost due to sickness absence	Dec-21	6%	7%	7%	↓		5%	5%	5%	5%	6%	6%	7%	7%	7%	7%			
		Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	Aug-21	85%	77%	77%	↑		76%	76%	76%	77%	77%	77%							
Aim 4:Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes	CRITICAL CARE	Critical care delayed transfers of care (4 hrs) days lost - GUH	Dec-21	84.8	65.0	67.0	↑		55	76	91	117	98	109	87	83	67	65			
	HIP FRACTURE	Prompt Orthogeriatric Assessment	Dec-21	93%	91%	91%	↑		96%	94%	93%	93%	93%	92%	92%	91%	91%	91%			
	MORTALITY	Crude hospital mortality rate (74 years of aged or less)	Feb-22	1.17%	0.88%	1.19%	↑		1.4%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	0.9%	
	SEPSIS SIX	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within 1 hour of positive screening	Nov-21	52%	100%	0%	↑		29%	43%	38%	67%	86%	43%	63%	0%	100%				
		Percentage of patients who presented to the Emergency Department with a positive screening who have received all elements of the 'Sepsis Six' first hour care bundle within 1 hour of positive screening	Nov-21	27%	0%	8%	↓		55%	43%	33%	39%	33%	32%	3%	8%	0%				
	CODING	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Dec-21	95%	86%	86%	↑		79%	73%	60%	86%	87%	86%	87%	87%	86%	86%			
	AGENCY	Agency spend as a percentage of total pay bill	Dec-21	8%	10%	10%	↑		11%	8%	6%	8%	6%	8%	8%	8%	10%	10%			
Efficiency & Productivity	Theatre	Theatre Utilisation (RGH)	Mar-22	85%	85.9%	85.9%	↑		80.7%	85.0%	85.6%	87.8%	86.3%	88.0%	84.7%	86.2%	86.7%	83.7%	81.0%	85.9%	85.9%
		Theatre Utilisation (NHH)	Mar-22	81%	81.7%	81.7%	↑		85.6%	84.0%	78.5%	79.8%	76.3%	86.0%	75.5%	75.7%	83.5%	81.8%	84.3%	81.7%	81.7%
		Theatre Utilisation (GUH)	Mar-22	68%	69.4%	69.4%	↑		63.4%	67.0%	68.9%	68.9%	70.0%	72.0%	65.4%	71.8%	65.6%	67.1%	68.9%	69.4%	69.4%
	Average LoS	Elective Surgical AvLoS (RGH)	Mar-22	3.17	3.0	3.0	↑		2.30	2.70	3.80	2.70	3.18	3.30	3.50	3.30	3.80	3.90	2.60	3.00	3.00
		Elective Surgical AvLoS (NHH)	Mar-22	2.18	3.4	3.4	↑		1.00	1.00	2.50	7.60	1.00	4.00	1.00	1.00	1.70	0.90	1.00	3.40	3.40
		Elective Surgical AvLoS (GUH)	Mar-22	2.95	2.0	2.0	↑		2.70	2.30	3.60	3.00	2.97	5.30	2.70	3.20	2.70	3.10	1.80	2.00	2.00
		Emergency Medical AvLoS (RGH)	Mar-22	10.20	9.6	11.3	↑		11.10	10.20	9.80	10.20	10.15	9.80	10.00	10.00	10.90	9.80	9.20	11.30	9.60
		Emergency Medical AvLoS (NHH)	Mar-22	10.40	12.4	13.7	↑		10.10	10.20	10.30	8.80	9.91	8.40	9.80	8.80	11.20	11.90	11.70	13.70	12.40
		Emergency Medical AvLoS (GUH)	Mar-22	4.29	4.4	4.7	↑		3.60	3.40	4.00	4.00	4.33	4.30	4.50	4.70	5.00	4.50	4.50	4.70	4.40
	Readmissions	Readmission Rate Within 28 Days (CHKS)	Feb-22	0.11	0.11	11.4%	↓		12.9%	12.0%	12.0%	11.6%	11.9%	10.7%	10.4%	10.2%	10.3%	10.7%	11.4%	10.5%	
	Cancellations	Elective Procedures Cancelled Due to No Bed	Mar-22	15	11.0	19.0	↑		0	4	22	9	38	14	33	18	5	2	16	19	11
	Hip Fracture	Prompt Surgery	Dec-21	66%	67%	67%	↑		65%	67%	66%	64%	66%	66%	68%	67%	67%	67%			
		NICE compliant surgery	Dec-21	79%	74%	75%	↓		84%	82%	81%	80%	80%	78%	77%	76%	75%	74%			
		Prompt Mobilisation After Surgery	Dec-21	77%	76%	78%	↓		74%	74%	77%	78%	78%	78%	78%	78%	78%	76%			
		Not Delirious When Tested	Dec-21	71%	77%	76%	↓		65%	68%	69%	69%	71%	72%	73%	74%	76%	77%			
		Return to Original Residence	Dec-21	76%	73%	75%	↓		77%	77%	76%	76%	76%	75%	76%	75%	75%	73%			

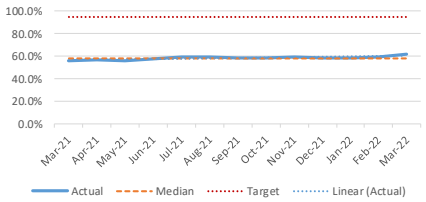
Trend Key

↑ Achieving rating target and improved against previous reported position
↑ Achieving rating target but deteriorated against previous reported position
↓ Not achieving rating target but improved against previous reported position
↓ Not achieving rating target and deteriorated against previous reported position

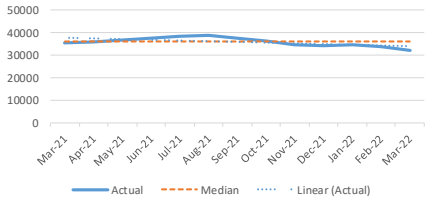
If measures are no longer in the Delivery Framework, current perfromance is measured against previous month

Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement

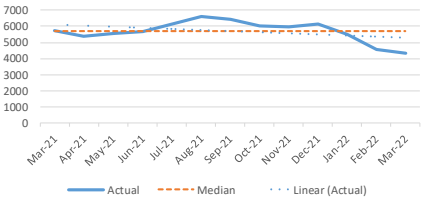
Patients waiting less than 26 weeks for treatment



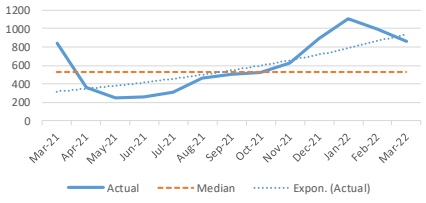
Patients waiting more than 36 weeks for treatment



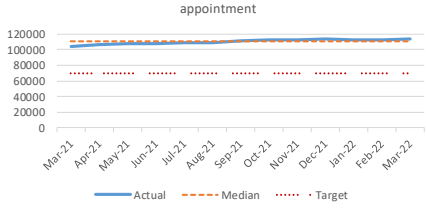
Patients waiting more than 8 weeks for a specified diagnostic



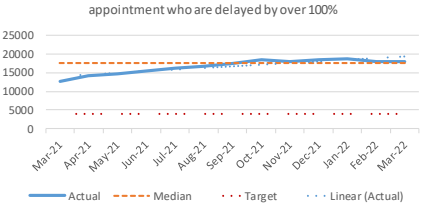
Patients waiting more than 14 weeks for a specified therapy



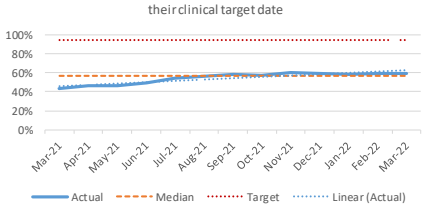
Number of patients waiting for a follow-up outpatient appointment



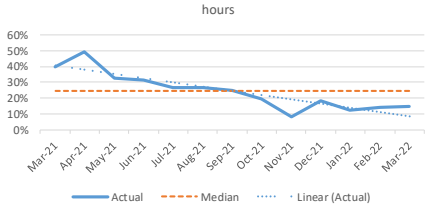
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%



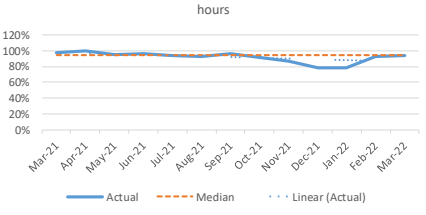
% of R1 patients who are waiting within 25% in excess of their clinical target date



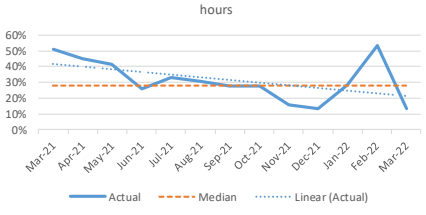
% stroke patients directly admitted to acute stroke unit ≤4 hours



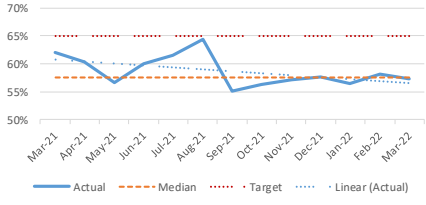
% of stroke patients assessed by a stroke consultant ≤24 hours



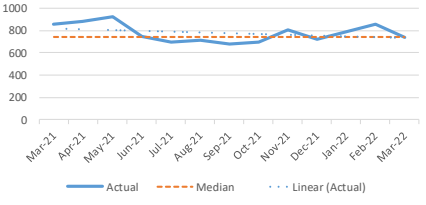
% of stroke patients assessed by a stroke consultant ≤24 hours



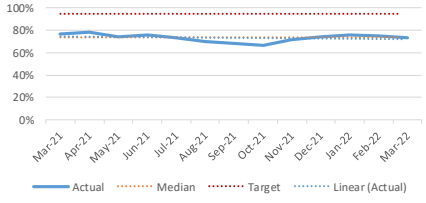
Category A ambulance response times within 8 minutes.



