Finance & Performance Committee

Wed 05 October 2022, 09:30 - 12:00

Microsoft Teams

Agenda

09:30 - 09:45
15 min

1. Preliminary Matters

1.1. Welcome and Introductions

Verbal *Chair*

1.2. Apologies for Absence

Verbal *Chair*

1.3. Declarations of Interest

Verbal *Chair*

1.4. Committee Action Log

Attachment *Chair*

1.4 F&PC Action Log October 2022 (V2).pdf (5 pages)

1.5. Draft Minutes of the meeting held on 6th July 2022

Attachment *Chair*

1.5 Draft F&P Committee Minutes- 06-07-22 (Chair Approved).pdf (8 pages)

09:45 - 09:55
10 min

2. Committee Governance

2.1. Committee Strategic Risk Report

Attachment *Head of Corporate Services, Risk & Assurance*

2.1 Finance and Performance Committee Cover Risk Report Sept2022 V1.pdf (6 pages)
2.1a Finance Risks _ June 2022 update FPC.pdf (25 pages)

09:55 - 11:05
70 min

3. Assurance in Respect of Financial Management and Performance

3.1. Financial Understanding of Health Board Commissioned Services

Attachment *Interim Director of Finance, Procurement & VBHC*

3.1 Fin.Perf. Committee_Commissioning_Oct22.final.pdf (21 pages)

3.2. Finance Performance Report, Month 5 202/23

Attachment *Interim Director of Finance, Procurement & VBHC*

3.2 FPC Finance Report _m5_October 22.pdf (30 pages)
3.2a Finance Report.pdf (19 pages)

3.2b Monitoring return for Month 5, 2022-23.pdf (28 pages)
3.2c Welsh Government Month 5 Monthly Monitoring Return.pdf (17 pages)

3.3. Revenue Financial Forecast Review 2022/23

Attachment *Interim Director of Finance, Procurement & VBHC*

3.3 FPC_fin forecast.recovery_final.2022.09.28.pdf (11 pages)
3.3a FandPC_Attachment_Fin.forecat.22.10.05.pdf (32 pages)

3.4. ABUHB Budgetary Control and Finance Control Procedure

Attachment *Interim Director of Finance, Procurement & VBHC*

3.4 F&PC Budgetary Control, Finance Control Procedure .pdf (6 pages)

3.5. COMFORT BREAK- 10 MINUTES

11:05 - 11:45
40 min

4. Assurance in Respect of Organisational Performance Management

4.1. Performance Management Report - Committee to receive report that was presented to September Board

Attachment *Interim Director of Planning & Performance*

4.1 Performance Report September 2022v4.pdf (22 pages)

4.2. Performance Exception Reporting

Attachment *Medical Director/Director of Operations*

1. Cancer
2. Planned Care (Presentation)
3. Six Goals of Urgent and Emergency Care

4.2a V2 Cancer Performance Finance Performance Committee - 5th Oct (002).pdf (10 pages)
4.2b Finance and Performance Committee 5th Oct - Six Goals Urgent and Emergency Care.pdf (8 pages)
4.2c six-goals-for-urgent-and-emergency-care.pdf (46 pages)
4.2d ABUHB Urgent and Emergency Care Six Goals Programme Plan V4 (Sept 2022).pdf (23 pages)
4.2e SLR Format 20th Sept 22.pdf (26 pages)

4.3. Information Governance Performance Indicators

Attachment *Head of Information Governance/DPO*

4.2 Information Governance Performance & Assurance.pdf (7 pages)

11:45 - 11:50
5 min

5. Other Matters

.

5.1. To confirm any key risks and issues for reporting/escalation to Board and/or other Committees

Verbal *Chair*

11:50 - 11:50
0 min

6. The next meeting of the Finance & Performance Committee will be held on Wednesday 11th January 2023, via Microsoft Teams

Verbal *Chair*

Finance & Performance Committee
October 2022 Action Sheet

(The Action Sheet also includes actions agreed at previous meetings of the FPC and are awaiting completion or are timetabled for future consideration for the Committee. These are shaded in the first section. When signed off by the FPC these actions will be taken off the rolling action sheet.)

Agreed Actions Key:

Overdue	Not yet due	Due	Transferred	Complete	In progress

Action Ref	Action Description	Due date	Lead	Progress	Status
0607/05.1 Committee Priorities for 2022/23	A more detailed forward work plan (FWP), identifying specific reports and timeframes, would be shared outside of the meeting, following Board approval in July 2022.	**October 2022**	**Director of Corporate Governance/ Secretariat**	Agenda item for discussion at the October 2022 meeting.	**Complete**
0607/05.2Committee Priorities for 2022/23	Members requested assurance about how Commissioned Services would be monitored through the Committee. A brief report on and financial review of Commissioned Services, through a *Long-Term*	**October 2022**	**Interim Director of Finance & VBHC/Secretariat**	Added to the Committee Forward Work Plan for the next meeting in October 2022.	**Complete**

	Agreement lens, would be presented at the next meeting.				
0607/05.32 Committee Priorities for 2022/23	Members were advised that a review of how the Health Board monitored Commissioned Services would be undertaken by the Executive Team, feeding back to the appropriate Committee(s)	**October 2022**	**Director of Planning, Performance, Digital and IT/Director of Finance & VBHC**	Discussion noted as an agenda item for the meeting in October 2022.	**Complete**
0607/06.1 Committee Strategic Risk Report	A review of risks aligned with the Committee's ToR would take place, including broader performance risks related to Capital Digital and overall performance. As a result of this review, the Committee Strategic Risk Report would be updated and presented to the next Committee meeting.	**October 2022**	**Director of Planning, Performance, Digital and IT /Head of Corporate Services, Risk and Assurance**	Development session with Executive Team scheduled for 19th September that will support the further review of the Corporate Risk Register. Updated risks will then be presented to the next Committee meeting.	**Complete**
0607/06.2 Committee Strategic Risk Report	The Chair requested that on pg.4 of Appendix 1, 'Mapping against 4 harms of COVID' that the *Harm from reduction in non-covid activity* be circled, as this was deemed as a risk.	**July 2022**	**Head of Corporate Governance, Risk and Assurance**	Complete.	**Complete**
FPC 0607/07.1	The initial Budget delegation plan for 2022/23 had been approved by the Board. An additional report	**July 2022**	**Interim Director of**	Presented to and approved by Board members in July 2022.	**Complete**

Financial Performance Report at Month 2, 2022/23, including detailed savings analysis	would be presented to the Board in July 2022, with recommendations based upon anticipated COVID funding, which in turn would allow delegation to budget holders across the Health Board.		**Finance & VBHC**		
FPC 0607/07.2 Financial Performance Report at Month 2, 2022/23, including detailed savings analysis	Independent Members requested information on reasons for the reduction in outpatient activity in General Medicine. A wider reflection of the Medicines plan would be included in the next formal report to the Board.	**July 2022**	**Interim Director of Finance & VBHC**	An overview of medicines activity, urgent care and bed pressures was presented to the Board in July 2022.	**Complete**
FPC 0607/07.3 Financial Performance Report at Month 2, 2022/23, including detailed	The Committee was informed that all delegation letters had been issued to Executives and were being cascaded through Divisions. The progress of the delegations would be monitored and promoted by the Finance Team. An update on the progress would be included in the next formal Board report.	**September 2022**	**Interim Director of Finance & VBHC**	To be presented to the Board in September 2022.	**Transferred**

savings analysis					
FPC 0607/09 ABUHB's Efficiency Review and 'Compendium' Presentation	Opportunities to link the 'Compendium' with the Corporate Risk register, which could provide further assurance to the Committee were noted. It was agreed that Head of Strategic Planning and Head of Risk and Assurance would meet to discuss this further outside of the meeting.	**October 2022**	**Head of Corporate Services, Risk and Assurance /Head of Strategic Financial Planning**	Head of corporate services has contacted the Head of Strategic Financial Planning and a meeting date is being confirmed.	**In progress**
FPC 0607/11 Value Based Healthcare Achievement Annual Report 21/22 & Efficiency Opportunities 22/23	Following the meeting, the full annual report would be posted on the Health Board website.	**July 2022**	**Assistant Director Value Based Healthcare**	The Annual Report has now been published on the VBHT site on Pulse.	**Complete**
FPC 0607/13.1 Performance Management Dashboard	It was agreed that a Performance Report would be presented to the Committee each Quarter and the presentation delivered at the meeting would be shared with members.	**July 2022**	**Director of Planning, Performance, and IT/ Secretariat**	Item recorded on the Committee Forward Workplan. Presentation shared with members outside of the meeting.	**Complete**

FPC 0607/13.2 Performance Management Dashboard	A link to the dashboard and an offer of further support to understand the tool would be provided to members outside of the meeting.	**July 2022**	**Assistant Director of Performance and Information**	The Assistant Director of Performance and Information shared relevant information to members outside of the meeting.	**Complete**
FPC 0607/13.3 Performance Management Dashboard	Independent Members requested that future updates include a summary report linked to the Health Board's performance against the IMTP aims and objectives.	**October 2022**	**Assistant Director of Performance and Information/Director of Planning, Performance & IT**	The IMTP Quarterly report brings together key performance information related to the IMTP. In addition, reports on the key IMTP programmes will be brought to the Committee.	**Complete**

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Minutes of the Finance & Performance Committee held on Wednesday 6th July 2022 at 9.30 am via Teams

Present:	
Richard Clark	Independent Member (Chair)
Pippa Britton	Independent Member (Vice-Chair)
Iwan Jones	Independent Member
Shelley Bosson	Independent Member
In attendance:	
Rob Holcombe	Interim Director of Finance, Procurement & Value Based Healthcare
Nicola Prygodzicz	Director of Planning, Performance, Digital and IT
Danielle O'Leary	Head of Corporate Services, Risk and Assurance
Suzanne Jones	AFD Financial Planning
Fidelma Davies	Head of Strategic Financial Planning
Greg Bowen	AFD Hospital Divisions
Chris Commins	AFD Out of Hospital Services
Glyn Jones	Interim Chief Executive Officer
Stephen Chaney	Deputy Head of Internal Audit
Nathan Couch	Audit Wales
Sarah Simmonds	Director of Workforce & OD
Lloyd Bishop	Assistant Director, Performance & Information
Dr Gareth Roberts	AMD Value Based Healthcare
Adele Cahill	Assistant Director of Value Based Health Care
Apologies:	
Rani Mallison	Director of Corporate Governance

	Preliminary Matters
FPC 0607/01	**Welcome and Introductions** The Chair welcomed everyone to the meeting.
FPC 0607/02	**Apologies for Absence** Apologies for absence were noted.
FPC 0607/03	**Declarations of Interest** There were no Declarations of Interest to record.
	Committee Governance
FPC 0607/04	**Finance & Performance Committee's Terms of Reference (ToR) and Operating Arrangements, as approved by Board**

	Danielle O'Leary, Head of Corporate Services, Risk and Assurance, presented the Committee with the ToR and operating arrangements. The Committee received its ToR and operating arrangements for 2022/23, following Board Approval in March 2022. Members requested that future ToRs included a reference of linking Committee monitoring to outcomes. Members were assured that the monitoring of outcomes linked to risks, and that Health Board risks would inform the Committee work plan. The Committee **ENDORSED** the ToR for 2022/23.
FPC 0607/05	**Committee Priorities for 2022/23** Danielle O'Leary presented the priorities for 2022/23 to the Committee, noting that this was a high-level approach to the role and function of the Committee, linking to the Integrated Medium-Term Plan (IMTP). A more detailed forward work plan (FWP), identifying specific reports and timeframes, would be shared outside of the meeting, following Board approval in July 2022. **Action: Director of Corporate Governance** Members requested assurance about how Commissioned Services would be monitored through the Committee. Members were informed that a brief report on and financial review of Commissioned Services, through a *Long-Term Agreement* lens, would be presented at the next meeting. **Action: Interim Director of Finance & VBHC/Secretariat** Members were advised that a review of how the Health Board monitored Commissioned Services would be undertaken by the Executive Team, feeding back to the appropriate Committee(s). **Action: Director of Planning, Performance, Digital and IT** The Committee thanked the Head of Corporate Services, Risk and Assurance for the presentation and welcomed the forward work plan.
FPC 0607/06	**Committee Strategic Risk Report** Danielle O'Leary presented the report to the Committee. Members were informed that divisions had received targeted support and intervention to review current risks and had been encouraged to undertake tailored business meetings around emerging risk themes. A review of risks aligned with the Committee's ToR would take place, including broader performance risks related to Capital Digital and overall performance. As a result of this review, the Committee Strategic Risk Report would be updated and presented to the next Committee meeting. **Action: Director of Planning, Performance, Digital and IT /Head of Corporate Services, Risk and Assurance** The Chair requested that on pg.4 of Appendix 1, 'Mapping against 4 harms of COVID' that the *Harm from reduction in non-covid activity* be circled, as this was deemed as a risk. **Action: Head of Corporate Governance, Risk and Assurance**