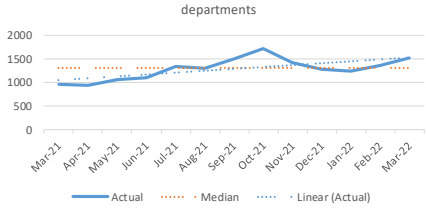
Number of ambulance handovers over one hour



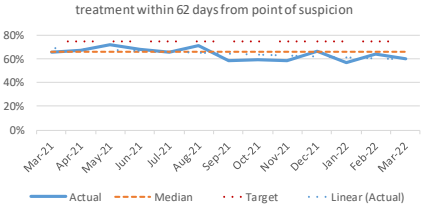
% patients waiting < 4 hrs in A&E figures inc. YAB & YYF



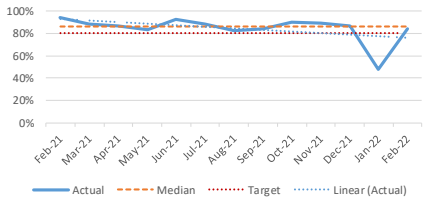
Number patients waiting > 12 hrs in ABUHB A&E departments



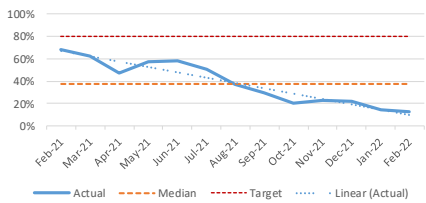
Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion



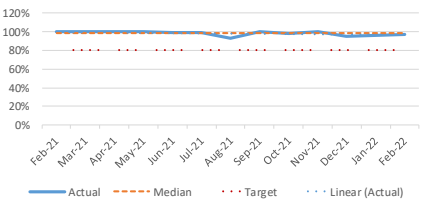
Assessment by LPMHSS within 28 days of referral.



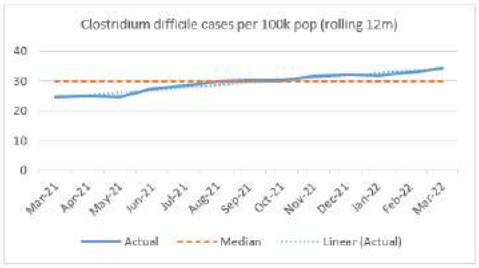
Interventions ≤ 28 days following assessment by LPMHSS.

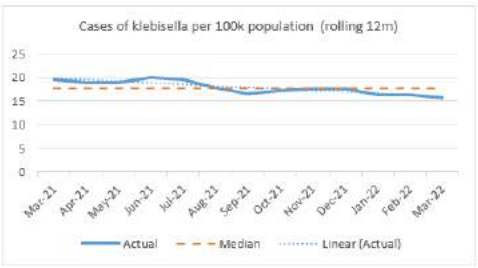


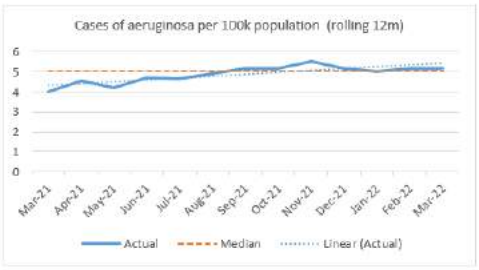
4+ Weeks Waiting List

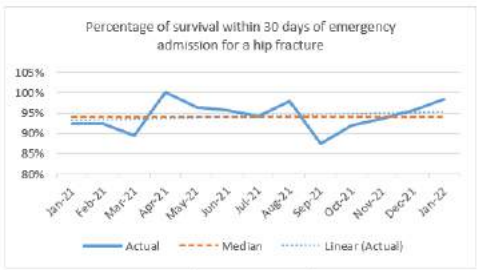


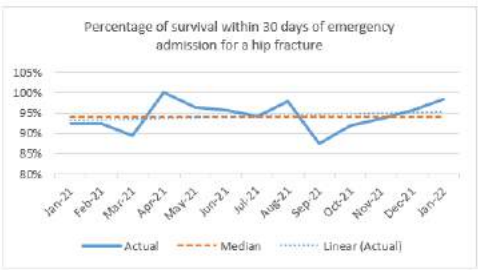
Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement



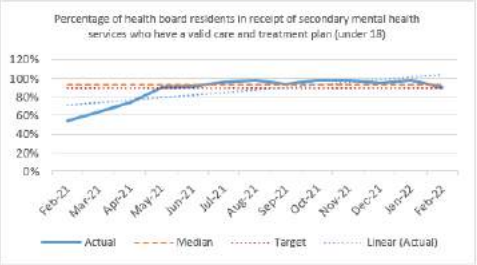


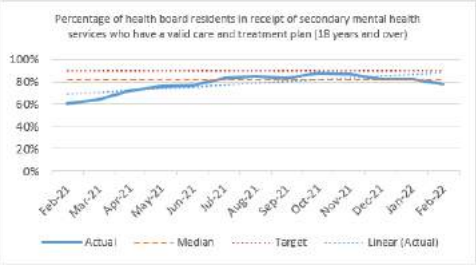




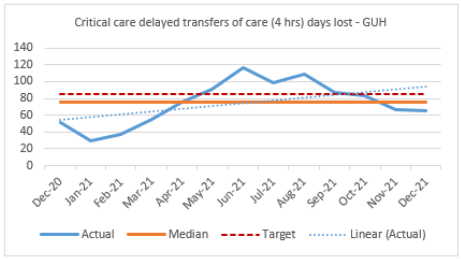


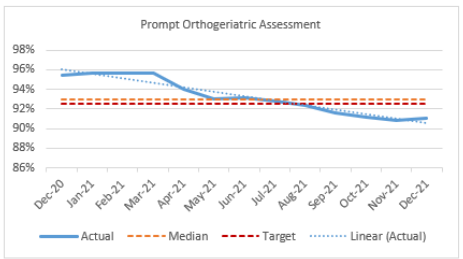
Aim 1: People in Wales have improved health and well-being with better prevention and self-management

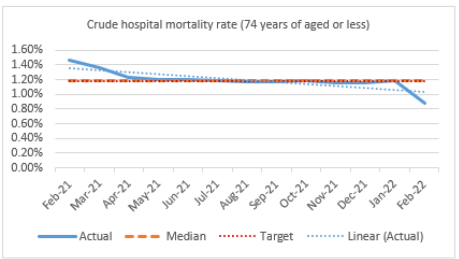


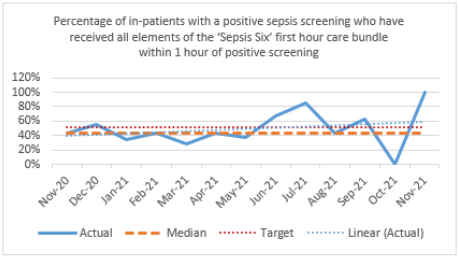


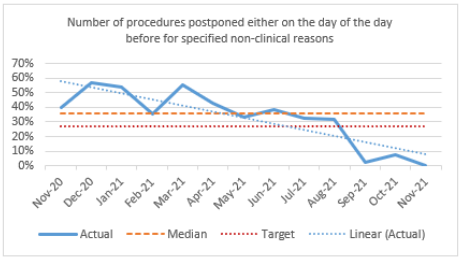
Aim 4:Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused

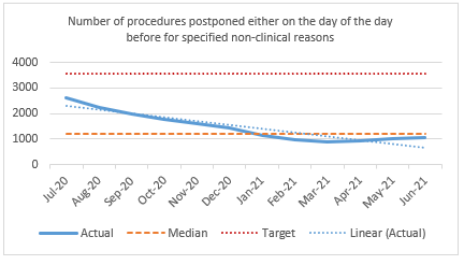




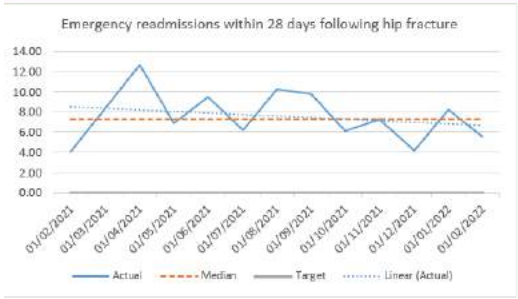


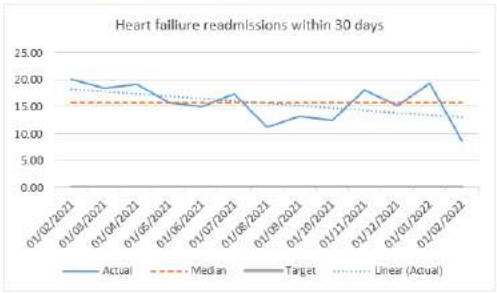






Local Measures





Aneurin Bevan University Health Board
25th May 2022
Agenda Item: 4.10

Aneurin Bevan University Health Board

STRATEGIC RISK REPORT

Executive Summary

This report provides an overview of all **23** strategic risks described on the Corporate Risk Register and makes recommendations to de-escalate one risk which has been managed down to an acceptable risk appetite level and is no longer perceived to be a strategic risk and can be managed operationally within service appropriate risk registers.

Response to the COVID-19 pandemic, through front line service delivery, restart and recovery plans and associated risks continues to have the greatest impact on service delivery. This sustained response continues to represent the most significant risk to the Health Board's delivery of its non-COVID-19 services and the achievement of the objectives outlined within the IMTP 2022/23.

This reporting period has seen continued progress in embedding the revised Risk Management approach including a further meeting of the Health Board's Risk Managers, Community of Practice which focussed on risk appetite, local interpretations and the need for greater consistency of approach in relation to all categories of risk management. This session was run as a pre-cursor to the scheduled risk appetite development session of the Board in June 2022.

Development work on the revised Board Assurance Framework (BAF) has commenced and critical links to the proposed Outcomes Framework (currently being developed by Corporate Planning colleagues) and revised IMTP, recently presented to the Planning, Strategy and Partnership Committee, is underway. The Health Board will undertake an in-depth review of its assurances and map them against each principal risk (scoring 15 and above) identified through the Corporate Risk Register. This will enable the Board to take assurance that risks associated with non-delivery of agreed Health Board objectives will be monitored and reviewed. A RAG rated assessment based on assurances can then be determined for each principal risk. Where gaps are identified, robust plans and SMART objectives to enable delivery will be established.

A Board Development Session on re-defining the risk appetite statement and associated definitions is scheduled for 22nd June 2022. It is anticipated the revised BAF will be presented to the Board at its July 2022 meeting, for final noting and endorsement.

The Board is asked to note the **23** risks which currently encompass the corporate risk register. The Board can be assured that its Assurance Committees (Audit, Finance and

Risk, Patient, Quality, Safety and Outcomes and People and Culture) have received and considered the risk profiles for which they are responsible for monitoring and reviewing. Further opportunity for escalation and de-escalation has been offered to risk owners and any change in position is reflected within the body of the report and the dashboard at ***Appendix 1***. Any concerns regarding these risk profiles will have been escalated to the Board via the Committee Assurance Report.

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

Executive Sponsor: Rani Mallison, Director of Corporate Governance

Report Author: Danielle O'Leary, Head of Corporate Services, Risk and Assurance

Report Received consideration and supported by :

Executive Team	**X**	**Committee of the Board [Audit, Risk and Assurance Committee Patient, Quality, Safety and Outcomes Committee People and Culture Committee]**	

Date of the Report: 10th May 2022

Supplementary Papers Attached:
Appendix 1 – Dashboard of Corporate Risk Register

Purpose of the Report

This report provides an overview of the **23** strategic risks which currently comprise the Health Board's Corporate Risk Register. The report aims to provide assurance to the Board that all risks have been reviewed by respective Committees and following Executive Team review, provides recommendations to remove one risk, note the deteriorating position of a further risk and endorse the addition of a risk related to the conflict in the Ukraine and potential impact on the Health Board.

Background and Context

In conjunction with the revised Board Assurance Framework (BAF) and the Risk Management Approach, the Health Board is able to review and assess its strategic risks against achievement of objectives as set out in the IMTP 2022/23.

The Health Board uses a Risk Matrix to assess the potential consequence and likelihood of occurrence of all predicted risks to form an overall risk score. In the risk identification and assessment process, a risk appetite level is agreed alongside a target score. Risks may then be **treated** or mitigated to a lower more manageable level or can be

tolerated, transferred or terminated dependent upon the level of organisational benefit in undertaking a specific mitigation or course of action.

Internal controls and action plans are then developed to mitigate the risk and reduce either the likelihood, consequence, or both. Committees are then responsible for the active monitoring and review of all risks which receive oversight from each respective committee.

Assessment and Conclusion

Risk Management ensures that the Health Board focuses on the risks and concerns that may impact on the organisations ability to deliver its objectives. Whilst active risk management is performed daily at an operational level, the Health Board's risk management strategy and process ensures that the Board is informed, engaged and assured about the approach that Health Board uses to identify and respond to perceived risks.

Whilst the key risks and issues need to be regularly considered at each of the Board's Committees and at the Executive Team, the way in which the Health Board responds to the COVID-19 pandemic and the risks associated with that response have taken priority.

The Health Board has reviewed its reporting mechanisms in relation to risk management and following internal reflection and comments received from Audit, Risk and Assurance Committee, it was agreed that an overarching dashboard would be developed to provide a high level view of all strategic risks. Each delegated committee would then receive the more detailed risk profile information for each risk which receives oversight at that committee.

This approach will strengthen the alignment between Board and committee business and the Board Assurance Framework; and provide a foundation for Board and Committee business to be risk based and focussed on assurance needs, ensuring the correct business is directed to the most appropriate committee.

Current Organisational Risk Profile:

There are currently **23** Organisational Risk Profiles, of which **13** form Principal Risks due to the scoring being 15 or greater and are included within the Board Assurance Framework. The following table provides a breakdown of the risks and level of severity:

High	13
Moderate	8
Low	2

A high-level breakdown dashboard of all strategic risks including, current score, target score, risk appetite level, risk treatment and trend since last reporting period is included at ***Appendix 1***. The Board can be assured that the risks which comprise the corporate

risk register continue to be reviewed and monitored via the Executive Team with complimentary Health Board escalation arrangements in place.

Changes in Risk Status Since Last Reporting Period

The Board is requested to note that since the last reporting period it has been recommended by the Director of Nursing that due to satisfactory de-escalation the following risk be removed from the Corporate Risk Register and can be managed effectively on a local basis:

> **CR0030** Limited contact with public and NHS services in addition to clinical deployment to support Public Health Mass Vaccination programme contributing to a compromised ***Safeguarding*** position (**re-framed to reflect DoLs position**) ***links to Workforce risk – CRR002**

This risk has been highlighted in red at ***Appendix 1***, for ease of reference. The Board is requested to endorse the de-escalation of this risk and removal from the Corporate Risk Register.

The Board is also requested to note the de-escalation of current risk scores for the following risks, which have been subject to review by relevant risk owners:

> **CRR013** Failure to prevent and control hospital and community acquired infections to include COVID-19; and,
> **CRR026** ***(June 2021 re-framed March 2022)***
> Impact of Covid 19 in-patient arrangements on service capacity due to substantial increase in pandemic levels. ***links to Workforce risk – CRR002**

At its April 2022 meeting, the Audit, Risk and Assurance Committee approved and recommended the following risk to be included on the Corporate Risk Register:

> **CRR034** Disruption to Health Board services due to Ukraine crisis.

The Committee also requested an additional assurance note on the Health Board response to the Ukraine crisis which was requested from the Head of Emergency Planning and Civil Contingencies and Assistant Director of Planning.

In relation to the Health Board's financial risks, the overview reported in this report provides a position as at end of March 2022 which was reported to the Audit, Risk and Assurance Committee on 7th April 2022. However, as the Health Board progresses into Quarter 1, the underlying financial position risk:

> **CRR016** Achievement of financial balance.

will deteriorate due to the continued impact of COVID and associated costs. This risk will form part of the principal risks to the Health Board during the next reporting period and

therefore will be reflected in the BAF and routinely reported to the recently established Finance and Performance Committee, in line with usual Health Board risk management arrangements.

Further Improvements Since Last Reporting Period

A further meeting of the Health Board's Risk Management Community of Practice has taken place where an interactive session was held on risk appetite as a pre-cursor for the Board session in June 2022. The group also approved a Terms of Reference to ensure a more formalised approach moving forward. These Terms of Reference will be shared with the Audit, Risk and Assurance Committee at its next formal business meeting.

Executive Team and the Audit, Risk and Assurance Committee also received a Risk Management Strategy Benefits Realisation Plan at its April 2022 meeting which highlighted the key deliverables to achieve all intended benefits of the revised risk management approach, by 2023. This plan will be monitored for progress through the Audit, Risk and Assurance Committee. Any points of escalation will be shared with the Board as necessary. A copy of the plan is available at the Board's request.

Recommendation

The Board is requested to:

- Note that delegated committees and Executive risk owners have reviewed their respective risks;
- Note the development work in relation to the revised BAF for 2022/23;
- Acknowledge the further progress made in relation to risk management community of practice and benefits realisation plan;
- Endorse the de-escalation, escalation and additional risks to the Corporate Risk Register; and,
- Receive and approve the report for assurance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the mitigation of risks or impact of realised risks may do so.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.

Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to the report, however, considerations will be included in considering the objectives to which the risks are aligned.
Glossary of New Terms	Not required.
Public Interest	Report to be published.

Risk ref and Descriptor	Current Score	Target Score (informed by Appetite level)	Risk Appetite Level	Managed to Agreed Level Y/N?	Risk Treatment	Date and Trend Since Last Reporting Period	Assurance/ Oversight Committee	Risk Owner
CRR019 Failure to meet the needs of the population who require high levels of emergency supportive care and inability to release ambulances promptly to respond to unmanaged community demand. **(re-framed Dec 2021)**	20	15	**Low** level of risk appetite in relation to patient safety risks. **Moderate** levels of risk with regard to innovation around mitigations to prevent demand and better manage the demand.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(PQSO April 2022)** 	**PQSO**	**Director of Operations**
CRR002 Failure to recruit and retain staff across all disciplines and specialities leading to adverse impacts on delivery of care to patients across acute and non-acute settings and non-compliance with safe staffing principles and standards **(re-**	20	10	**Low** level of risk appetite in relation to potential patient safety risks. **Moderate** levels of risk with regard to innovation and changing roles to attract more staff and deliver services in different ways through new roles.	**No**	**Treat** the impact of the risk by using internal controls.	**(P&C April 2022)** 	**P&C**	**Director of Workforce and OD**

framed Jan 2022)								
CRR013 Failure to prevent and control hospital and community acquired infections to include COVID-19	12	10	**Zero or low** due to patient safety and quality of service.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(PQSO April 2022)** 	**PQSO**	**Director of Nursing**
CRR020 Failure to implement WCCIS leading to inaccessibility of essential patient information.	16	10	**High** level of appetite for risk in this area to innovate in the area of digital technologies. **Low** level risk appetite for the realisation of this risk and to maintain patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(AFR April 2022)** 	**AFR**	**Director of Planning, Digital and ICT**
CRR023 Potential risk to population health in relation to avoidable harm due to priority being given to management of the COVID pandemic.	20	20	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to different ways of working to address backlog. This would include the use of technologies and innovations.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(PQSO April 2022)** 	**PQSO**	**Director of Operations**
CRR007 Inability to reflect demands of an increasingly aging population.	16	12	**Zero or low** level of risk appetite in terms of protecting patient safety and the quality of services. **Moderate** level of risk appetite in relation to some risk controls and mitigations is required due to interdependencies with partner organisations.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work and some are out of the Health Board's control.	**(Mar 2022 Board)** 	**PPHPC**	**Director of Primary, Community and Mental Health Services & Director of Public Health and Strategic Partnerships**

CRR010 Inpatients may fall and cause injury to themselves.	15	10	**Zero or low** in the interests of patient safety.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(PQSO April 2022)** 	**PQSO**	**Director of Therapies and Health Science**
CRR027 Effectiveness of COVID vaccination and booster programme compromised leading to a Variant of Concern	25	20	**Moderate** risk appetite level will need to be applied to this risk profile, given the unpredictability of the potential of variants of concern. The Health Board will ensure that it can behave appropriately to address the risk, should it materialise however, emergence of a variant of concern is beyond the Health Board's control.	**No**	**Treat** the potential impact of the risk with mitigations. **Tolerate** the unpredictable element of the VoC and other mutations.	**(PQSO April 2022)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR028 Continued inappropriate admissions of Children and Young People to adult mental health in-patient beds.	20	10	**Low** risk appetite level in relation to patient safety and experience. **Moderate** level risk appetite would be encouraged in order to explore more innovative ways of managing this risk alongside Health Board partners.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(PQSO April 2022)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**
CRR030 Limited contact with public and NHS services in addition to clinical deployment to support Public	16	5	**Low** risk appetite in this area due to potential impact on quality, experience and patient outcomes.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(PQSO April 2022)** 	**PQSO**	**Director of Nursing**