	Members thanked the Head of Corporate Services, Risk and Assurance for the comprehensive presentation of risks associated with the Committee business. The Committee; - • **RECEIVED** the report for **ASSURANCE** and compliance and thanked the Head of Corporate Services, Risk and Assurance for the improved format. • **ACKNOWLEDGED** the updates reflected in the appendices for the last reporting period. • **ENDORSED** the approach to utilising the risk profiles for this Committee to inform the Committee work plan throughout the year.
	Assurance in Respect of Financial Management & Performance
FPC 0607/07	**Financial Performance Report at Month 2, 2022/23, including detailed savings analysis** Rob Holcombe, Interim Director of Finance, Procurement & Value Based Healthcare, supported by Suzanne Jones, AFD of Financial Planning, provided the update outlining the Health Board's financial performance, for the month of May 2022 (month 2) and the year-to-date performance position for 2022/23. The report summarised the Health Board's performance against financial targets, statutory financial duties and forecast position. At Month 2, the revenue position was reported as £4.9m deficit. The capital position, as reported to Welsh Government, was break-even, reported at high-risk. The significant level of risks to be mitigated in order to achieve the financial position and forecast, as outlined in the report, were noted. It was explained that the anticipated income assumed for COVID was £27m for national schemes, £49m for local schemes, subject to review across Wales, and £19m identified as exceptional costs, supported by Welsh Government. A significant increase in pay/variable pay was noted, due to ongoing operational service pressures. System pressures and the associated financial implications continued on from Quarter 4 of the previous financial year. There was a national assumption that, with COVID easing, there may be a reduction in cost base due to a potential drop in demand, however, this was not reflected in current Health Board service demand. Operating costs currently exceeded planned costs however, the Committee was advised that the Health Board had established an internal financial management approach for delivering the Integrated Medium-Term Plan (IMTP) with potential cost reductions, and teams were in the early stages of developing proposals. Work was being undertaken with Divisions to identify further savings and any identified savings would be reported to WG at the end of Quarter 1. The Board has approved the 2022/23 – 2024/25 IMTP and the initial Budget delegation plan for 2022/23. Members were informed that an additional report would be presented to the Board in July 2022, with recommendations based upon anticipated COVID funding, which in turn would allow delegation

	to budget holders across the Health Board. **Action: Interim Director of Finance & VBHC** Further progress had been made against the Long-Term Agreements (LTA's) as outlined in the report. The Health Board had achieved the sign off of all LTA's by the required date of the 30th June 2022. The savings target was noted as £26.2m, with an expectation for the Health Board to manage COVID and exceptional costs, in addition to the savings target. Current forecasting indicated that the Health Board would make the £6m of the savings target, with £20m remaining at high risk. It was noted that the Health Board had identified various opportunities for long term sustainable financial recovery, with an agreed focus on transformation, through the IMTP process. Shelley Bosson, Independent Member, requested further information on the Health Board's variable pay savings plans. The initial plans for the reduction in the use of agency nursing were noted although further updates on progress would be helpful. Rob Holcombe commented that this had recently been refreshed, and the Health Board would anticipate some impact over the coming months. Further information would be included in the designated agenda item on *Variable Pay Savings Plans (Agency reduction)*. Shelley Bosson requested information on reasons for the reduction in outpatient activity in General Medicine. A wider reflection of the Medicines plan would be included in the next formal report to the Board. **Action: Interim Director of Finance & VBHC** Shelley Bosson discussed the 'budget delegation letters' that set out clear expectations regarding management of delegated budget levels and requested further information on the progress of Executive Director and Divisional sign off. The Committee was informed that all delegation letters had been issued to Executives and were being cascaded through Divisions. The progress of the delegations would be monitored and promoted by the Finance Team. An update on the progress would be included in the next formal Board report. **Action: Interim Director of Finance & VBHC** Glyn Jones, Interim Chief Executive Officer, discussed the current financial position. Three broad areas of focus were outlined for future discussions, to provide assurance to Board members. Areas of focus for assurance were noted as: 1. Basic efficiencies: Seeking assurance that budgets were delegated and accepted. In addition, ensuring plans were in place for efficient use of medicine management, to include impact on patient outcomes. 2. Areas of service change: Improving services for patients while utilising best use of resources. 3. Choices on where the Health Board spends its money for best patient outcomes. Regular discussions with stakeholder's, Board members and Welsh Government would be required around areas of focus. The Committee **RECEIVED** the report for **ASSURANCE** and compliance.

FPC 0607/08	**ABUHB's Sustainability Approach for 2022/23** Rob Holcombe, Interim Director of Finance, presented the update on the Health Board's approach to sustainability for 2022/23. The report provided details of the proposed approach to sustainability to deliver financial balance as part of the IMTP. Rob Holcombe advised that the 2022/23 IMTP identified a savings requirement of £26m and cost risks of £19m that would need mitigation and management. The Executive Team had identified four key areas of focus within the agenda, noted as: 1. People Focused 2. Support to drive transformational change 3. Autonomy and Accountability 4. Monitoring and reporting, and holding to account The four key elements would be operationalised through a system wide set of actions, as outlined in the report. Pippa Britton, Independent Member, enquired if planning and estates had been considered when assessing savings. Rob Holcombe responded that this has been considered through the Agile Working Programme, a review of Health Board maintained properties through an Estates Efficiencies Framework, a review would be undertaken to identify any potential savings opportunities. A task force had been established to assess current leases and potential refurb of current estates, with the cut in Capital Funding for 2022/23 noted as a challenge. The Committee thanked the Interim Director of Finance and **NOTED**; - • the Health Board approach to long term sustainability • the operational implementation action taken • the financial recovery 'turnaround' status of ABUHB
FPC 0607/09	**ABUHB's Efficiency Review and 'Compendium' Presentation** Fidelma Davies, Head of Strategic Financial Planning, provided the Committee with an overview of the '2022/2023 Efficiency Review' of the Health Board, and a presentation of the 'Efficiency Opportunities Compendium' ('Compendium'). Fidelma Davies presented the 'Compendium' to the Committee. Efficiency opportunities were captured in the 'Compendium', converting non-financial metrics using the Health Board's costing information. As of May 2022, the calculated worth of the efficiency assessment of the Health Board, aligned to the key priorities of the IMTP, was £57.887m. The 'Compendium' captured business intelligence to support Divisions to improve efficiencies, based on best practice. Opportunities to link the 'Compendium' with the Corporate Risk register, which could provide further assurance to the Committee were noted. It was agreed that Head of Strategic Planning and Head of Risk and Assurance would meet to discuss this further outside of the meeting. **Action: Head of Corporate Services, Risk and Assurance/Head of Strategic Financial Planning**

	Glyn Jones, Interim Chief Executive, left the meeting. The Chair praised the 'Compendium' as a great resource, noting the support and resources available to divisions, and enquired how interaction from divisional managers was monitored. Suzanne Jones, AFD Financial Planning, responded that Finance teams were not monitoring its use but promoting the opportunity to utilise the tool and supporting Divisions to do so. 'Compendium' metrics were intended to help form a baseline and link to improved services and outcomes for the Health Board. The Committee thanked Fidelma Davies and the Finance Teams for the work undertaken on the 'Compendium', noting the requirement for divisional leads to utilise the 'Compendium' metrics to improve services.
FPC 0607/10	**2021/22 Recovery Funding Utilisation Report** The Committee received the report providing an overview of the utilisation of Covid Recovery funding received in financial year 2021-22. Greg Bowen, AFD Hospital Divisions, informed members that the Welsh Government had awarded the Health Board a total of £26.9 million in non-recurrent recovery funding. The funds were used in a variety of ways, as detailed in the report. Workforce availability was noted as affecting the ability to achieve Health Board recovery plans. Members noted the positive impact of COVID-19 funding on patient care in 2021/22**.** The Committee **RECEIVED** the report for information, and **NOTED** the impact made on patient care in 2021-22 from the application of non-recurrent Covid-19 recovery monies.
FPC 0607/11	**Value Based Healthcare Achievement Annual Report 21/22 & Efficiency Opportunities 22/23** Adele Cahill, AD of Value Based Healthcare, supported by Gareth Roberts, AMD for Value Based Healthcare, provided the Committee with a summary of the annual report, which demonstrated the collaborative work between the Value-Based healthcare teams (VBHT) and operational teams to deliver Value-Based healthcare across a range of priority programmes. Following the meeting, the full annual report would be posted on the Health Board website. **Action: Assistant Director Value Based Healthcare** Gareth Roberts provided a presentation that demonstrated an example of work being undertaken by the VBHT in Ophthalmology, with a focus on Cataracts. Ophthalmology was noted as the 2nd highest waiting list in the Health Board, and the cataract surgery rate in the Health Board was below average for NHS Wales. Patient Reported Outcome Measures (PROMs) may help target intervention on those patients most likely to benefit. Nicola Prygodzicz, Director of Planning, Performance, Digital and IT, highlighted to the Committee the Health Board plans for the reconfiguration

	of Ophthalmology services such as the Regional Cataract Centre, noting the opportunity to increase workforce resource and improve service change. The Committee **RECEIVED** the Value-Based Healthcare Teams Annual Report and **NOTED** progress made during 2021-22.
FPC 0607/12	**Variable Pay Savings Plan (Agency Reduction)** Sarah Simmonds, Director of Workforce and OD, supported by Linda Alexander, Interim Director of Nursing, presented the Variable Pay Savings plan to the Committee. Demand for staffing had significantly increased, with reliance on variable pay, specifically agency, across staff groups since the start of the COVID-19 pandemic. The most notable increase had been within Registered Nursing and Healthcare Support Workers, due to the significant rise in demand and system pressures. Progress against the 'variable pay reduction plan' would be monitored and reported to the Health Boards Strategic Nursing Workforce Group. In addition, a working group, with representatives from Finance, Divisions, Workforce & OD and Nursing leadership would also be established to monitor and track progress against the plan and potential opportunities. Linda Alexander informed the Committee that throughout the agency reduction plan, patient safety and safer staffing principles would be considered as the plan developed. Shelley Bosson, Independent Member, queried if there were set goals and targets for the outlined plans. Linda Alexander responded that work was being undertaken, alongside finance, divisions, and rostering teams, to produce a trajectory of measurable outcomes. The Committee **RECEIVED** the report and **NOTED** the actions and next steps toward achieving the agency reduction action plan and progress to date.
	Assurance in Respect of Organisational Performance Management
FPC 0607/13	**Performance Management Dashboard** Nicola Prygodzicz, Director of Planning, Performance, Digital & IT, supported by Lloyd Bishop, Assistant Director of Performance, and Information, provided the Committee with a summary of the Health Boards Sitrep and Performance reporting for each level and frequency, alongside the timetable of performance reporting. It was agreed that a Performance Report would be presented to the Committee each Quarter and the presentation delivered at the meeting would be shared with members. **Action: Director of Planning, Performance and IT/Secretariat** Lloyd Bishop provided members with a live demonstration of the Health Board's automated version of the Performance Management Dashboard. A link to the dashboard and an offer of further support to understand the tool would be provided to members outside of the meeting. **Action: Assistant Director of Performance and Information** Shelley Bosson, Independent Member, requested that future updates include a summary report linked to the Health Board's performance against the IMTP

	aims and objectives. **Action: Assistant Director of Performance and Information** Members were informed that the Outcomes Report and the Performance Dashboard would be presented to the Board in July 2022. The Committee thanked Lloyd Bishop for the demonstration and welcomed further tuition on the Performance Management Dashboard.
	Other Matters
FPC 0607/14	**To confirm any key risks and issues for reporting/escalation to Board and/or other Committees** There were no items to escalate.
	Date of Next Meeting
FPC 0607/15	The date of the next meeting was noted as: - Wednesday 5th October 2022 09:30 -12:30 via Microsoft Teams.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Finance and Performance Committee 5th October 2022 Agenda Item: 2.1

Aneurin Bevan University Health Board

Finance and Performance Committee - Strategic Risk Report

Executive Summary

This report provides an overview of the profile of risks that are required to be reported to the Finance and Performance Committee. The risks reflect the sustained challenges of the financial context of the Health Board against a backdrop of continued disruption and delays caused by the COVID pandemic alongside restart and recovery of previously paused operational services and increasing demand for services.

The Finance and Performance Committee is asked to note this report.

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

Executive Sponsor:	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	**N/A**	**Committee of the Board:**	• **Finance and Performance Committee**

Date of the Report: 26th September 2022

Supplementary Papers Attached:
Appendix 1 – Risk Profiles for Finance and Performance Committee

Purpose of the Report

This report is provided for assurance purposes and seeks to provide a summary of the current key risks related to the Finance and Performance Committee, which also form strategic risk profiles for the Health Board and as such, feature on the Board Assurance Framework.

Background and Context

In conjunction with the 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 revised IMTP.

This report provides the Finance and Performance Committee with an opportunity to review the organisational strategic risks pertinent to the Finance and Performance

Committee and which also form part of the risks featured in the Board Assurance Framework.

The Health Board utilises the All-Wales Risk Matrix to assess the potential impact and likelihood of occurrence of all predicted risks to form an overall risk score. Risks may then be tolerated, treated, transferred or terminated in line with the Health Board Risk Management Strategy.

Assessment & Overview of Current Status

Revised Risk Management Approach and Update on National OfW Risk Module

The revised risk management approach remains in the embedding phase throughout the organisation. A plan for implementation and full realisation of the risk management strategy has been developed and is being monitored and reported through the Audit, Risk and Assurance Committee.

Continued engagement throughout the organisation has taken place to strengthen the utilisation of the Health Board's internal electronic risk management system (DATIX). This is being driven, informed and underpinned by the National work being undertaken by Once for Wales to develop a dedicated and specific Risk Management module. It is anticipated that the electronic risk management system will form one of the key sources of business intelligence in respect of identification and escalation of operational risk, in conjunction with Executive level horizon scanning led risk identification.

Plans to review the current Risk Management Strategy are underway and it is anticipated that the December Audit, Risk and Assurance Committee will receive a full review of the strategy alongside a position update against the realisation plan that was endorsed in April 2022.

Current Status

There are currently **26** risks that form the Corporate Risk Register, of which **6** form risks within the remit of the Finance and Performance Committee. The following tables provide a breakdown of the risks, level of severity and risk appetite assessment:

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
CRR016 Achievement of Financial Balance 2022/23	16	4	**Low** level of risk appetite in relation to the Health Board's financial statutory requirements. However, responding to COVID 19 implications and maintaining safe services take precedence.	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**Finance & Performance**	**Director of Finance and Procurement**
CRR032 Failure to achieve underlying recurrent financial balance due to ongoing service pressures, under-achievement of recurrent savings and efficiency delivery and investments not supported with recurrent funding sources.	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.	**(Sept 2022 Board)** 	**Finance & Performance**	**Director of Finance and Procurement**
CRR020 Failure to implement WCCIS leading in inaccessibility of essential patient information	10	10	**High** level of appetite for risk in this area for innovations related to digital technologies **Low** level risk appetite for the realisation of the risk and to maintain patient safety	**Yes**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**Finance and Performance** ***proposed to be deescalated from the CRR***	***CEO at present**

CRR017 Partial or full failure of ICT infrastructure and cyber security	15	12	**Low** appetite in relation to adverse impact on quality and safety **Moderate to High** level risk appetite for innovating to identify digital ICT system solutions	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**Finance and Performance**	***CEO at present**
CRR008 Health Board estate not fit for purpose	15	15	**Low** risk appetite in relation to adverse staff and patient experience **Moderate** risk appetite about 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.***	**(Sept 2022 Board)** 	**Finance and Performance**	**Director of Operations**
CRR033 Civil contingencies Act compliance	20	9	**Low** risk appetite in respect of legislation compliance	**No**	**Treat** the potential impacts of the risk by using internal controls.	**(Sept 2022 Board)** 	**Finance and Performance**	**Director of Planning**

Detailed risk profiles for which the Committee provides oversight (**6 profiles in total**), are appended to this report at ***Appendix 1***.

The Committee is requested to note the proposed removal of:

CRR020 – WCCIS implementation – this has now taken place and the platform is operational across the Health Board. The programme risks are proposed to be managed locally and escalated as and when necessary.

The Committee will also note that the ***CRR008 – Health Board estate not fit for purpose***, continues to be managed within an agreed risk appetite level but remains on the Corporate Risk Register due to the consequence of risk realisation being catastrophic.

The Committee is asked to note that ***CRR016 – Achievement of financial balance 2022/23*** – although the risk score has remained the same since the last reporting period, the trajectory of this risk is set to escalate should current mitigations not be implemented successfully. This risk continues to be actively monitored and reviewed by Executive Team and assurances related to this risk are evidenced in financial reports to the Committee.

We will be actively working to review risk targets to ensure realistic and as far as possible; set within the context of the Board's appetite for risk.

Organisational risks that feature on the Corporate Risk Register and receive oversight from this Committee will be actively reviewed as part of the identification of the Committee's priorities and agenda setting process to ensure a risk focussed approach is taken to managing the business of the Committee. This will also strengthen assurance in relation to Committee priorities and ensure appropriate focus is placed on most significant areas. On the Committee's agenda, items related to efficiencies can clearly be linked to CRR032 and reporting on financial position can be linked to CRR016. It is anticipated that these detailed reports provide a level of assurance to the Committee on the management of the risks identified within this paper.

Recommendation & Conclusion

The Committee is asked to:

- **NOTE** the content of this report, including trajectory of risk trends, risks being managed within agreed risk appetite levels and recognising that there will be further iterative development work to embed the revised risk management approach across the organisation.
- **ENDORSE** the proposal to de-escalate CRR020 from the Corporate Risk Register.
- **ACKNOWLEDGE** the updates that have been received and reflected in the appendices for the last reporting period.

Supporting Assessment & 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 & Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.

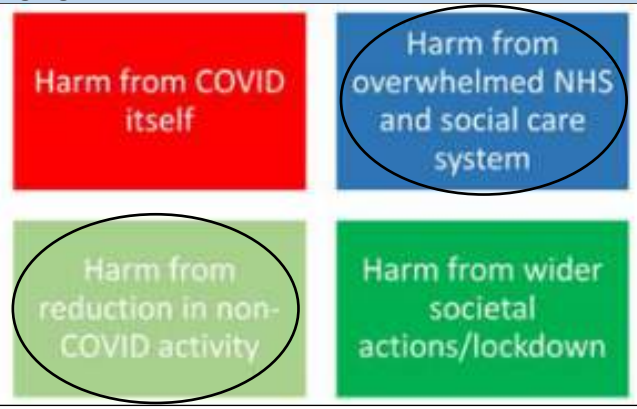
Equality & Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health & Care Standards	This report contributes to the good governance elements of the H & CS.
Linked to Integrated Medium Terms Plan & Corporate Objectives	The objectives will be referenced to the IMTP
The Wellbeing 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 Terms	None
Public Interest	Report to be published

<table>
<tr><th colspan="2">Applicable Strategic Priorities – IMTP 2022/23 – 24/25</th><th colspan="4">Risk Description, Appetite and Decision</th></tr>
<tr><td colspan="2">This is an enabler risk and therefore applies to all Health Board priorities</td><td colspan="4">CRR016 (Dec-2020)
Threat Cause: Due to the operational pressures and uncertainties due to -
the COVID-19 Pandemic,
acute emergency and urgent care pressures,
delayed transfers of care
the elective delivery targets
Non-delivery of transformation plans for improved efficiency
and potential significant cost of the organisational response to the above key pressures and risks, above IMTP 22/23 – 24/25 planned levels.
Threat Event: Failure to achieve financial balance at end of 2022/2023.

TREAT</td></tr>
<tr><td>High Level Themes</td><td>Reputational
Public confidence
Financial
Patient Outcomes</td><td colspan="2">Risk Appetite</td><td colspan="2">Low level of risk appetite in relation to the Health Board's financial statutory requirements. However responding to COVID 19 and operational service pressures and their implications and maintaining safe services take precedence.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Finance & Performance Committee</td><td>Health Board IMTP 2022/23-24/25
Standing Financial Instructions (SFIs)</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td colspan="2">Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk</td></tr>
</table>

	• Health Board Standing Orders • FCP Budgetary control • Budget holder training • Audit reviews • 22/23 savings plans & opportunities • Regular monitoring at Executive Team reviewing level of deliverable recurrent savings along with assessing cost avoidance and deferred investments. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • IMTP Delivery Framework and Divisional Assurance meetings in place which will incorporate implementation of savings plans and delivery of service and workforce plans within available resources. • Financial assessment and review (as agreed at Board, regular financial reports to			***appetite/attitude level for the risk.***

	Board, FPC and Welsh Government) to incorporate financial impact of COVID-19 and other key costs. • Quarterly financial budget plan approach agreed.						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	4	4	4	3	4
• IMTP Financial Plans submitted to Welsh Government include financial consequences of Core service delivery, COVID-19 response and exceptional national cost pressures (Energy) as part of ongoing discussions to secure additional funding. • Quarterly budget setting process established with Board. • Executive team agreed internal financial recovery turnaround focus to manage risks to achievement of financial balance. • Efficiency Opportunity Compendium developed and circulated. • As new priorities emerge service, workforce and financial plans developed to identify financial risks and support funding discussions with Welsh Government (e.g. mass vaccination programme).	Ongoing Ongoing Ongoing Ongoing	**20**		**16**		**12**	

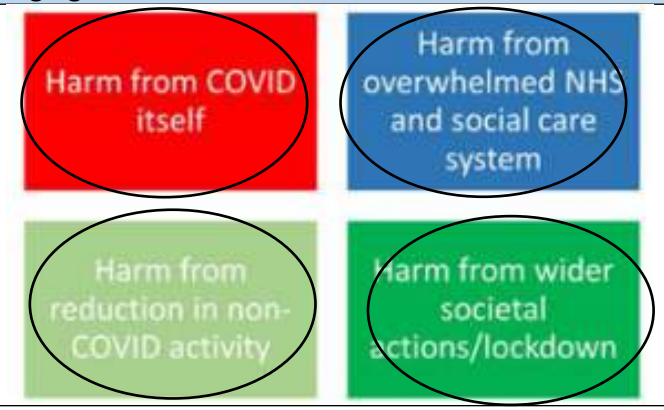
Trend		Executive Owner: Director of Finance, Procurement & Value
Mapping Against 4 Harms of COVID		**Update**
		August 2022: Following the Month 4 financial performance assessment, there is an extreme risk to financial balance achievement for 2022/23. The forecast risk is not reducing. An internal financial recovery 'turnaround' status has been agreed by the Executive team to improve short term delivery and acceleration of savings to support break even for 2022/23. Proposed actions are being actively considered and will be evaluated for patient and target impact as well as financial improvement by the Executive team. Proposals will be shared with the Board for consideration.

<table>
<tr><td colspan="2">Applicable Strategic Priorities – IMTP 2022/23 – 24/25 and Clinical Futures Strategy</td><td colspan="4">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">This is an enabler risk and therefore applies to all Health Board priorities</td><td colspan="4">CRR032 –
Threat Cause: Failure to achieve underlying recurrent financial balance due to ongoing service pressures, under-achievement of recurrent savings and efficiency delivery and investments not supported with recurrent funding sources. Transformation Plans not delivering sustainable solutions in line with expected timelines.

Threat Event: Non-achievement of the Health Board’s long-term financial strategy.

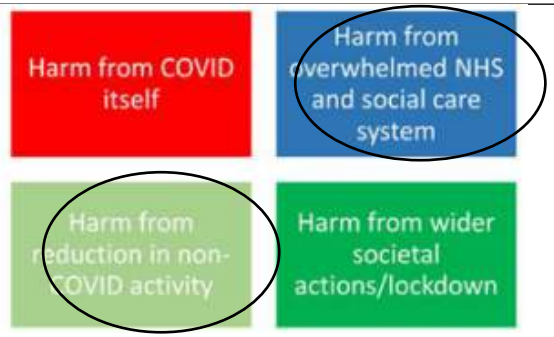
TREAT</td></tr>
<tr><td>High Level Themes</td><td>• Reputational
• Public confidence
• Financial
• Patient Outcomes</td><td colspan="2">Risk Appetite</td><td colspan="2">Low level of risk appetite in relation to the Health Board's financial statutory requirements.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Finance and Performance Committee</td><td>• Health Board IMTP 2022/23-24/25
• Standing Financial Instructions (SFIs)</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td colspan="2">Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk</td></tr>
</table>

	• Health Board Standing Orders • Financial Control Procedures • 22/23 savings plans & opportunities • Regular monitoring at Executive Team reviewing level of deliverable recurrent savings along. • Health Board financial escalation processes. • Health Board Pre-Investment Panel (PIP) process. • Focus in IMTP planning process					***appetite/attitude level for the risk.***	
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	4	4	4	3	4
• IMTP Financial Plans submitted to Welsh Government include financial plan for 3 years and recurrent improvement of underlying position. • Transformation Programme approach to long term financial recovery and sustainability. • Executive team agreed internal financial recovery turnaround focus to manage risks to achievement of financial balance – including recurrent opportunities.	Ongoing monthly review	**20**		**16**		**12**	

• As new priorities emerge service, workforce and financial plans need to demonstrate efficiency and value improvement for future sustainability. • Prioritisation process being developed for investment decisions.	Ongoing monthly review			
Trend		**Executive Owner: Director of Finance, Procurement and Value**		
Mapping Against 4 Harms of COVID		**Update**		
		August 2022: The 2022/23 Health Board IMTP describes the programme priority approach to sustainability, performance improvement and service re-design, using a Value-Based approach to sustainability and improved patient outcomes and efficiency. Programme delivery needs to be accelerated to deliver impacts during 22/23. The actions of this work will need to be accelerated to deliver the 22/23 closing underlying position.		