Health Mass Vaccination programme contributing to a compromised ***Safeguarding*** position (**re-framed to reflect DoLs position**) ***links to Workforce risk – CRR002**								
CRR001 High levels of seasonal influenza	8	8	**Low** level of risk appetite in relation to patient experience. **Moderate** levels of risk appetite can be applied to pursue innovative models and technologies to encourage uptake.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work. ***Managed within agreed risk appetite level, therefore proposed to remove as a strategic risk and continue to be managed locally.***	**(PQSO April 2022)** 	**PQSO**	**Director of Public Health and Strategic Partnerships**
CRR003 Mental Health services will fail to meet the anticipated increased demand of the Health Board population, for Mental Health support, in light of the COVID 19 pandemic.	12	8	**Low** risk appetite level in the interests of patient safety. **Moderate** risk appetite levels will need to be taken to explore further innovations and appropriately reconfigure services and implement new arrangements.	**No**	**Treat** the potential impacts of the risk by using internal controls. **Tolerate** the impacts of some mitigations and acknowledge that some may not work.	**(PQSO April 2022)** 	**PQSO**	**Director of Primary, Community and Mental Health Services**

CRR026 ***(June 2021 re-framed March 2022)*** Impact of Covid 19 in-patient arrangements on service capacity due to substantial increase in pandemic levels. ***links to Workforce risk – CRR002**	10	5	**Low** risk appetite level will be applied.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(PQSO April 2022)** 	**PQSO**	**Director of Operations**
CRR004 Failure to comply with WBoFG Act and Socio-Economic Duty	4	4	**Low to Moderate** - Risk appetite in this area is low in terms of compliance with the Legislation. However, further innovation is required to develop new approaches and ways of working therefore, risk appetite in this area is defined at a moderate level.	**Yes**	**Treat** the potential impacts of the risk by using internal controls. **Take Opportunities** and use positive risk management to realise efficiencies, better ways of working and realise our long-term strategic aims.	**(ARA April 2022)** 	**PPHPC**	**Director of Public Health and Strategic Partnerships and Board Secretary**
CRR017 Partial or full failure of ICT infrastructure and cyber security	15	12	**Low** appetite in relation to adverse impact on Quality, Safety. **Moderate to High** level risk appetite for innovating to identify digital ICT system solutions.		**Treat** the potential impacts of the risk by using internal controls.	**(ARA April 2022)** 	**ARA**	**Director of Planning, Digital and ICT**
CRR016 Achievement of Financial Balance	4	4	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements. However responding to COVID 19 implications and maintaining safe services take precedence.	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(ARA April 2022)** 	**F&P**	**Director of Finance and Procurement**

CRR012 Inability to address health inequalities across the population leading to increased dependency on Health Board services in the longer term and impacts ability of achievement of strategic aims/objectives. **(re-framed Dec 2021)**	12	4	**Low** risk appetite in terms of patient safety and services**.** **Moderate** risk appetite with regard to innovation and developments in primary care and public health initiatives.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Mar 2022 Board)** 	**PPHPC**	**Director of Public Health and Strategic Partnerships**
CRR008 Health Board Estate not fit for purpose (**Re-framed Dec 2021**)	15	15	**Low** risk appetite in relation to adverse staff and patient experience due to poor Health Board estate. **Moderate** risk appetite with regard to innovation and developments across the Health Board estate.	**Yes**	**Treat** the potential impacts of the risk by using internal controls and continue to maintain the current position with ongoing monitoring and review. ***Although this has reached its target score, it is recommended that this risk continues to be monitored strategically as the impact/consequence should the risk be realised, is significant.***	**(ARA April 2022)** 	**ARA**	**Director of Operations**
CRR032 Failure to achieve underlying recurrent financial balance	16	12	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(ARA April 2022)** 	**F&P**	**Director of Finance and Procurement**

CRR033 (Dec 2021) Civil Contingencies Act Compliance	20	9	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(ARA April 2022)** 	**ARA**	**Director of Planning, Digital and ICT**
CRR021 Welsh Language Act Compliance	12	8	**Low** risk appetite in this area is low in terms of compliance with the Legislation.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(P&C April 2022)** 	**P&C**	**Director of Workforce and OD**
CRR025 Well Being of Staff and normalisation of risk	12	8	**Low** risk appetite in relation to adverse staff experience due to current and ongoing significant operational pressures.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(P&C April 2022)** 	**P&C**	**Director of Workforce and OD**
CRR034 (NEW RISK April 2022) Disruption to Health Board services due to the Ukraine crisis.	10	5	**Low** risk appetite in this area in respect of patient safety however, a **higher** risk appetite will need to be applied when reviewing regional responses to the crisis and how the Health Board and its Partners can work collectively to address and mitigate the risks.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**ARA Committee April 2022** **NEW RISK**	**ARA**	**Director of Planning, Digital and ICT**

Aneurin Bevan University Health Board

Executive Team Report

Executive Summary
This report provides the Board with an overview of a range of activities regarding the Executive Team, including local, regional, and national issues, along with updates from the organisation. This report covers the period since the last Board meeting of 23rd March 2022.

The Board is asked to:			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only	✓		
Executive Sponsor: Glyn Jones, Interim Chief Executive			
Report Author: Rani Mallison, Director of Corporate Governance			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: May 2022			
Supplementary Papers Attached: None			

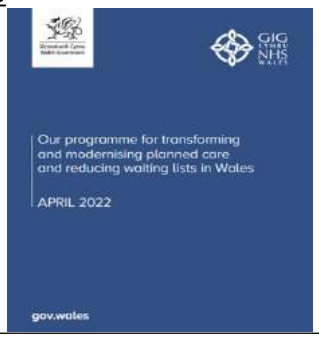
Purpose of the Report

This report provides the Board with an overview of a range of activities regarding the Executive Team, including local, regional, and national issues. The report also provides the opportunity to update the Board on organisational achievements, issues and actions being taken which might not otherwise be brought to the attention of Board, as key discussion papers.

Highlights

Welsh Government Publications

Programme for transforming and modernising planned care in Wales and reduced waiting lists



On 26th April 2022, Welsh Government published its *"programme for transforming and modernising planned care in Wales and reduced waiting lists"*: Our programme for transforming and modernising planned care in Wales and reducing the waiting lists (gov.wales)

The Plan sets out actions and targets for health and social care organisations to focus on:

- transforming outpatient services
- prioritising diagnostic services
- early diagnosis and treatment of suspected cancer patients
- patient prioritisation to minimise health inequalities
- those waiting a long time
- building sustainable planned care capacity
- improving communication and support.

The Health Board's Integrated Medium-Term Plan 2022/25, approved by the Board in March 2022, sets out a number of priorities for 2022/23, focussed on Outpatient Transformation; Diagnostics; and Pathway Optimisation.

Six Goals for Urgent and Emergency Care

On 27th April 2022, Welsh Government formally launched its *"Six Goals for Urgent and Emergency Care Policy Handbook, 2021-2026":* Right care, right place, first time: Six Goals for Urgent and Emergency Care - A policy handbook 2021-2026 (gov.wales). This sets out Welsh Government's expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health. All to be achieved through consistent and integrated delivery of six goals for urgent and emergency care to help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care.

A paper setting out the Health Board's response to the Six Goals will be presented to the Board in July 2022.

Executive Team Business

The Interim Chief Executive Officer meets with the Executive Team on a weekly basis, in a formal capacity (Executive Team Business Meetings), with a view to ensuring the effective operational co-ordination of all functions of the organisation, and thus supporting the Interim Chief Executive Officer to discharge the responsibilities delegated to them, including those as Accountable Officer.

During February and March 2022, the Executive Team considered several updates, proposals and service developments, much of which has informed substantive agenda items for Board and Committees. In addition, the following items were considered:

- Out of Hours Catering Service at the Grange University Hospital
  In light of concerns raised by staff at the Grange University Hospital (GUH) with regards to limited food options available to staff outside of core/office hours, the Executive Team supported a three-month pilot, with investment, to extend opening times, seven days a week to 02:00am. An evaluation of the pilot will inform longer-term arrangements.
- Art for the Grange Programme
  The Art for the Grange Programme ran from 2015 with the final art installation in December 2021. The Executive Team received a final report which concluded the programme, reflecting on the background, its outputs, impact and lessons learnt. The Board will consider its Arts in Health Strategy in July 2022, which will be informed by the learning from this Programme.
- Haematology Consultant Establishment
  Clinical Haematology is a specialty of strategic significance to the Health Board, dealing with both non-malignant conditions such as haemostasis and thrombosis, together with a wide variety of haematological malignant conditions such as leukaemia, lymphoma, and myeloma. The Haematology clinical service also supports the haematology laboratory and anticoagulation clinics and provides specialist advice to both primary and secondary care.
  The service has been placed under significant pressure over recent years as a result of consultant sick leave, rising referral demand, along with other factors. The Executive Team therefore agreed an increase in the consultant establishment along with a clinical trials nurse in support of providing a sustainable service for the future.
- System Pressures
  The Executive Team continues to focus its time and efforts on the ongoing pressures placed on health and social care and the impacts associated with this. The Executive Team has scheduled a dedicated session for 18th May 2022 to explore actions to be prioritised to support the system, over and above the plans already in place.
- Quality & Safety Briefings
  The Executive Team has received weekly safety briefings which have included a summary of recent Patient Safety Incidents, Complaints, Never Events and Injurious Falls.

Wellbeing Centre of Excellence

As a further extension to support to staff, the Health Board has moved closer to the development of a Wellbeing Centre of Excellence model with £1.4 million being secured to renovate and create the Wellbeing Centre, building work has begun and completion is expected in autumn 2022. The 'Centre' aims to lead the way for wellbeing in NHS Wales and supports the priority placed on Employee Engagement and Wellbeing within 'A Healthier Wales'.

The remaining step to realise the Wellbeing Centre of Excellence is to secure the required funding from Welsh Government to secure the revenue costs associated with expanding the capacity of the wellbeing team. Following an unsuccessful bid in September 2021, we have been advised by Welsh Government colleagues to submit an updated bid this financial year. The content of the bid will focus on achieving stage 3 of the development of the model which includes re-creating the spoke team function of the "Hub and Spoke" model that was successfully piloted during the first Covid-19 wave. The spoke arm of this model will enable the establishment of integrated wellbeing roles within services allowing for evidenced based localised approaches and innovations. This model will increase our capacity to proactively address the wellbeing needs of staff which continue to emerge as a consequence of the pandemic. In addition, the bid includes the additional roles needed

to deliver the research and development and consultancy arms of the Wellbeing Centre of Excellence which aims to develop a portfolio of world class research and teaching and will be able to offer a service to the public sector across Wales, developing a range of products that can be offered to our partners. The original approved bid will be refreshed and will request similar resources and financial support over a two-year timeframe to the value of circa £840K per annum. The Health Board plans to resubmit the bid in early June 2022 following final consideration by the Executive Team.

Support for Ukraine

The Health Board has established a Ukraine Response Planning Group with representation from across all Divisions to understand the potential risks from the Ukrainian conflict and the plans that can be developed to mitigate the impact on the organisation. This includes risks of cybercrime, impact on procurement, cost rises and workforce implications. As part of this response there is also significant work being undertaken to provide a health provision for refugees from the Ukraine coming to the Local Authority areas within Gwent. This service has been established to provide screening in line with national requirements and to respond to individual needs.

Regional Working

The CEOs of the 3 health boards in SE Wales – Aneurin Bevan, Cardiff & Vale and Cwm Taff Morgannwg University Health Boards – have committed to work together to develop and implement collective plans to address key service / access and workforce issues. The following mandate and principles have been agreed.

Mandate

We are committed to working collaboratively across South East Wales either bilaterally and/or across all organisations to bring together our collective resources, talent and expertise in order to achieve the best outcomes for the populations we collectively serve. The need to do this in the context of the current scenario is not debatable but the way in which we do that is very much territory for discussion and engagement with our teams and with our communities. We mandate our colleagues to use the principles set out below to co-create solutions and plans to meet our collective challenge. We commit to support and enable you to do this important work, to work with you with integrity to address difficulties and differences and to seek to agree the right solutions collectively and with stakeholders, always putting the needs of patients and those who need our expertise and care at the centre of our motivation.

Principles

- To reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level.
- To improve resilience, for example, by providing mutual aid.
- To make effective use of capacity and capability in whichever organisation it sits.
- To create critical mass for effective high quality care delivery when and where it makes sense to do so accepting that my not reside in every organisation.
- Take all opportunities to use the evidence base and best practice to improve quality, efficiency, productivity, and use of finite resources.
- To enable clinical leaders, and others, to work together, lead together and learn together.
- Leadership can be and will be distributed. (The SRO maybe from organisation A, clinical lead from org B and delivery of service in B and C.)
- To approach all aspects of the collaboration with benign intent, honesty, transparency, and integrity in order to build trusting and effective relationships.

- To agree approaches to engagement and communications together.
- To avoid leaving anyone behind. Good OD and workforce deployment and development planning will be essential in order to ensure equity of access to opportunities to practice and develop.
- To establish an effective but not overly bureaucratic governance structure to agree the vision, strategy and planning alongside safe and shared decision making and the monitoring of progress.
- Learn from past regional initiatives and as we go in an open, honest and humble way.

In addition, a programme director is to be jointly appointed, to implement the necessary programme governance and delivery arrangements across the health boards, with an initial focus on the following three services – each with a CEO lead sponsor:

- Diagnostics – CEO, CTMUHB,
- Ophthalmology – CEO, ABUHB, and
- Orthopaedics – CEO, CAVUHB.

The Health Board is already making progress on the planning and delivery of ophthalmology services across the region – led by the Director of Planning, Digital & IT.

As plans are developed these will be presented to the board for consideration.

Staff Celebrations, Achievements and Events

Staff Recognition Awards 2022

On Monday 28th March 2022, the Health Board held the first Staff Recognition Awards since before the Covid-19 Pandemic began.

Postponed from December 2021, the event- which usually sees colleagues from across the Health Board gathering to celebrate each other's achievements at the Christchurch Centre in Newport- was held virtually for the very first time.

Despite the alternative setting, the purpose and ethos of the event remained the same- celebrating the hard work, dedication and outstanding care given by teams across Aneurin Bevan University Health Board.

The event was hosted by Interim Chief Executive, Glyn Jones, with former Chief Executive of Aneurin Bevan University Health Board, Judith Paget CBE, also joining the event to present the Chief Executive's Award.

We are delighted to confirm that the winners were as follows. Congratulations to all winners and nominees!

- **Employee Health & Wellbeing at Work**
  Winner – Dr Josie Cheetham
  Runners up – Sarah Flowers and the Clinical Psychology Speciality; Robert Callen Davies
- **Improving Patient Experience**
  Winner – Sarah Power, Neonatal Sister at The Grange University Hospital

Runners up – Emma Davies (Project Lead) and The Cardiac Rehabilitation Team; Shannon Greenway, Occupational Therapy Support Worker

- **Leadership**
  Winner - Mezz Bowley, Deputy Director of Public Health and Senior Responsible Officer for the Covid 19 Mass Vaccination programme, and Dr Liam Taylor, Deputy Medical Director & Interim Divisional Director, Primary Care Community Services Division
  Runners up - Joanne Hook, Senior Nurse County Hospital; Dr Adrian Neale, Head of Employee Wellbeing
- **Partnership Working**
  Winner – ICU, Anaesthetics and Theatres
  Runners up – The Welsh Ambulance Services NHS Trust in collaboration with Aneurin Bevan University Health Board Primary and Secondary Care, Respiratory, GP, CRT, Frailty and District Nurses; The Covid Follow up and Rehabilitation Clinics, represented by Dr Sara Fairburn and Dr Rachel Rouse
- **Quality, Sustainability and Efficiency**
  Winner - The Robotic Process Automation Team
  Runners up - Bladder and Bowel Nursing Service and the South West District Nursing Team; The Heart Failure Nurse Led Service – represented by Linda Edmunds and Karen Hazel
- **Team of the Year**
  Winner - The Respiratory Team from across the Health Board
  Runners up- Switchboard Services; The Mortuary and Care after Death Hub Team
- **Education, Research and Innovation**
  Winner - St David's Clinic – Team lead - Dr Peter Speirs
  Runners up - The representatives of the Practice Educator Nominees- Audra Davies and Lis Welton, The Pre-Registration Nurse Education Practice Facilitator Team, Annie Ming and Ali Kirton; The Aneurin Bevan Primary Care Academy represented by Specialist Nurse Dawn Parry
- **Patient's Choice Award**
  Winner - Her Majesty's Prison, Usk, Healthcare Department
- **Population Health and Well-being Award**
  Winner - Star Moyo, Senior Nurse, and the Asylum Seekers and Vulnerable Groups Team
  Runners up - The Mass Vaccination Centre Booking Team; Carole Williams, Advanced Nurse Practitioner, Talygarn Community Mental Health Team
- **The Chair's Award**
  The Gwent, Test, Trace, Protect Service, represented by Eryl Powell, Consultant in Public Health
- **The Chief Executive's Award**
  The Pharmacy Service
- **The Aneurin Bevan Community Health Council Award**
  The Person-Centred Care Team
- **Special Recognition**
  Christine Culleton, Staff Nurse at Brynhyfryd Clinic
- **Living Our Values:**
  Richard Lane- "The Singing Security Guard at The Grange University Hospital"
  YYFM Radio – Steven Davies & Team at Ysbyty Ystrad Fawr
  Professor Charlotte Lawthom – Consultant Neurologist
  Jane Turner – Colorectal Specialist Nurse
  Rebecca Pearce – Senior Programme Manager
  Dan Davies – Chief of Staff

James Hodgson – Head of Communications
Ed Valentine – Consultant in Emergency Medicine

International Nurses' Day

International Nurses' Day was held on Thursday 12th May 2022 and homage was paid to our extraordinary nursing workforce across the organisation.

The Chief Nursing Officer (CNO) for Wales, Sue Tranka, met five of the internationally trained nurses who have joined Aneurin Bevan University Health Board recently. Joining the team from Nevill Hall Hospital, the CNO said *"it was very special to meet the new cohorts today as I joined the NHS in a similar way. I know they will be full of excitement about their new opportunities, and I wish them well in their new career and life in Wales. I know first-hand that NHS Wales will very much welcome them with open arms, as I have really had a wonderful welcome since joining as CNO last year."*

The CNO Excellence Award was awarded on International Nurses' Day to our Practice Educator, Maria Cruz. Maria joined the Health Board five years ago, having left the Philippines with her family, and has progressed her career since.

The CNO, Sue Tranka, said; "Maria is a shining light in nursing in Wales. Her motivation and passion for her own career and that of others is extraordinary."

Speaking to the newly recruited Internationally trained nurses at Nevill Hall, Maria said; "I am so proud to receive this award. I love my job; I now have the career I've always dreamed of. I am the living proof that we can, we are capable".

In addition, Karen Jewell, Chief Midwifery Officer for Wales, visited the Serennu Children's Centre in Newport and met with some of the Health Board's Children's Nursing Team. The Serennu Children's Centre is a purpose-built centre that provides care, treatment and activities for children and young people with disabilities and developmental difficulties. The Chief Midwifery Officer said, *"I want to say thank you to all the nurses out there who do an amazing job every day and I hope you are celebrating well. It's been great to be here and celebrate with everybody and the team in Serennu"*.

Royal College of Nursing Betsi Cadwaladr Scholarship Award

Vicky Coughlan, Advanced Nurse Partitioner, was announced as the winner of the Royal College of Nursing Betsi Cadwaladr Scholarship Award at the Chief Nursing Officer for Wales Conference on 8th April 2022, for the Trial without Catheter (TWOC) project.

The service is thrilled that this work has been recognised. It has been a fantastic project with the support of so many. This has realised fantastic outcomes for patients, waiting times, admission avoidance, DN workload and reduction in Catheter Associated Urinary Tract Infections (CAUTI).

Recommendation

The Board is asked to note this report for information.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	COVID-19 and system pressures remain key risks on the Board's Corporate Risk Register.
Financial Assessment, including Value for Money	There are no direct implications arising from this report.
Quality, Safety and Patient Experience Assessment	There are no direct implications arising from this report.
Equality and Diversity Impact Assessment (including child impact assessment)	An EQIA has not been undertaken on the contents of this report.
Health and Care Standards	The range of activities outlined in the report will contribute to the Health Board's approach to Health and Care Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	The range of activities outlined in the report will contribute to the Health Board's strategic objectives.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	The range of activities outlined in the report will contribute to the Health Board's approach to the Well Being of Future Generations Act.
Glossary of New Terms	No new terms have been identified.
Public Interest	This report is written for the public domain.

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Wednesday 25th May 2022 Agenda Item: 4.12

Aneurin Bevan University Health Board

Committee and Advisory Group Update and Assurance Reports

Purpose of the Report

This report acts as a mechanism for Committees to provide assurance to the Board with regard to business undertaken in the last reporting period. It also allows the Committee to highlight any areas that require further consideration or approval by the Board.