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="4">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">Enabler risk and links to all priorities</td><td colspan="4">CRR020 – (May-2019)
Threat Cause: Failure to implement Welsh Community Care Information System (WCCIS)
Threat Event: Inability to access patient clinical information across all services, departments and partner organisations (such as Local Authority).
TREAT</td></tr>
<tr><td>High Level Themes</td><td>Patient Outcomes and Experience
Quality and Safety
Reputational
Financial
Public confidence</td><td>Risk Appetite</td><td colspan="3">There is a high level of appetite for risk on this areas to innovate in the area of digital technologies however, low level risk appetite to maintain patient safety. Therefore the Health Board will Treat this risk.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Patient Quality, Safety and Outcomes Committee</td><td>Risks managed at Local ABUHB & Regional Programme Boards
Escalation routes in place to ABUHB exec team, Regional Partnership Board and National Leadership Board
Internal audit carried out by NWSSP gave substantial assurance that arrangements to secure governance, risk</td><td>Inherent Risk level before any controls/mitigations implemented, in its initial state.</td><td>Current Risk level after initial controls/mitigations have been implemented.</td><td>Target Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.</td></tr>
</table>

	management and internal control are applied effectively • Extension of current supplier contract into 2022 • Legal team supporting supplier contract negotiations						
Action Plan *SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.*	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	2	5	2	5
• Impact assessment and re-planning of later phases underway to include new phases for integration delivery and roll out of the WCCIS mobile app	May 2022	**20**		**10**		**10**	
Trend since last reporting period		**Executive Owner: CEO**					
Mapping Against 4 Harms of COVID		**Update**					

	September 2022: Phase 1 service went LIVE on WCCIS on 19th August. Cutover, support plan and service management model in place and support is ongoing. Supplier contract successfully negotiated and contract variation in place ahead of go LIVE. Discussions have commenced with the national programme team and Advanced to review the integration and mobile app delivery plans and high-level planning underway to consider further rollout to other services (Phase 2 – 5). **PROPOSED TO BE DE-ESCALATED FROM THE CORPORATE RISK REGISTER AND WILL COMINTUE TO BE MANAGED LOCALLY**

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="2">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">This is an enabler risk which would impact on the Health Board’s ability to delivery against all of its strategic priorities.</td><td colspan="2">CRR033 (NEW RISK) –
Threat Event: Widespread harm to Health Board staff and patients
Threat Cause: Failure to comply with the full set of civil protection duties;

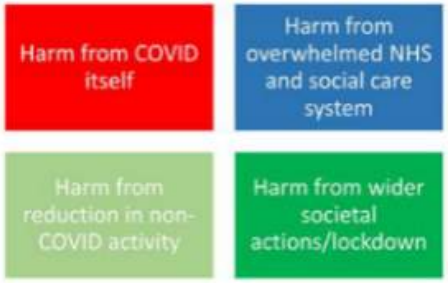
• Assess the risk of Emergencies occurring and use this to inform contingency planning
• Put in place Emergency plans
• Put in place Business Continuity Management arrangements
• Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
• Share information with other local responders to enhance coordination
• Cooperate with other local responders to enhance coordination and efficiency

TREAT</td></tr>
<tr><td>High Level Themes</td><td>• Reputational
• Public & staff confidence
• Partnership working
• Patient, Quality and Outcomes</td><td>Risk Appetite</td><td>LOW</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="2">Risk Score</td></tr>
</table>

Audit, Finance and Risk Committee.	• Plans & Policies that cover Pandemics, Major Incidents & Business Continuity Incidents.	**Inherent** ***Risk level before any controls/mitigations implemented, in its initial state.***		**Current** ***Risk level after initial controls/mitigations have been implemented.***		**Target** ***Risk level after all controls/mitigations have been implemented and taking into consideration the risk appetite/attitude level for the risk.***		
Action Plan ***SMART actions that will positively impact on the risk and help achieve the target risk score or maintain it.***	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	
		4	5	4	5	3	3	
Engagement with Divisions, Directorates, and service areas to embed contingency planning in the culture of the organisation, conduct BIA's develop plans, exercise, review, to mitigate the risks and threats to service delivery. This work continues to progress although service pressures and the ongoing COVID pandemic has and is delaying BCM activity. A new wave of engagement commenced in July/August 2021 with Specialities, Departments and Wards to start the BIA process to record principal service activities or functions to assess the risk of not being able to	Ongoing Ongoing	**20**		**20**		**9**		

provide the function or service. This will be scored against impact and likelihood to provide a rational for score and RAG rate. Progress in most areas but some services are still to embed BCM into their services. When Divisions, Directorates and Departments have completed this process, we will start to develop individual Business Continuity Plans to mitigate vulnerabilities or single points of failure. The high-level plans will consider, loss of; building/department, Staff, IT, Utilities and Procurement. Some of these plans are in place however others are yet to commence. Service BC leads have made good progress with BIA's and the development of plans given the pressures on the HB at this time of year and the effects of the tail end of the Omicron Covid variant. Update 14/7/22 – EP and Informatics have and are continuing to work with services to develop BCP's for planned or unplanned Network disruption across the HB. We have an initial business continuity workshop set for end of July with F&T, it will scenario based with services building their plans as we progress through the scenario. If this proves successful, we will roll these out across all directorates,	Ongoing Complete Complete			

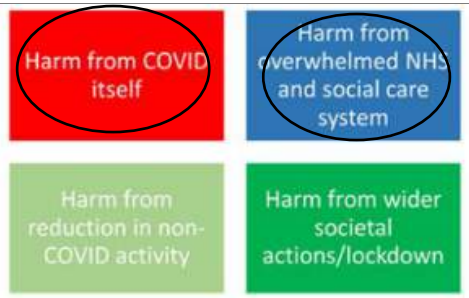
which should in the long term reduce our likelihood/consequence scores. ED at GUH is now engaged in the BC lifecycle and planning is under way. Review of the business Continuity policy and response guidance has been conducted as a result of the cyber-attack on a 3rd party informatics provider and the impact this had on services and the resulting BC response arrangements. There were and are undoubtedly issues with C3 structure from service senior management. The review is focussed on the command, control and coordination by the service owner and the responsibility that they must manage a BC incident and support the operational service leads. To accompany the review there will be a business continuity awareness campaign to encourage all staff to engage in the BCM process.	End September 22			
Trend		**Executive Owner: Interim Director of Planning and Performance**		
Mapping Against 4 Harms of COVID		**Update**		

	September 2022: The COVID pandemic has highlighted the need for contingency plans to address business impact analysis assessments for high level risk to buildings, staff, ICT and services resulting from pandemic. The emergency planning team working with leads across the health board have progressed BIAs. Divisions have been requested to provide Business Continuity Management leads some returns have been received. Avenues will be explored to further capitalise on the risk manager community of practice forum and the interface between this and business continuity. Emergency Planning continually monitors any service impact leading from Brexit and COIVD. March 2022: A business continuity incident that disrupted the Health Board IT networks in mid-November 2021 highlighted the Board's reliance on informatics and the gaps in service plans to maintain normal functions. The incident debrief report by Informatics and Emergency Planning details several actions required by departments to review or develop plans that take account of the service or function they provide to stakeholders and how that information is passed between departments during BC disruptions. A serious incident debrief meeting has been held with BC leads to discuss the communications cascade of timely information and recovery time objectives. Workshops have also taken place, and more are planned to further enhance BC knowledge and awareness across the Health Board. Ukraine Crisis – EP have set up a Ukraine Response Planning Group to horizon scan and contingency plan for possible risks to HB services. The Group has representation from across the HB and is discussing plans relating to the following themes: Workforce, ICT, Fuel and Medical Supplies, Procurement, and equipment (including servicing). Of these themes the threat of a targeted cyber malware attack on the NHS IT infrastructure is most likely should Russia decide to target the west in retaliation for economic sanctions. The HB Informatics Cyber security team ICT are continuing to monitor and update the Health Board's antivirus software on equipment. Communication have been cascaded to staff, informing them to

	regularly update and refresh their IT equipment. All service leads have been urged to review there plans for network disruption. The EPRR team will plan to conduct an audit of all service BC plans set against the current high level risk area of a loss to network applications/functions. This will provide data that will provide the HB with snapshot of engagement in the BC process and where gaps exist. The desired outcome will be targeted engagement and develop with areas that require support.

Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22		**Risk Description, Appetite and Decision**	
• **Enabler risk and links to all priorities**		***CRR017 (Dec-2018) – Threat Cause: Complete or partial failure of ICT systems to protect patient information (malware attack) across the Health Board (including independent contractors and partners) incorporating system outages, provided nationally by third parties or locally provided systems.*** ***Threat Event: Security of Patient, Staff or Health Board information is compromised leading to harm or damage.*** **TREAT**	
High Level Themes	• Partnership • Patient Outcomes and Experience • Quality and Safety • Reputational • Public confidence • Finance	**Risk Appetite**	Low appetite in relation to adverse impact on Quality, Safety, Outcomes and Experience however, moderate to high level risk appetite for innovating to identify digital ICT system solutions.

Committee Assurance	**Internal Controls – Policies/Procedures**	**Risk Score**					
Finance and Performance Committee	• The ICT team is reviewing this risk with the aim of having a complete schedule for the required systems. • CWS is being redesigned to be resilient to patching and allow for business continuity tests to be carried out without interrupting live service. • Implementing relevant Capital schemes on the critical replacement programme.	**Inherent**		**Current**		**Target**	
Action Plan	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		4	5	3	5	3	4
• Participate in Cyber Resilience Unit (CRU) CAF Audit • Further development of the Target Operating model for Cyber Resilience in conjunction with the external consultant review	Dec-2021	**20**		**15**		**12**	
Trend		**Executive Owner: CEO**					
Mapping Against 4 Harms of COVID		**Update**					

	Sept-2022 • The Cyber Security team is working with the WG Cyber Resilience Unit and DHCW to undertake a Cyber Assessment to provide a baseline for the NIS Directive. • The Cyber Assessment Framework Review is scheduled for September 2021 and the cyber security team is working in preparation for this. • The Cyber Resilience consultants continue to work on the target operating model. A board development session was delivered in early September Mitigations are consistent with the previous update

<table>
<tr><td colspan="2">Applicable Strategic Priorities – Clinical Futures and Annual Plan 2021/22</td><td colspan="4">Risk Description, Appetite and Decision</td></tr>
<tr><td colspan="2">Getting it right for children and young adults
Supporting adults in Gwent to live healthy and age well
Provide high quality care and support for older adults
Staying healthy
Care closer to home
Less serious illness which require hospital care</td><td colspan="4">CRR008 (Nov 2021) – (Reframed)
Threat Cause: The current Health Board estate is not fit for purpose
Threat Event: Service delivery and patient experience is compromised

TREAT</td></tr>
<tr><td>High Level Themes</td><td>Partnership
Quality and Patient Safety
Patient Outcomes and Experience
Finance
Public Confidence
Reputational
Environmental</td><td colspan="2">Risk Appetite</td><td colspan="2">Moderate risk appetite regarding innovation and developments across the Health Board estate.