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

The Board is asked to:	
Approve the Report.	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	✓
Note the Report for Information Only	

Executive Sponsor:	Rani Mallison, Board Secretary		
Report Author:	Bryony Codd, Head of Corporate Governance		
Report Received consideration and supported by:			
Executive Team	**N/A**	**Committee of the Board [Committee Name]**	**As outlined.**
Date of the Report: 9th May 2022			
Supplementary Papers Attached: Committee Assurance Reports			

Background and Context

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

Required Committees:

- Audit, Finance and Risk Committee
- Charitable Funds Committee
- Patient Safety, Quality and Outcomes Committee
- Mental Health Act Monitoring Committee
- Remuneration and Terms of Service Committee
- Stakeholder Reference Group
- Healthcare Professionals Forum

Additional Committees and Groups:

- Strategy, Planning, Partnerships and Wellbeing Group
- People and Culture Committee

Assurance Reporting

The following Committee assurance reports are included:

1. Patient Safety, Quality and Outcomes Committee – 5th April 2022

2. Audit, Risk and Assurance Committee – 7th April 2022
3. People and Culture Committee – 14th April 2022
4. Partnerships, Population Health and Planning Committee – 25th April 2022

External Committees and Group

Representatives from the Health Board also attend a number of Joint sub-Committees or partnerships of the Health Board, these are:

- Emergency Ambulance Services Committee
- Welsh Health Specialised Services Committee
- Shared Services Partnership Committee

In order to provide the Board with an update on the work of these Committees and Groups the following minutes, assurance reports and briefings are included:

- Shared Services Partnership Committee – 24th March 2022
- WHSSC/EASC – provided within Agenda item 4.8 – An Overview of Joint Committee Activity.

Assessment and Conclusion

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

Recommendation

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

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	There are no key risks with this report. However, it is good governance practice to ensure that Committee business and minutes are reported to the Board. Therefore, each of the assurance reports might include key risks being highlighted by Committees.
Financial Assessment, including Value for Money.	There is no direct financial impact associated with this report.
Quality, Safety and Patient Experience Assessment	A quality, safety and patient experience assessment has not been undertaken for this report as it is for assurance purposes.
Equality and Diversity Impact Assessment (including child impact assessment)	An Equality and Diversity Impact Assessment has not been undertaken for this report.
Health and Care Standards	This report will contribute to the good governance elements of the Standards.
Link to Integrated Medium Term Plan/Corporate Objectives	There is no direct link to the Plan associated with this report, however the work of individual committees contributes to the overall implementation and monitoring of the IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	Not applicable to this specific report, however WBFGA considerations are included within committee's considerations.
Glossary of New Terms	None
Public Interest	This report is written for the public domain.

Name of Committee:	Patient Safety, Quality and Outcomes Committee
Chair of Committee:	Pippa Britton
Reporting Period:	5th April 2022

Key Decisions and Matters Considered by the Committee:

Assurance Report: National Clinical Audit and Local Clinical Audit Arrangements

The Committee received the report and an update on the Health Board's compliance and performance against National and Local Audit reports. The report provided oversight of results from Clinical Audits, Confidential Inquiries and Peer reviews, giving oversight of the improvements underway to address performance.

The Committee was assured that all Health Board actions, particularly arising from Audits, could now be tracked, and recorded through the newly purchased specialist software AMAT, further strengthening assurance mechanisms. A high-level overview of the Health Board's Local Clinical Audit to come back to a future meeting.

Committee members discussed recent national maternity service issues. Members were assured that regular reporting was rooted through the Health Board's Maternity Services Assurance Group, with Highlight reports to the PQSOC. The Health Board was currently undertaking a review based on recent findings and recommendations from the Ockenden Review regarding Maternity Services at Shrewsbury & Telford NHS Trust. A report and maternity Overview to come back to a future Committee.

Committee Members discussed the papers and recognised more work was required to provide assurance on gaps identified.

Assurance Report: Compliance with Cleaning Standards, including Benchmarking Data, and Actions underway to address associated issues and risks

The Committee received a report on the organisational compliance with Cleaning Standards, workforce challenges and current risk mitigation.

The Committee were informed that the Health Board Facilities Teams had appointed a Recruitment and Retention officer to facilitate the recruitment process and avoid any delays in start dates, also implementing several actions to help improve staff experience.

The Committee received the report for assurance and noted the plans in place to overcome the workforce supply challenges, which are critical to maintaining cleaning standards compliance.

Dementia Standards Update, including a patient story

The Committee received an overview of the new Dementia Standards and the launch of the All-Wales Hospital Dementia Charter.

A patient story, outlining the importance of adhering to standards and the impact the pandemic has had on patients and their families, was shared with the Committee members. The Committee were assured that the significant and complex complaint involving the patient was being addressed through Putting Things Right processes.

The Health Board's Action Plan was discussed. The Dementia Charter starts on the 6th April 2022, with four ABUHB wards piloting a VIPS tool to rate progress in patient centred care.

The Committee recognised there is significant work required nationally, regionally, and locally to improve care of people living with dementia.

Committee Annual Workplan and Priorities 2022/23
Further communications to take place between the Director of Corporate Governance and Committee Members outside of the meeting.

The Committee were assured that the reinstatement of IM visits was being discussed and a timetable would be produced, with alignment with the Health Boards Integrated Medium Term Plan (IMTP) priorities.

Healthcare Inspectorate Wales: Inspections Update
The Committee received an update on progress against the Healthcare Inspectorate Wales (HIW) inspections and ABUHB' response. The update covered inspections that have taken place since 2018 to the present day, noting that inspections prior to 2018 have previously been reviewed and closed.

The Committee was assured that the Health Board's aim is to ensure the recommendations were addressed and ensure proportionate and appropriate responses, ensuring Divisional actions address the recommendations.

The Committee was informed that the awaited Grange University Hospital (GUH) report had been published by HIW, week commencing 28th March 2022, which will be presented to the next PQSOC.

Patient Quality and Safety Outcomes Report
The Committee received an overview of the report, noting that reporting continues to adopt a proportionate approach due to Health Board challenges, focusing on high-risk matters. The update focused on two risk areas with a red rag rating; Urgent Care and Stroke Services.

Members were informed that Infection Prevention and Control (IPAC) has reduced from 'red' to 'amber' RAG rating, due to overall performance against the six Welsh Government reportable expectations.

Members were informed that an Internal Audit review on the management of inpatient falls had been conducted, eliciting a 'reasonable assurance' rating. The Health Board had received a Regulation 28 from the Gwent Coroner, relating to management of falls and was preparing a response, to be included in the next PQSO report.

Members were informed that a Self-Harm and Suicide Prevention Task and Finish Group had been established by the Health Board, aligning to national work being undertaken due to an increase in the number of suicides in children and young people during the Covid period. A future update on this area would come back to the Committee.

Members were informed that the Stroke pathway required further strengthening and focus. The Stroke Directorate were working alongside 'Getting It Right First Time', who were conducting an external review. Recommendations from this exercise would support the Health Board in improving future Stroke services. This would be overseen by the Health Boards Stroke Recovery Group.

Members were assured that, in relation to the inability to use the Stroke Therapies room for stroke services, that the Executive Team were in full support that the Stroke Therapies Room should be used to deliver stroke patient care. A 'Hospital Full' protocol was in place that enabled the use of identified areas to accommodate patient demand and facilitate

system pressures. All areas identified in the Health Boards 'Hospital Full' protocol have been risk assessed for patient placement. The Stroke Programme Board are reviewing options to identify alternative temporary rooms during increased demand and capacity to mitigate this risk.

Members were informed that the Urgent and Emergency Care system remained under sustained pressure. Urgent Care performance was flagged as a national issue, with the Health Board implementing a recent 'two-week reset' to mitigate risk, alongside all Health Boards. The impact of the reset was being completed and an update would be presented to Board. Contextual issues impacting urgent care were summarised for the Committee.

The Committee received the report and noted the high risks and actions being taken to mitigate the position. The Urgent Care pressure is the subject of an in-committee discussion.

Patient Safety, Quality and Outcomes Committee Risk Report
The Committee were advised that the report included risks that had recently been reported to the Board as part of the Corporate Risk Register.

Members were assured that the risk report would continue to inform the Committee workplan and priorities going forward.

Assurance Report: Access to Primary Care Services
The Committee received the report for assurance, noting the actions and next steps taken by the health Board based on the findings of an in-depth review undertaken by the Health Board in June 2021.

Members were informed that the Health Board had completed review of Access arrangements across all 72 GP practices to seek assurance in respect of access to services for patients, an issue raised by the Community Health Council.

Members were informed that challenges around workforce availability in primary care were an ongoing problem. Members were assured that a Primary Care Sustainability Framework was in place to support practices with recruitment issues. The Health Board Primary would repeat the Sustainability Review, alongside the continuation of the GMS Access review, to actively monitor and support GMS access in line with contractual requirements.

Highlight Assurance Reports:

- ***Quality, Patient Safety and Outcomes Group***
  Report received for assurance.

- ***Children's Rights & Participation Forum***
  Report received for assurance. The Committee supported the request for a Board Development session.

- ***Welsh Health Specialised Services Committee (WHSSC) Quality & Patient Safety Committee Chair's Report***
  Report received for assurance.

Transition and handover- Children's and Adults Health Care Services
Letter noted by the Committee.

Investigating and Learning from Cases of Nosocomial Covid-19
Report received by the Committee, noting a detailed update on the ABUHB approach would be presented at a future Committee.

Internal Audit Reports:
a) GUH Quality Assurance Report
b) Falls Management Report
The above reports were to be discussed further at the upcoming Audit Risk and Assurance Committee.

Committee Terms of Reference
The Committee Terms of Reference were previously approved by the Board.

Matters Requiring Board Level Consideration or Approval:

None

Key Risks and Issues/Matters of Concern:

The continued pressures in Urgent Care, noting a paper was being prepared for the Board in May 2022.

Planned Committee business for the Next Reporting Period:

- Presentation and update in respect of Safe Accommodation
- Learning From Death Report
- Covid Claims agenda
- Audit Wales Quality Governance Report – report and management response
- Assurance Report: Health and Care standard 2.1, Managing Risk and Promoting Health and Safety
- Patient experience report
- Neonatal Peer Review GUH
- National review of Venous Thromboembolisms (VTE) Draft Report - Letter from Jonathan Webb- for information
- Internal Audit Reports- Care After Death

Date of Next Meeting: Tuesday 7th June 2022

Name of Committee:	**Audit, Risk and Assurance Committee**
Chair of Committee:	**Shelley Bosson**
Reporting Period:	**07 April 2022**
Key Decisions and Matters Considered by the Committee:	

Counter Fraud Annual Report 2021/22
The Annual Report was presented to the Committee noting two (2) key points.
Component 12: Gifts and Hospitality Policies and Registers, and Conflicts of Interest. The declaration could not be included in this report because the Health Board's first Audit Committee meeting of the financial year occurred prior to the completion of the self-assessment return. The Local Counter Fraud Specialists had requested dispensation from the NHS Counter Fraud Agency's Senior Quality and Compliance Inspector that the declaration and outcomes be included in the second Audit Committee report of the financial year, and that this would be considered compliance with that specific aspect of the components/requirements.