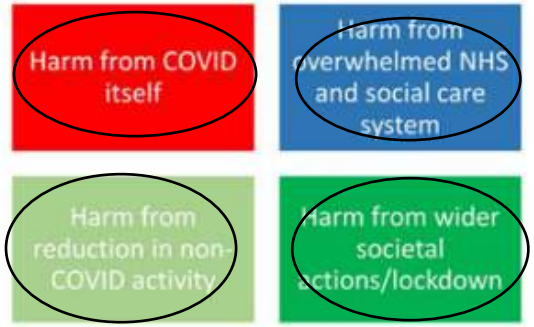
Low risk appetite in relation to adverse staff and patient experience due to poor Health Board estate.</td></tr>
<tr><td>Committee Assurance</td><td>Internal Controls – Policies/Procedures</td><td colspan="4">Risk Score</td></tr>
<tr><td>Audit, Finance and Risk Committee</td><td>6 Facet survey completed in 2019 and the Division is currently updating this to reflect the present position.
The divisional risk register reviewed quarterly at SMB this is reported to QPSOG and risks escalated via this route.</td><td>Inherent</td><td>Current</td><td>Target</td></tr>
</table>

	• Multiple policies and SOPs published and communicated to staff. • Stat and Mand training to include FIT testing on commencement of employment with the Division. • Estates strategy completed in 2019/20 to align with the Clinical Futures program. • Recently appointed an external authorising engineer for Water Management providing independent external audits. • Robust internal training program in place covering all aspects of Estates management including food hygiene. • Regular annual audits across all services conducted by NWSSP. Attached are three of the most recent audits conducted by specialist estates shared services HV, Water, Ventilation. All			

	scored reasonable assurance. • Recently appointed a water and ventilation engineer to oversee annual validation and compliance. This is as a direct consequence of Covid 19 and the change in legislation. • Recently appointed building energy management engineer to help control and drive down energy consumption. • Waste management audit recently completed by Shared Services with reasonable assurance. *  AB Waste Management Audit •  2022_03_18_ABUHB_AE(V)%20annual%20rep  2022_03_18_ABUHB_AE(V) annual report 20			

	HYR37725 - ABNHSHB - AUDIT MI • A previously agreed asbestos reinspection programme taking place over a 3 year period has now been extended to 4 years due to the availability of capital funding. It is not envisaged that this will change the current risk rating.						
Action Plan	**Due Date**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**	**Likelihood**	**Consequence**
		5	5	3	5	3	5
Estates Prioritisation takes place annually to focus available investment. Plan for replacement Nurse Call Systems which is an additional Capital Requirement. PPD submitted but due to high cost will need to be costed and set up in priority order. Capital bid has been submitted for consideration of the replacement of obsolete Nurse Call systems throughout the Health Board. Additional services arranged to mitigate risk – external company introduced to complete flushing programme on infrequently used outlets. Additional sampling undertaken. Water Risk	Annual Capital bids reviewed monthly awaiting outcome This is carried out 3 x weekly	**25**		**15**		**15**	

assessment brought forward for RGH. New contract set up for Water Risk Assessments – spec is now more specific and detailed than previous contracts. Alert to all divisions RE communication/notification with Estates on closures/re-opening of wards to ensure appropriate steps can be taken such as additional flushing and sampling prior to re-opening and during closures. External AE water currently being set up including further auditing by external organisation. The external AE now been appointed formally and has commenced. A water/ventilation engineer due to take up post October 2022 where all critical ventilation systems will undergo its annual validation in accordance to HTM 04/01.	Completed			
Trend		**Executive Owner: Director of Operations**		
Mapping Against 4 Harms of COVID		**Update**		



September 2022:

A recent paper was presented to Executive Team to request £820k per annum recurring to provide preventative measures to attempt to slow the Health Board estate deteriorating any further. The request was agreed, and progress will be monitored and reviewed as part of the management of this risk, going forward, however due to the reduction in available finance from April 2022 the Health Board is unable to support the request at this time. This will be reviewed later in the financial year. This does not mean that the risk score will increase; however, the backlog maintenance work will increase.

A recent refresh of the IMTP has now included £320k of the £820k and is being funded by revenue, a decision is still awaited on the remaining £500k.

A proposal was presented to Executive Team in April 2022 regarding a solution to include a water safety team to strengthen current mitigations. This was approved June 2022 for £380k recurring.

Over the last 4 years the department has expanded the Health, Safety and Compliance Team to provide expert training and guidance on issues such as Legionella, asbestos and deliver statutory and mandatory training to all staff at all levels. The Division now has included statutory and mandatory training as part of the induction process, for all new starters, this includes FIT testing for masks. This is anticipated to increase compliance in this area.

External training has been provided for high-risk engineering areas i.e. Authorised person High Voltage, Medical Gas, Water Management, Ventilation and decontamination services. In addition to this specialist estate shared services have appointed all personnel to carry out these duties in writing; and also audit annually, each of these specialities.

An upgrade of the liquid oxygen systems at NHH and RGH following the first wave of COVID which has effectively doubled our capacity to meet the increased demand.

During the planning stage for GUH the site has 100% back up in respect of oxygen supplies.

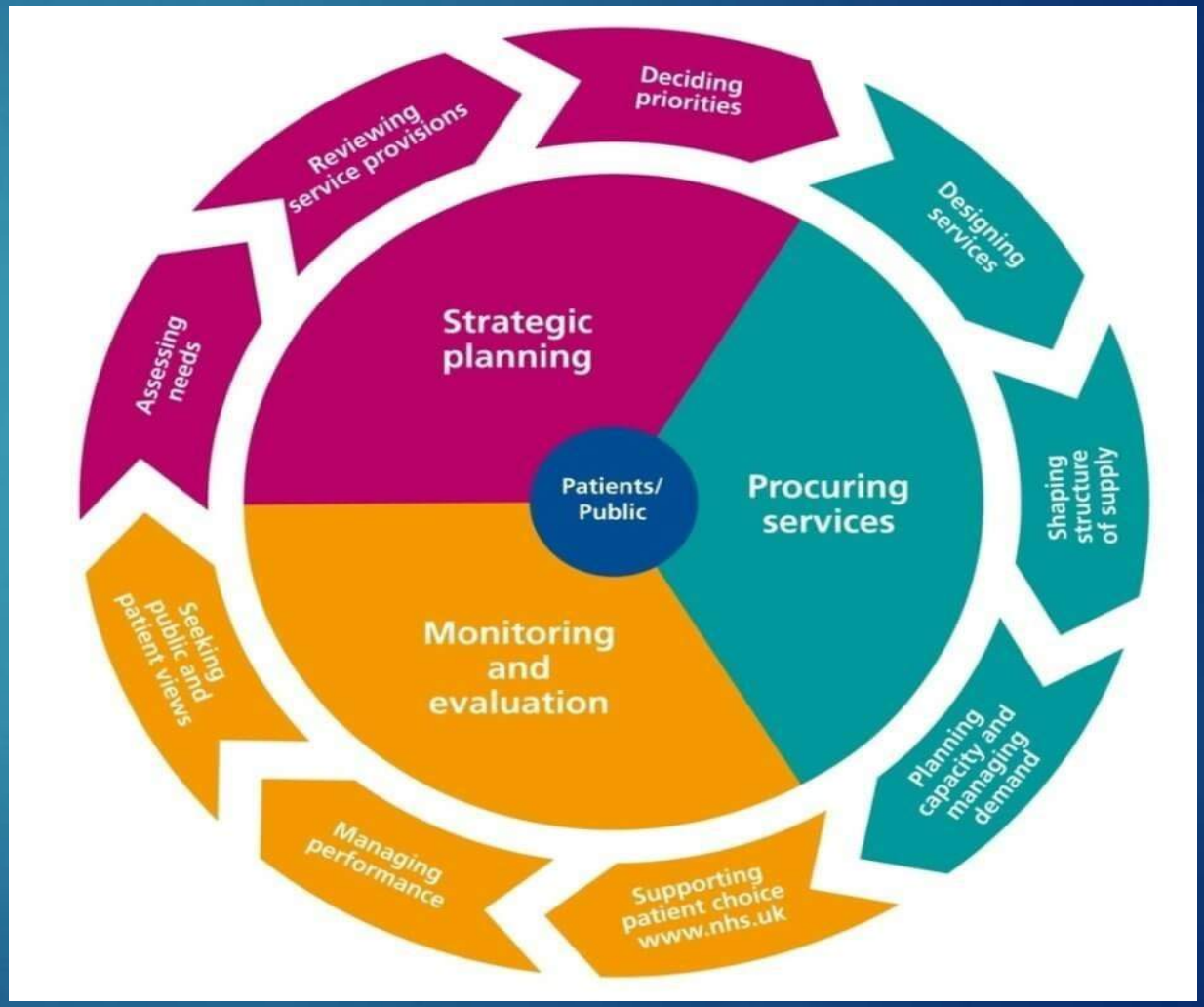
	The current risk score reflects all actions undertaken in order to mitigate the critical risks. The target for the Division will be to maintain this position, continuing to assess the opportunities to reduce the risk further with the progression and implementation of the Estates Strategy. A remodelling of the management structure for soft FM services is being considered to enhance compliance, comply with national standards, improve governance and standardisation of approach.

Finance & Performance Committee October 2022

Commissioning

What is Commissioning?

Commissioning is the process of assessing needs, planning and prioritising, purchasing and monitoring health services, to secure the best health outcomes for the Health Boards population



ABUHB Commissioning

- ABUHB commissions a range of services as part of its core business. These include
  - Healthcare Services from other NHS Bodies (Wales and England)
  - Outsourced & Insourced Providers
  - Continuing Care Placements & Care Packages
  - Service level Agreements with the Third Sector

ABUHB Commissioning Team

- Small team of 7 which report to the Assistant Director of Finance – Capital, Commissioning, Financial Planning & Strategy
- Key responsibilities of the ABUHB Commissioning Team
  - Commission Secondary Care Services from NHS Providers under Long Term Agreements
  - Manage the income contracts with other NHS Commissioners where ABUHB has provided services to non ABUHB residents
  - Act as commissioners to scrutinise & advise ABUHB on the Welsh Health Specialised Services Committee (WHSSC) portfolio including the development of the IMTP
  - Lead Secondary Care Cross Border Arrangements
  - Manage the Out of Area Referrals under the Out of Area Policy – Referral Management service & process
  - Support divisional developments including repatriation and introduction of new services to be used by other NHS Commissioners
  - Lead on the Commissioning, procurement and management of outsourcing services
  - Maintain a review of quality issues identified with providers

ABUHB Commissioning Portfolio

AB as a commissioner (expenditure)

Cardiff and Vale	£35.658m
Cwm Taf Morgannwg	£23.685m
Velindre	£28.416m
Swansea Bay	£1.313m
Gloucester Hospitals	£3.072m
North Bristol	£1.667m
University Hospitals Bristol	£0.980m
Wye Valley	£2.113m

External Providers- Outsourcing

Practice Plus Group	£0.500m
St Josephs	£0.958m

AB as a provider (income)

- Powys £12.443m
- Cwm Taf £1.321m
- Cardiff and Vale £1.211m

Non Contract Activity

- As a Commissioner £1.515m
- As a Provider £1.888m

AB as a commissioner of Specialised Services

- WHSSC £135.6m
- EASC £43.5m

Budget Holder : Director of Finance

Long Term Agreements

- Long Term Agreements negotiated annually with Welsh Providers
- The LTA includes a plan of the services being commissioned, to be delivered in line with the NHS Wales Delivery Framework-
  - Ensuring access to services from the provider
  - Delivery of Welsh Government waiting times targets
  - Delivery of high quality services that comply with National and local standards
- The LTA also outlines the process for changes to services being commissioned or provided as well as an escalation process in the event of disagreement or dispute
- Activity is commissioned by care type eg inpatient, daycase, outpatient
  - Welsh Providers – historic local prices
  - English Providers – National Tariff
- Pass through costs are funded separately eg NICE / High Cost Drugs
- During COVID, to provide stability to providers, block contracting arrangement were agreed with no performance variation
- 2022-23 is a transitional year as HBs move back to historic LTA arrangements

ABUHB as a Commissioner – 5 Year Expenditure Trends

	2018/19	2019/20	2020/21	2021/22	2022/23
NHS England LTAs	£7,763k	£8,158k	£8,346k	£8,500k	£8,625k
Non Contract Expenditure	£1,788k	£1,718k	£730k	£1,318k	£1,309k
Cwm Taf LTA	£21,148k	£21,488k	£21,983k	£23,118k	£23,585k
Cardiff LTA	£28,329k	£30,385k	£31,469k	£32,527k	£36,208k
Other Welsh LTAs	£2,480k	£2,140k	£2,203k	£2,274k	£2,346k
Velindre LTA	£19,536k	£21,408k	£23,032k	£26,755k	£30,616k
Total Contract Expenditure	**£81,043k**	**£85,297k**	**£87,763k**	**£94,491k**	**£102,689k**

ABUHB as a Provider – 5 Year Income Trends

	2018/19	2019/20	2020/21	2021/22	2022/23
NHS England Income	£2,661k	£2,564k	£1,294k	£1,383k	£1,865k
Cwm Taf LTA	£1,078k	£1,316k	£1,325k	£1,373k	£1,421k
Cardiff LTA	£1,114k	£1,123k	£1,155k	£1,179k	£1,211k
Other Welsh LTAs	£621k	£499k	£490k	£538k	£503k
Powys LTA	£12,806k	£13,093k	£13,436k	£13,727k	£11,763k
Total Contract Expenditure	**£18,279k**	**£18,595k**	**£17,699k**	**£18,201k**	**£16,763k**

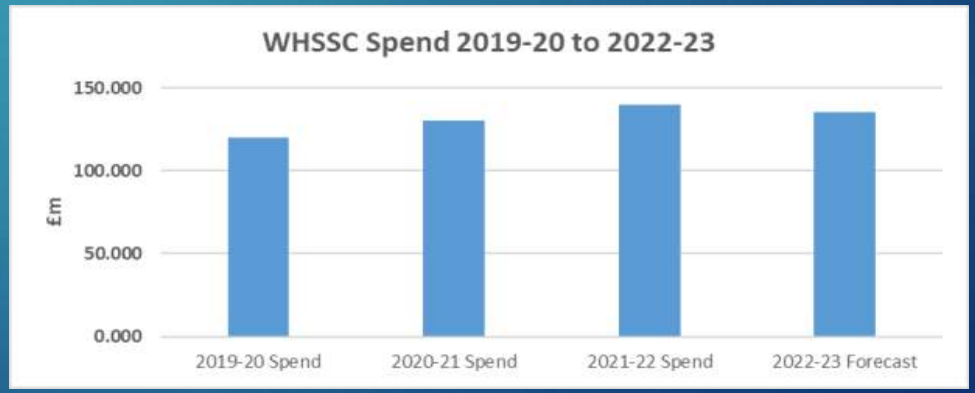
ABUHB as a Provider

- Most Significant Provider Agreement is with Powys totalling c£11m
- Following the opening of the Grange University Hospital and the reclassification of Nevill Hall Hospital as a Minor Injuries Unit there has been a significant reduction in patient flow into ABUHB from Powys
- Significant loss of income - c£2.2m reduction negotiated for 22/23
- Revised contract assumes a new baseline of activity – if this is not achieved further income will be lost
- Divisions have been funded for the historic levels of Powys activity as part of ABUHB IMTP, however, due to other service cost pressures this budget has not been clawed back.
- It was agreed that this income pressure would be borne by Commissioning, some budget has been delegated to offset the impact but the resulting overspend for Commissioning is £680k in 22/23 increasing to £1,243k in 23/24

ABUHB as a Commissioner – Specialised Services (WHSSC)

- ABUHB Share of WHSSC Integrated Commissioning Plan £135.6m
- Contribution agreed annually by Chief Executives at the Joint Committee
- Principle of Risk Sharing
- Main Scrutiny Process via WHSSC Management Group (made up of HBs representative and WHSSC Executive Team) includes
  - Prioritisation process
  - Clinical Impact Assessment process

- Key Financial Risks
  - Recovery – English Providers are recovering at a faster rate than Welsh Providers
  - Sustainability of Specialised Services in Wales
  - New technologies

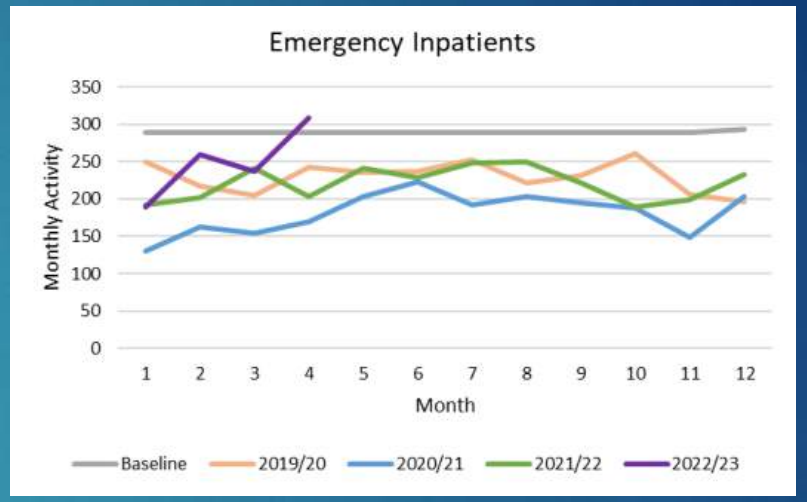


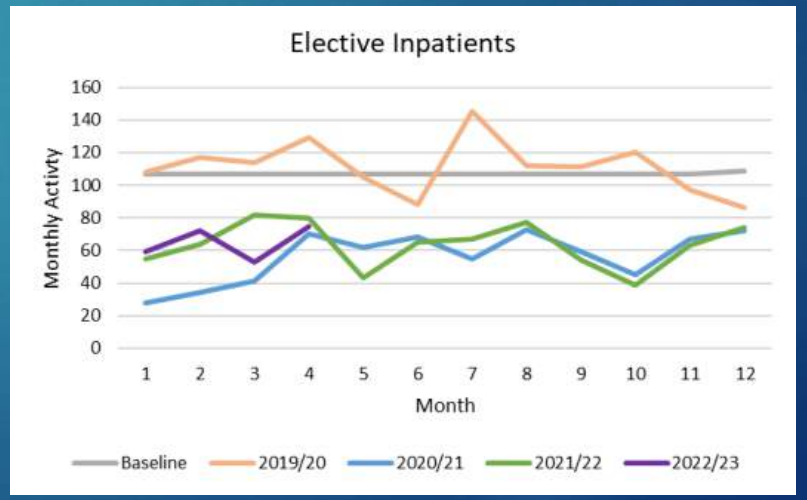
ABUHB as a Commissioner – EASC

- Emergency Ambulance Services Committee (EASC)
- ABUHB Share of EASC Plan £43.5m
- Remit covers
  - Commissioning Emergency Ambulance Service
  - Emergency Transfer & Retrieval Service
  - Non Emergency Patient Transport
  - Grange University Hospital Inter Site Transport
  - National Collaborative Commissioning Unit (NCCU)
- EASC Arrangements managed across ABUHB divisions
- New Developments 2022-23
  - Demand & Capacity £0.7m investment in 2022-23
  - Paramedic Band 6 Initiative £0.3m
- Future Developments
  - Further Investment in Demand & Capacity
  - NCCU Development - Sexual Assault Referral Centre

Cardiff & Vale UHB LTA

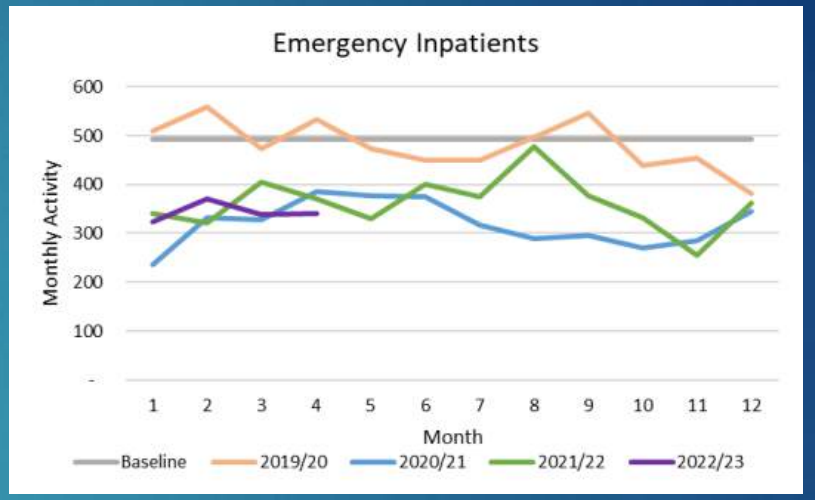
- LTA Baseline Value c£35m
- The LTA covers access to emergency services for AB patients as well as clinically established elective tertiary pathways
- Key focus on delivery and in particular delivering at least 19-20 activity
- Particular concern around Gynae Cancer Waiting times
- 2022-23 LTA reflects is the repatriation of Neurology Services back to ABUHB
- Vascular surgery centralisation from July 2022 will result in c300 ABUHB patients pa being treated in Cardiff
- Details of the waiting list projection for AUHB residents is being developed by C&V

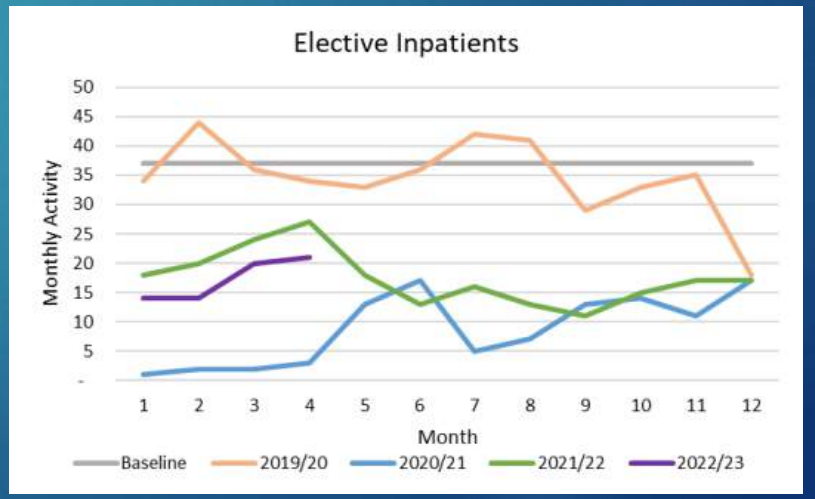




Cwm Taf Morgannwg UHB LTA

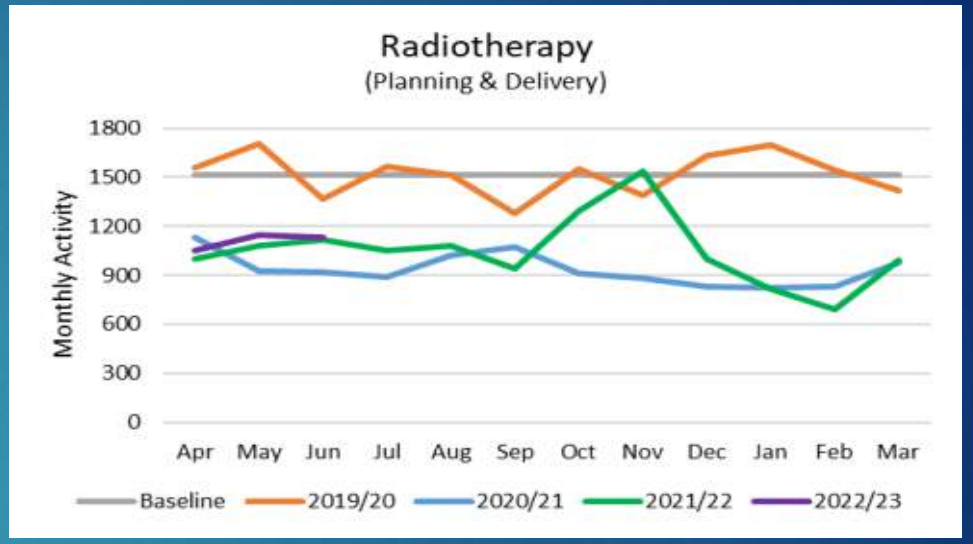
- LTA Baseline Value £23m
- The LTA predominantly includes access to emergency services for AB patients but also a small amount of elective activity where there are established referral pathways
- There has been a significant reduction in Emergency Inpatient activity for AB residents compared to pre-covid levels and underperformance is being recovered through the contract mechanism. A&E attendances have not reduced to the same degree.
- The main areas of underperformance are emergency inpatients- in particular
  - Trauma & Orthopaedics
  - General Medicine
  - General Surgery
- Elective Inpatients also still significantly below 2019-20 levels
- Details of the waiting list projection for AUHB residents is being developed by CTM

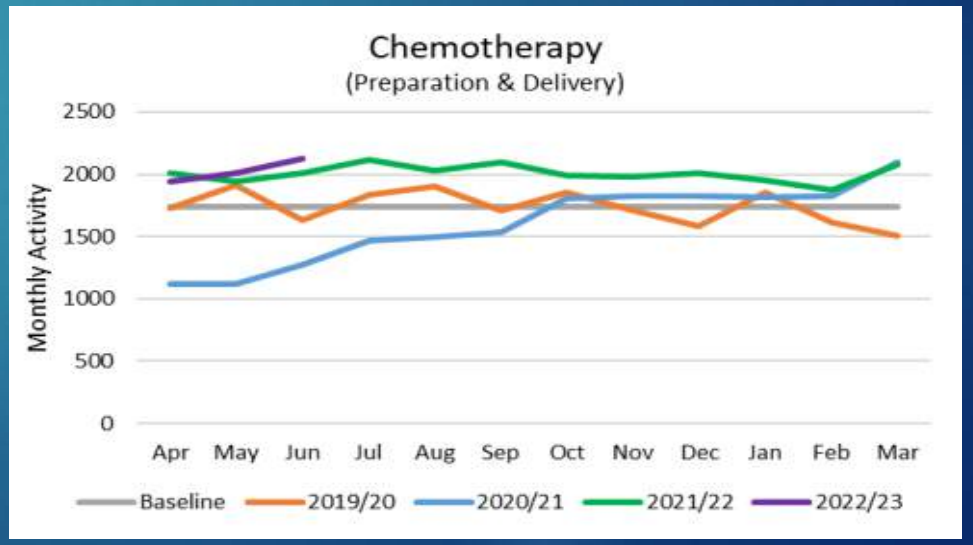




Velindre NHS Trust

- LTA Baseline Value £30m including NICE drugs
- The LTA is for the provision of cancer services, predominantly radiotherapy and chemotherapy
- There are concerns over radiotherapy performance and waiting times
- Clinical operational group established to consider waiting times issues
- Chemotherapy (SACT) continuing to overperform. Future ability to overperform may be limited by loss of Rutherford capacity.
- NICE Growth 21% up on previous years
- A new contract Framework has been agreed with Velindre to ensure that costs and activity are accurately reflected by each Health Board, which is anticipated to help performance and contract management. This will be implemented at the earliest opportunity.