The second point of note was compliance; the Health Board would be reporting green for all 12 components and requirements. This would be reported to a future Audit Committee meeting alongside the formal legal declaration.
The Committee suggested a stand-alone metric be put in place against the Prevention Agenda that would depict what good looks like based on the number of employees, then triangulate it against how many of those should be receiving refresher training every year versus how many are receiving it. This would provide valuable insight and provide assurance that prevention agenda is fit for purpose.
The Committee endorsed the Annual Report 2021/22.

Counter Fraud Annual Workplan for 2022/23
The workplan for 2022/2023 was presented to the Committee as a dynamic document that would need to be flexible and change to meet the needs of the organisation.

The Committee endorsed the plan, stating it appeared reasonable and proportionate.

Update on Outpatient Transformation
The Committee was provided with an update, noting that the current focus was to coordinate and streamline activity to avoid duplication of effort and to ensure efficiencies in delivering on the national work programmes in terms of the recovery plans and the outpatient transformation programme.

Significant work had been undertaken in the last 12 months in terms of patient communication, validation, and signposting to alternative treatment pathways. In addition, a specialised team had been formed to serve as a single point of contact and to deliver communications. It was noted that all the initiatives outlined in the report should result in a reduction in the number of patients on waiting lists as well as significant financial benefits, most notably in cost avoidance, but, noted the challenge would be to shift resources based on intelligence and information.

An Outpatient Strategy Group, chaired by the Director of Operations, was identified as a significant enabler in progressing the transformation. The Committee was advised that while the outpatient infrastructure would not save money, it would gain efficiencies from each directorate that used the outpatient space. To support programme delivery and embed the

required change a request had been made to clinical leads across all directorates to allocate time within their job plans to quality improvement.

The Committee had concerns in relation to the pace at which the programme was progressing and wanted to know what barriers there were, and what opportunities there were to overcome the barriers. It was noted that the Health Board would face financial challenges as Welsh Government funding was reduced over the next few years, so redesigning services was critical to service delivery and as such the Committee extended its support as well as that of the Board's to overcome any barriers.

Status Update: Estates Efficiency Framework
The Committee received an update noting the Health Board has had limited opportunity to fully apply the framework to specific proposals since the approval of its use, however, the general principles were being applied in terms of considering agile working and 'fitting' services into GUH, eLGH, and office accommodation proposals.
The framework provided assurance to the Committee, but it was concerned about the pace with which estates were being rationalised, and it would welcome regular reporting on milestones. A discussion took place about collaboration with partner organisations and the use of estates in the public sector. It was felt that a more strategic approach, as well as greater consideration of the Future Generations Act, were required. The Committee agreed that more work should be undertaken to examine what the Health Board has in its existing estate that is not necessarily needed or used should be an area of focus that would see the estates framework deliver tangible efficiencies.

The Chair advised that going forward further updates would be presented to the Finance and Performance Committee.

Update on Governance and Financial Control Procedures
The Committee noted a technical accounting issue, which is a national issue initiated in the 2019/2020 tax year described as 'scheme pays'. The Committee was assured that there were no financial implications for the Health Board, but there were audit implications due to the regulatory nature of the payment.

The Health Board had continued to meet the Public Sector Payments target of 95% and was on track to meet the target at the end of the financial year and noted the Single Tender Actions (STAs) taken since the last reporting period. As a result, the Health Board may have a technical qualification applied to that element of the accounts; this was also noted as having an impact on Welsh Government accounts.

The Committee endorsed the proposed changes to the charitable funds and financial control procedures.

Losses and Special Payments Report
The Committee was informed that Community Pharmacy Wales Contractors had received an ex-gratia payment of £603k for WP10(HP) prescriptions, which had been approved by Welsh Government. The payment was a one-time payment to community pharmacists who dispense hospital-prescribed medications. The national discount scheme for some of the drugs on the WP10(HP) forms had not been applied to the purchase cost of the high-cost medications dispensed by the community pharmacist.

Finance Report
The Committee received the Month 11 report and noting that the Health Board continued to forecast a breakeven position for both revenue and capital.

A key priority for next year would be to improve efficiency and reduce costs through transformation; changes in service models are required to develop more efficient pathways of care, reduce the use of hospital beds and workforce requirements, thereby lowering variable pay expenditure. It was noted that the Care Closer to Home Pathway would be reviewed in collaboration with local authority partners under the auspices of the RPB Community Subgroup.

Assurance was sought in respect of the Registered Nurse Agency Reduction Plan and whether it was fit for purpose or needed to be revised. The Committee was assured that this was a top priority for the Executive Team.

Internal & External Audit Recommendation Tracker
The Committee was presented with the draft procedure for managing internal and external audit recommendations, which outlined the responsibilities as well as a process for monitoring and tracking progress alongside a revised audit tracking tool that would provide information to assist in taking assurance that progress is being made on those actions that are past due for implementation in relation to the original agreed-upon timescales.

The Committee endorsed the revised tracker stating it was as reasonable and proportionate in its approach.

Risk Management Strategy Realisation Plan
The Committee received the Risk Management Strategy Realisation Plan, which outlined the actions required to embed the agreed-upon objectives within the revised Risk Management Strategy.
The Committee approved the Risk Management Strategy Realisation Plan and endorsed the proposal to defer the implementation of the Once for Wales Datix Risk Management Module.

Committee Risk Report
The Committee received the report and was informed that the Health Board had engaged in multi-partnership discussions relating to the Ukraine Crisis in the context of planning and emergency response. An internal risk management profile had been created, highlighting the potential consequences for the Health Board.
A concern was raised in relation to risk CRR002 Implementation of WCCIS. The concern was regarding the handover process and the risks associated with the transition from the current system to the new platform. The Chair requested a position statement outlining organisational readiness linked to local authority implementation be prepared and circulated prior to the implementation date.

Committee Priorities 2022/23
The Committee received a presentation outlining the 2022/23 priorities which was developed based on the Committee's revised Terms of Reference (ToRs) and would underpin Committee work plans as well as inform the Board's work plan.

The development of an Accountability Framework was identified as a priority in the IMTP's governance workplan. This was highlighted as an area of focus, alongside preparedness for the COVID-19 Inquiry and Clinical Audit arrangements.

Internal Audit Plan Progress Update
The Committee was informed that there were eleven (11) outstanding reports, three (3) of which were in draft form and eight (8) of which were in progress.

Internal Audit Review, Limited Assurance: Mental Health & Learning Disabilities Continuing Health Care (MHLD CHC)
A detailed review of the MHLD CHC arrangements had been undertaken, looking at the requirements that were in place during the pandemic. It was noted that several key aspects had been stepped down as directed by the Welsh Government, which was a focus for the report alongside the Commission reviews with providers and support arrangements.

The Committee was assured that the twelve (12) recommendations in the report were being implemented and progressed. A target date for improvement had been set for the end of July, with a review scheduled for the end of May.

Record keeping was identified as a continuing source of concern, with the Committee requesting assurance on the measures in place to assist staff with accurate record keeping. It was agreed that the Patient Quality & Safety Committee would be provided with an update on recent/upcoming audits centred on record keeping for oversight and assurance.

Internal Audit Plan 2022/23 - Draft
The Committee received the draft plan, noting that it had not been formally considered by the Executive Team and that it would be brought back to the Committee for formal approval at the next meeting.

Audit Wales Performance Update Report
The Committee received the update and noted the reports scheduled for April.

Audit Wales Audit Plan 2022
The Committee received the draft plan, noting that it had not been formally considered by the Executive Team and that it would be brought back to the Committee for formal approval at the next meeting.

Matters Requiring Board Level Consideration or Approval:

- There were no matters requiring consideration or approval.

Key Risks and Issues/Matters of Concern:

- There were no issues or matters of concern.

Planned Committee Business for the Next Reporting Period:

Date of Next Meeting: Tuesday 17th May 2022 at 09:00am via Microsoft Teams

Name of Committee:	People & Culture Committee
Chair of Committee:	Louise Wright
Reporting Period:	14th April 2022

Key Decisions and Matters Considered by the Committee:

Committee Priorities

The Committee received a presentation of the role, function and priorities for the forthcoming year for the Committee. The Committee welcomed the overview and agreed that it was helpful, comprehensive, and aligned to the IMTP.

People First Update

The Committee received an update in relation to the current position of the project. It was noted that so far, the project was moving in the right direction and momentum was growing across the Health Board. The engagement and support from the Executive Team had been invaluable with the Executive Team requesting that the sessions continue into the next phase. Phase 3 is currently being developed working closely with two areas that have shown interest using the methodologies outlined in the report
The Committee welcomed and supported the report and the ongoing work and requested regular progress updates.

Equality Impact Assessment

The Committee received an overview of the new approach to the Equality Impact Assessment (EqIA) process to ensure that the Health Board meet their obligations in relation to equality, Welsh measures, Wellbeing of Future Generations Act and socio-economic duty.

An update was also received in relation to work that has been undertaken with teams across the Health Board since September 2021 which has included piloting the new template, applying the new arrangements and gathering feedback.

The Committee supported the proposal for the establishment of the EqIA Group to build common understanding, learning and to develop skills across the Health Board.

Agile Working Update

The Committee received an overview of the current position of the Agile Delivery Board. The Committee noted the work undertaken and acknowledged the next steps. It was agreed that regular update reports would continue to be submitted to the Committee.

Committee Risk Report

The Committee noted that all risks have been updated to reflect the actions to support the new People Plan. The recruitment and retention risk has been reframed and updated to reflect the cessation of the Coronavirus Act 2022 and the extension of the Pension Scheme Regulations.

The Committee noted the updated risk registers and agreed the changes detailed in the report.

Audit Wales Report, Taking Care of the Carers and ABUHB's Management Response

The Committee accepted the report and agreed to monitor its implementation on the management response to the recommendations.

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:
• Update report on Agile Working • Updated Risk Report • Update on established of the EqIA Group
Date of Next Meeting: Tuesday 12th July 2022 at 09:30am via Microsoft Teams

Name of Committee:	**Partnerships, Population Health, and Planning Committee**
Chair of Committee:	**Ann Lloyd**
Reporting Period:	**25th April 2022**

Key Decisions and Matters Considered by the Committee:

Committee Terms of Reference & Operating Arrangements
The Committee received its Terms of Reference (ToR) and operating arrangements for 2022/23, following Board approval in March 2022. Members requested that the ToR included a focus on the governance and reporting arrangements of the Regional Partnership Board (RPB).