ABUHB as a Commissioner - England

- ABUHB commission secondary care acute services (predominantly emergency activity) from
  - Gloucester Hospitals Foundation Trust (c£3.1m)
  - North Bristol Trust (c£1.7m)
  - University Hospitals Bristol Foundation Trust (c£1.0m)
  - Gloucestershire Health & Social Care Trust (c£0.5m acute mental health services, and c£0.4m community services)
  - Wye Valley Trust (c£1.7m acute services, and c£0.4m community services)

- Cross Border
  - ABUHB is funded for the care of circa 10,000 English resident registered with Welsh GPs
- Out of Area Policy
- Non Contracted Activity £1.5m – Emergency treatment for AB residents at any other NHS body in the UK

LTA Monitoring

Meeting with Providers

- Regular meetings with all Welsh providers focused on
  - Current performance
  - Waiting Times
  - Service Issues
  - Quality
- Quarterly meetings with English Providers

Quality

- Information sources such as Board papers, HIW reports etc reviewed on a monthly basis
- Current key quality and waiting times issues
  - Cancer Waiting Times for Pancreatic Surgery (Swansea Bay), Gynae Cancer Surgery (Cardiff) and Radiotherapy Services (Velindre)
  - Maternity services in CTM

ABUHB as a Commissioner of Regional Services

- Major Trauma Centre
  - Launched Sept 2020
  - Commissioned by WHSSC
  - Annual Cost (All HBs) £14m
  - Evaluation Process underway incl Peer Review & WG Review
  - Concerns over relative usage by HBs
  - In particular C&V accounts for 36% of the activity with a financial risk share of 21%
  - AB accounts for 24% of the activity with a financial risk share of 25%
- Vascular Centralisation
  - Launched July 2022
  - Annual Cost c£2.7m for ABUHB
  - Identification of savings with the relevant divisions
  - Review of activity, resources and outcomes will be undertaken throughout the first year of implementation

Outsourcing

- **Practice Plus Group (£0.5m)**
  - Current contract 1st July 2021 - 30th June 2022
  - Due to internal issues at PPG there were 95 patients that had not been seen. It has been agreed that these patients will be seen throughout August and September 2022
  - Joint service reviews (JSR's) quality reviews are undertaken quarterly.
- **St. Joseph's Hospital (£0.9m)**
  - Current contract 4th April 2022 - 31st March 2023
  - This contract is for use of part of the hospital and support staff along with ABUHB medical staff. It provides endoscopy services and diagnostic imaging

Opportunities

- Rigour in the LTA Process
  - Annual LTA Negotiation Process
  - Scrutiny of Investments including Value for Money
  - Repatriation eg Neurology - Negotiating full cost withdrawal
  - Provider function eg Powys - Seeking the most advantageous 'deal' for ABUHB including fixed cost retention
  - Disinvestment – however need to avoid destabilising provider
  - WHSSC – Scrutiny of the IMTP incl risk assessment and prioritisation
  - These are unlikely to result in cash savings but could mean better value for money and an improved service for the patient
- Demand Management
  - Use ABUHB Services to their funded full capacity before referral to other providers
  - Avoiding referrals to other providers which could have been dealt with internally eg Neurology patients being referred back to C&VUHB to be put on homecare packages
  - This could avoid expenditure

Opportunities

- Restructuring LTAs
  - Medium to longer term aspiration
  - Promote a Value approach to LTAs focusing on outcomes, incentives, risk and reward
  - Develop a Framework to incentivise delivery
  - Consider standard costing – Welsh tariff
  - Current barriers – lack of outcome data, clinical coding
  - All Wales Workstream led by DOFs
  - Regional workstreams
  - Reviewing pathways ie Gynae and Pancreatic Cancer and Radiotherapy
  - More likely to be value for money and improved services than cash releasing

Conclusion

- Key Opportunities in the Commissioning Portfolio
  - Manage demand – avoid flows externally where possible
  - Maximise internal capacity that has already been funded
  - Avoid use of Outsourced Providers – premium cost
  - Avoid use of Insourcing – premium cost
  - Repatriation – significant risks if new ABUHB Service doesn't deliver to at least existing quality and cost
  - Regional Opportunities include major trauma centre, ophthalmology, diagnostics and vascular

Aneurin Bevan University Health Board
Finance & Performance Committee

Finance Report – August (Month 5) 2022/23

Executive Summary

This report sets out the financial performance of Aneurin Bevan University Health Board, for the month of August 2022 (month 5) 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 & July 2022 Board meetings and updated during the year. The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board's performance against them.

Aug-22
Performance against key financial targets 2022/23
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Trend	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	3,105	17,441	↑	**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 £48,662	1,063 2.2%	8,282 16.9%	↔	**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)	%	96.6%	94.5%	↔	**>95%**

Performance against requirements 21/22		**19/20**	**20/21**	**21/22**	**3 Year Aggregate (19/20 to 21/22)**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue	✓	**(32)**	**(245)**	**(249)**	**(526)**
Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital	✓	**(28)**	**(13)**	**(50)**	**(91)**
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	✓				

Underlying Financial Position (Brought Forward ULP)	**19/20**	**20/21**	**21/22**
This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.	**£11.405m Deficit**	**£16.261m Deficit**	**£20.914m Deficit**

Note: The Health Board has submitted an IMTP for 2022/23 – 2024/25, which has been approved by WG on the basis of achieving financial balance.

Key points to note for month 5 include:

- A reported year to date position of **£17.4m deficit**, (the original IMTP plan for month 5 was £3.17m deficit), the revised in year profile for month 5 was expected to be £17.1m year to date deficit.
- Income - includes anticipated Covid-19 and exceptional cost pressure funding of c.£103m,
- Pay Spend (excluding annual leave provision and in-month agency adjustments) – has increased by c.£0.1m (0.1%), due to increased bank costs (Registered and HCSW) to cover vacancies and enhanced care, particularly in community hospitals.
- Non–Pay Spend (excluding capital adjustments) - has increased by c£0.3m (0.4%) due to increases in Primary Care contract costs in line with expected profiles. These costs are off-set by reduced CHC, Individual Patient Treatment Referral (IPTR) and out of area treatment costs.
- Savings – overall achievement is £3.4m below plan as at month 5 (£2.3m achievement versus £5.7m plan) with significant risks with delivery of a number of savings opportunities where achievement is assumed after quarter 1. These savings plans remain amber for month 5 reporting to enable the Health Board the opportunity to drive these plans into an achievable position. These will be under continual review for future monthly reporting.

***At Month 5, the year to date reported revenue position is a £17.4m deficit and the reported capital position is break-even. The forecast position for both is break-even, however, the revenue position has <u>extremely significant risks</u> that need to be mitigated to achieve this* forecast.**

The Board was provided with a comprehensive forecast risk assessment on the 27th July. The Board agreed to continue to forecast financial balance on the basis of actions being identified and considered during the rest of 2022/23 to manage this. All budget holders were asked to clarify their forecast for the financial year providing options to reduce and mitigate expenditure for month 5 reporting. There were no material changes to the forecast risk as a result of this request. Further mitigating actions are being developed by the Executive for Board consideration.

Month 6 is a crucial month for submitting a forecast to WG, organisations will be expected to maintain this forecast, or improve on it, for the remainder of the financial year. Given the extreme risk to forecast break-even the CEO has commenced additional focussed sessions of the Executive team to review income opportunities and cost reduction opportunities and likely delivery levels for 22/23. This will provide the basis for consideration with the Board of an updated service, workforce and financial plan and forecast for 2022/23.

The underlying financial deficit coming into 2022/23 (£20.9m) will need to be addressed to support financial sustainability and recurrent balance in future years. The IMTP assumes recurrent savings opportunities will be achieved to reduce the underlying financial deficit for 2023/24 (to £8m). This assumption will need to be adjusted if the recurrent savings and mitigating actions are not achieved during the year. This is now at significant risk given the challenges faced in 2022/23.

The Board has approved the 2022/23 – 2024/25 IMTP initial Budget delegation plan for 2022/23 as well as an update for quarter 2. WG have approved the IMTP which assumes financial balance.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	

Discuss and Provide Views			
Receive the Report for Assurance/Compliance			√
Note the Report for Information Only			
Executive Sponsor: Rob Holcombe – Interim Director of Finance, Procurement & VBHC			
Report Author: Suzanne Jones – Interim Assistant Director of Finance			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board**	√
Date of the Report: 23rd September 2022			
Supplementary Papers Attached: 1. Glossary 2. Appendices 3. Month 5 WG Monitoring Returns			

Purpose of the Report

This report sets out the following:

- The financial performance at the end of August 2022 and forecast position – against the statutory revenue and capital resource limits,
- The savings position for 2022/23,
- The 2022/23 forecast,
- The significant level of risk to the financial position,
- The revenue reserve position on the 31st of August 2022,
- The Health Board's underlying financial position,
- The Capital position, and
- The Month 5 WG Monthly Monitoring Return (MMR)

Assessment & Conclusion

- **Revenue Performance**

  The month 5 position is reported as a **£17.441m deficit,** with a forecast **year-end out-turn reported position as break-even, however, there is significant risk to this forecast which the Board will further consider at the September Board meeting**. A summary of the financial performance is provided in the following table.

Summary Reported position - August 2022 (M05)	Full Year Budget £000s	YTD Reported Variance £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	271,231	(944)	(1,334)	390
Prescribing	99,190	3,101	2,050	1,051
Community CHC & FNC	71,296	(1,844)	(1,170)	(675)
Mental Health	104,853	3,960	2,562	1,398
Director of Primary Community and Mental Health	311	(63)	22	(85)
Total Primary Care, Community and Mental Health	**546,881**	**4,210**	**2,131**	**2,079**
Scheduled Care	226,287	10,097	7,470	2,627
Medicine	106,819	9,250	7,996	1,254
Urgent Care	41,204	2,676	2,358	319
Family & Therapies	119,405	(346)	13	(358)
Estates and Facilities	104,043	588	(37)	625
Director of Operations	7,634	392	311	81
Total Director of Operations	**605,392**	**22,659**	**18,112**	**4,547**
Total Operational Divisions	**1,152,273**	**26,869**	**20,242**	**6,626**
Corporate Divisions	111,486	(6,406)	(4,513)	(1,893)
Specialist Services	172,248	(957)	(499)	(458)
External Contracts	83,965	605	732	(126)
Capital Charges	34,734	(159)	(67)	(92)
Total Delegated Position	**1,554,706**	**19,952**	**15,895**	**4,057**
Total Reserves	28,595	(2,511)	(1,559)	(952)
Total Income	(1,583,301)	0	0	0
Total Reported Position	**0**	**17,441**	**14,336**	**3,105**

The year to date overspend is £14.3m higher than forecast in the submitted IMTP. The position has been underpinned by appropriately releasing part of the annual leave accrual, maximising available non-recurrent opportunities and assuming an on-going level of funding for Covid-19 and exceptional pressure to match related costs. Current service pressures being experienced are incredibly challenging, presenting an increasingly significant risk to the Health Board's ability to meet its statutory requirement to break-even. The Health Board reaching a break-even position in 2022/23 was predicated on:

- Achieving savings of at least £26m,
- Managing and mitigating the £19m risks included in the IMTP through cost avoidance,
- Managing any new in year cost pressures,
- WG funding for Covid-19 (local and national), exceptional cost pressures and wage award.

The CEO has commenced additional focussed sessions of the Executive team to review income opportunities and cost reduction opportunities and likely delivery levels for 22/23. If this is not achieved there is a significant risk to achieving break-even for 2022/23.

The Chief Executive has asked all budget-holders across the UHB to consider various short-term measures and approve revised local forecasts for month 5 reporting. The Board meeting on the 28th July noted the current financial position with the level of risk shown whilst holding a break-even position to enable further actions to be considered to improve the financial outlook for 22/23 with due consideration to the impact on patients, workforce, service delivery and performance.

To ensure delivery of the IMTP service, workforce and financial plans, progress must be made to deliver transformational change to support value driven efficiency improvement and financial sustainability. While transformation is the preferred sustainable solution for long term efficiency and value gain, short term actions need to be strengthened to support 2022/23 balance in parallel with accelerating efficiency delivery through the IMTP priority transformation programmes.