Committee Priorities
Members received a high-level overview of the Committees priorities for 2022/23. The outlined priorities would inform the Committee workplan, which will be presented to the Board in May 2022. Members requested that the governance of RPB be included in Committee priorities for 2022/23. The Committee approved the Committee priorities, with amendments.

Overview of work of the Gwent PSB, including an update in respect of Developing a Marmot Region
Members received the proposal outlining the rational for asking the Public Service Board (PSB) to drive the development of Gwent as a Marmot region.

Members requested further discussions between the Health Board and the PSB around the fourth priority, the 'Economy', highlighting the importance of the Health Board to be part of discussions, as one of the biggest employers.

Members were informed that the Health Board planned to deliver a response analysis to the PSB in June 2022 and the Well-being Plan in September 2022, ensuring legal compliance with the Well Being of Future Generations Act.

Members were informed that a communications plan was being developed, to strengthen community involvement. The Communications plan would be presented to the PSB in June.

Members were assured that any papers presented at the PSB would be shared with the Committee at future meetings for discussion.

Members requested an explanation in respect of the difference between the Foundational Economy programme, an Anchor institution and how these fitted with the Marmot proposals, to be presented at a future Committee meeting. In the meantime, an explanatory note would be circulated to all Board members.

Integrated Medium Term Plan, 2022-2025
The Committee received an overview of the Health Board's plans and intended delivery framework for the IMTP.

Members were informed that a paper on the Health Boards revised performance reporting, including delivery objectives and dates, linked to the development of the Outcomes Framework, would be presented to the Committee in July, with an analysis of the 'first look' and implementation of the Outcomes Framework to come back to the Committee at the end of the first Quarter.

A report would be presented to the Committee each quarter, linked to the Board Assurance Framework (BAF), updating members on progress against each priority area.

Members were assured that, in terms of measuring performance against outcomes, Health Board Planning team members were part of National Measures Groups with the intention to influence a strategic focus.

Members requested a report outlining the purpose of the Same Day Emergency Care (SDEC) and how it fitted into the current system and would alleviate pressures. Progress be presented to a future meeting of the Committee.

Decarbonisation Strategy and Update of Progress to-date
The Committee received a presentation on the Health Boards intended Decarbonisation Framework. Members were informed that a draft Decarbonisation Framework was in development and would be shared with Welsh Government (WG) on completion.

Regional Planning Update
The Committee received an update in respect of regional planning.

Members were informed of the positive progress made on Ophthalmology service plans and development of a proposal for a Regional Cataract Centre.

Members were informed that, based upon a readiness assessment and risk analysis, that there may be some delay in the 'go live' date of the 14th of June 2022 for Vascular Services. Members were assured that the CEO of each Health Board was meeting in the coming week to agree regional working priorities and to discuss further progress on Vascular services, alongside the priorities on Ophthalmology and Orthopaedics.

Matters Requiring Board Level Consideration or Approval:

None

Key Risks and Issues/Matters of Concern:

None

Planned Committee business for the Next Reporting Period:

- Review of Clinical Futures Strategy Implementation.
- Update of the Implementation of the Mental Health Strategy.
- Review of the evaluation of the eLGH's and future plans for the County Hospital and St Woolos Hospital.
- Update on agile working and the consequences for the estates strategy.

Date of Next Meeting: Thursday 7th July 2022

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	24 March 2022

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Recruitment Modernisation Programme

The Director of People and Organisational Development and the Deputy Director of Employment Services gave a detailed presentation of the work being undertaken in Recruitment to support the significant increase in activity since the start of the pandemic. Looking back to when NWSSP was first established in 2011, significant progress has been made in streamlining the recruitment process, demonstrated by a reduction in the average time-to-hire from 132 to 71 days. New services have been taken on and the Welsh Language functionality has been enhanced. Last summer, further initiatives were progressed relating to the Workforce Directors' Responsiveness Programme including enhancements to TRAC, development of the applicant web page, and maintaining virtual pre-employment checks.

During late summer 2021, the service was faced with unprecedented and unplanned levels of recruitment across NHS Wales due to the Covid response, resulting in the usual high level of compliance with KPI targets not being sustained. This led to the need to review the way in which recruitment is undertaken in Wales and where applicable modernise the service further through changes to processes, technology, and education.

The Deputy Director provided details of specific initiatives under each of the headings of process, technology, and education. One key technological initiative is investment in pre-employment check software that enables identification documents to be held in ESR and viewed via the ESR app. This has been promoted by the Home Office, however the technology is not currently available, but it will be fundamental to virtual pre-employment checks continuing after the current proposed Home Office end-date of September 2022. Due to the short notice provided by the Home Office over this software, funding to purchase it still needs to be confirmed.

The Modernisation Action Plan is to be taken to the All-Wales Workforce and OD peer group meeting in early April, with a formal update to the May Committee.

The Committee **NOTED** the presentation.

Chair's Report

The Chair updated the Committee on the activities that she had been involved with since the January meeting. This included chairing her first Welsh Risk Pool Committee which had been very informative; attending the Hywel Dda Sustainability Committee; and also attending the NHS Wales Chairs' meeting which allowed her to keep updated on the latest developments and issues. Going forward there will be a number of attendances at board meetings, starting with Digital Health Care Wales and then Health Education and Improvement Wales. The Chair is keen that these are not used solely for NWSSP to update on performance, but to elicit a two-way exchange of ideas and information.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The IMTP has now been formally submitted to Welsh Government for their consideration;
- As part of a UK-wide response to the war in Ukraine, Welsh Government asked NWSSP to identify any surplus equipment and consumables that could be donated to Ukraine. Review of current stocks identified items to the value of £524k that could be donated as they are surplus to current requirements (PPE, ventilators, and medical consumables). Thus far, over £131k of surplus items has already been sent to Ukraine from NWSSP;
- The purchase of Matrix House in Swansea was completed by the end of March. The building is currently 75% occupied by NHS Wales, with Public Health Wales and the Welsh Ambulance Service NHS Trust as tenants in addition to NWSSP. Acquisition of this asset will lead to a reduction in future revenue costs to NHS Wales and the opportunity to create a wider public sector hub at some point; and
- The Minister for Health and Social Care visited our Imperial Park 5 Warehouse on 17th March, providing an opportunity to demonstrate to her the extensive range of services that now operate from this facility.

Items Requiring SSPC Approval/Endorsement

Lease Car Salary Sacrifice

In July 2021, the Committee agreed to reduce the CO2 emissions for Salary Sacrifice vehicles through the NHS Fleet scheme. Whilst the intentions of this decision were well founded, the implementation of the first phase from 120g/km to 100g/km has generated the following issues:

- Those staff who do not have driveways and therefore home charging facilities, are either unable to participate in the scheme or have a very limited choice of cars;
- Only certain EV and hybrid cars meet the lower CO2 limits – therefore a large number of small fuel-efficient cars e.g. 1 litre VW Polo, Ford Ka etc are no longer available to staff. This is particularly problematic to those staff who live in the more rural areas

In view of the above it is evident that some staff are opting not to apply for salary sacrifice cars but instead are continuing to use their private cars, commonly referred to as the 'grey fleet'. These cars are generally older and emit more pollution than the vehicles that were previously available on the lease car salary sacrifice scheme.

In view of this, it was proposed to reinstate the 120g/km cap for petrol and hybrid vehicles from 1st April 2022 but not to allow diesel vehicles to be ordered. The impact of this will be to increase the range of vehicles available, remove new diesel vehicles from the Scheme and provide greater access to those staff who do not possess home charging facilities.

It was also noted that NWSSP do not administer this Service to all Health Boards and Trusts, and it was agreed that the provision of the administration of service to an all-Wales service should be explored

The Committee **APPROVED** the proposed:

- Adjustment in the CO2 emissions;
- Removal of the ability to order new diesel cars on the scheme

Items For Noting

Energy Update

The Committee received a paper relating to the current situation with energy prices. Due to the nature of the markets and high expenditure, the Energy Price Risk Management Group (EPRMG) was formed in 2005 to manage exposure to risk across the NHS Wales energy contracts. The overarching aim of the group is to minimise the impact of energy price rises through proactive management and forward buying.

There have been very significant increases in gas and electricity prices during the year, particularly during recent weeks following the outbreak of the Ukraine war. The EPRMG strategy of purchasing ahead has meant that NHS Wales has benefitted substantially and avoided most of the price increases for gas and electric supply. Whilst this strategy has protected NHS Wales from the huge increase in market prices for 2021/22 it is likely that there will be very significant hikes in energy costs in 2022/23 because of the current contracts coming to an end.

The recent increase in energy costs is very unwelcome, but is unavoidable given the current war in Ukraine, the sanctions applied to Russia and the removal of Russian Gas and Oil from supplying the global market. However, the EPMRG will attempt to manage the energy costs for NHS Wales as best as we can over the year ahead.

The Committee **NOTED** the paper.

Finance, Performance, People, Programme and Governance Updates

Finance – The Director of Finance & Corporate Services reported that NWSSP was on track to meet each of its revenue financial targets for 2021/22 and the projected outturn on the Welsh Risk Pool was in line with the Integrated Medium-Term Plan. Additional capital funding had been received in quarters three and four, but plans were in place to ensure the funding was fully utilised by the end of the financial year.

Performance – Most KPIs are on track except for those relating to Recruitment Services which was the subject of the deep dive earlier in the agenda. The move towards qualitative output focused measures continues within NWSSP.

People & OD Update – Sickness absence rates remain at very low levels with an absence rate of 2.93% for the last quarter. Performance and Development Reviews and Statutory and Mandatory training results continue to improve although there is still room for further improvement. Headcount is increasing due mainly to the additional staff recruited as part of the Single Lead Employer Scheme. The ESR database has been modified such that most of the facilities it provides can be accessed and delivered in Welsh

Corporate Risk Register – there are two red risks. The first relates to the pressures currently being noted within the Employment Services Directorate, and particularly in Recruitment and Payroll Services, which was the subject of the earlier deep dive. The second refers to the energy price increases which again was the subject of an earlier agenda item.

Papers for Information

The following items were provided for information only:

- PMO Highlight Report
- Audit Committee Highlight Report
- Quality and Safety Assurance Report
- 2022/23 Forward Plan
- Finance Monitoring Returns (Months 10 and 11)

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	19 May 2022