Financial impact of service and workforce pressures

- During August 2022, pay expenditure (excluding the effect of reduced annual leave provisions) increased compared with July. Variable pay costs increased compared with July due to increased bank costs (Registered and HCSW) to cover vacancies and enhanced care, particularly in community hospitals. Medical agency costs decreased due to reduced service recovery costs. Significant operational pressures continue due to vacancies, enhanced care hours and sickness. Non–Pay Spend (excluding capital adjustments) - has increased by c£0.3m (0.4%) due to increases in Primary Care contract costs in line with expected profiles off-set by reduced CHC, Individual Patient Treatment Referral (IPTR) and out of area treatment costs.

- The number of Covid-19 positive patients in hospital has decreased throughout August. The total number of patients (positive, suspected and recovering) is 157 (31st August 2022) which is at similar levels to August 2021 (153 as at 31st August 2021). There are a considerable number of patients recovering from Covid-19 across several wards in the Health Board. The temporary staffing cost to operate these areas, some of which is surge capacity, remains significant and is impacting on efficient bed utilisation.

- Demand for emergency and urgent care across all services, including primary care, mental health, acute and community hospitals, remains in many cases above the levels seen pre-pandemic. In August the levels of patients deemed ready for discharge but remained in hospital increased notably. There are 286 patients who are fit for discharge as at the end of August; approximately 29% of the blocked bed days are health related, 50% are social care related with the remaining 21% relating to other reasons e.g. patient/family related, nursing homes etc..

- The extrapolated cost of the associated blocked bed days which are Health or Social care related is c.£8.3m using a £150 cost per bed day. The surge capacity required for this as well as the increased Covid measures in place continue to result in overspends across the UHB. There also remain challenges in terms of demand and flow 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 together with the cost of enhanced care and increasing elective activity result in significant financial pressures. If the service response to Covid-19 implications could be de-escalated it should result in cost reductions to some of the operational factors currently in place where funding is assumed, which is a requirement of WG.

Additional local Covid-19 costs are being incurred due to the following, but the most significant problem is the delayed discharges resulting in blocked beds.

- Additional services implemented to deal with exceptional emergency pressures across all sites,
- 'green' patient pathways to minimise infection,
- GUH ward A1 urgent care temporary ward,
- additional bed capacity across hospital sites,
- the number of patients requiring enhanced care,

- delayed discharges for patients waiting for social care support and packages of care, and
- service models being flexed to respond to service pressures faced.

To mitigate, key areas of focus for the Health Board are:

- System level working – reviewing DTOCs, updating bed capacity forecasts & additional capacity requirements
- Urgent care and elective care re-design,
- Demand and flow management, - reviewing the social care community actions,
- Workforce efficiency, reducing variable pay in particular HCSW agency and medical temporary pay costs,
- Review of Medicines management,
- Review of CHC pathways within Mental Health and Complex Care,
- Review of current savings plans, current investments made and service options across Divisions,
- Corporate opportunities and Executive Director options, and
- Other actions to improve the financial position e.g. review of income/allocations

These areas for mitigation aligned with turnaround actions need to be invigorated and implemented as a priority, whilst maintaining patient safety, to support achievement of financial balance.

Workforce

The Health Board spent £60.4m on workforce in month 5 22/23 an increase of £0.1m compared with month 4 (21/22 monthly average of £58.3m). **The workforce costs for ABUHB have continued at the same level since quarter 3 2021/22 despite a reduction in Covid demand.**

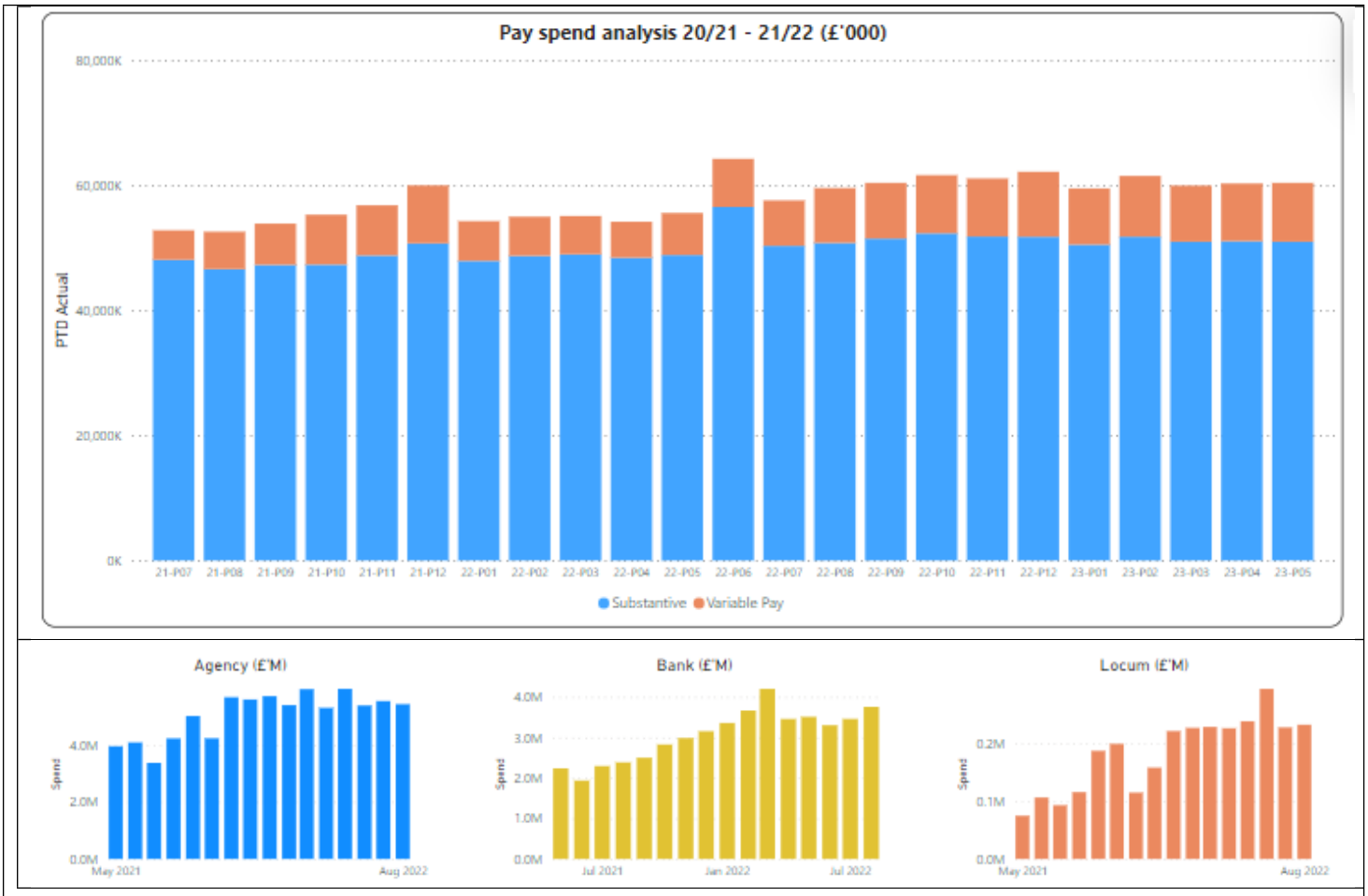
Substantive staffing costs (excluding notional 6.3% pension costs in March) have decreased by £0.1m (0.2%) compared with July due to a decrease in additional hours.

Compared with month 4, bank costs have increased by £0.3m (8.6%). Agency costs have decreased by £0.1m (2%). Bank HCSW costs have increased due to increased enhanced care shifts covered by this group of staff particularly within the Primary Care and Community Division. There continues to be 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 £51m in August (exc. annual leave related adjustments) – a £0.1m decrease compared with July. Administrative & Clerical costs increased by £0.2m within Primary Care and Community services off-set by reduced Medical and Registered nursing costs.

Variable pay
Variable pay (agency, bank and locum) was £9.4m in August – an increase of £0.2m compared with July.

The Executive Team has agreed a variable pay programme which is aimed at reducing high cost variable pay and developing alternative solutions. This includes a number of areas including recruitment of substantive staff, review of specialist rates, reduction in HCSW agency as well as detailed review of nurse staffing across ward areas. Current service demand for agency as well as the on-going use of off-contract agencies is challenging the level of achievement.

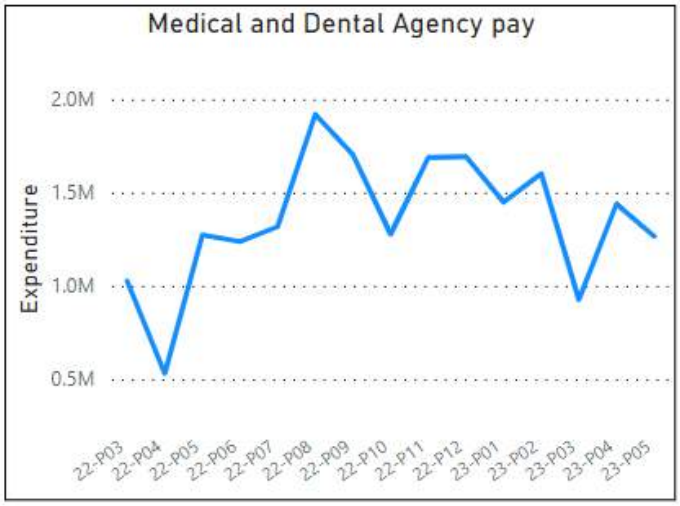
It should be noted that the number of unfilled nursing shifts remains at a high level throughout the HB (183wte for the week commencing 10th September which was approximately 8% of all shifts required). If all these shifts were filled through variable pay the cost impact would be significant.

Bank staff

Total bank spend in August was £3.8m – an increase of £0.3m compared with July. There remains continued high usage of enhanced care shifts especially within the community hospitals in August. Other areas where bank usage has increased include Mental Health, Urology and GUH ED.

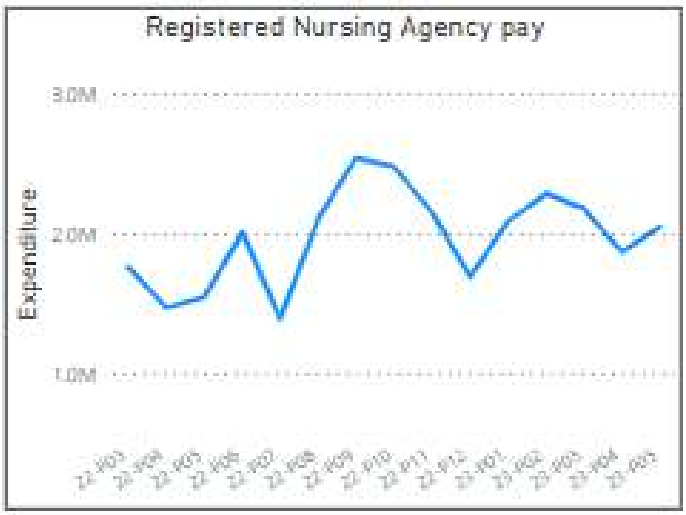
Agency

Total agency spend in August was £5.4m (excluding the in-month agency adjustment) a decrease of £0.1m compared with July. A specific review of shifts booked between 1st April 2021 and 31st July 2022 was undertaken by finance, workforce and nursing teams. As a result £0.67m of shifts have been cancelled across all Divisions. This review of accrued shifts undertaken will continue over the next few months. Costs stated on the following page exclude this review.



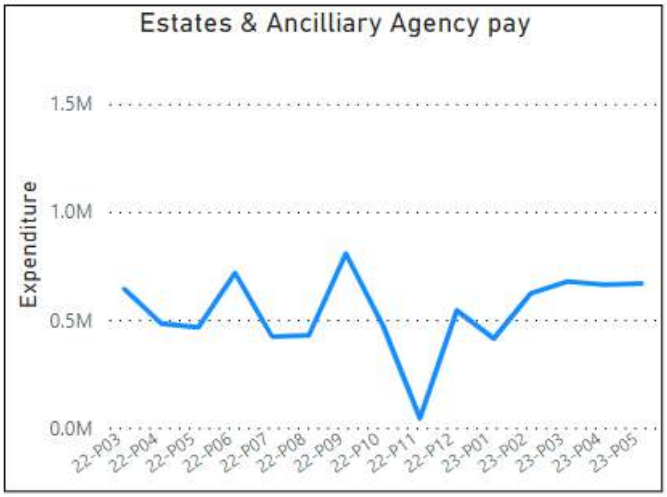
- In-month spend of £1.3m, a £0.2m decrease compared to July.
  - Continued pressures in Medical wards, GUH ED and community hospitals.
  - Increases in Mental Health and Gynaecology for operational pressures.
  - Increase in radiology and Ophthalmology to cover vacancies and additional recovery activity.
  - On-going costs for managed practices (£0.18m in August) with a likely further increase due to notice of closure in 22/23.

- Medical agency spend averaged c.£1.3m per month in 2021/22.



- In-month spend of £2m an increase of £0.2m compared to July (excluding accrual adjustment)
- Reasons for use of registered nurse agency include:
  - Additional service demand including opening additional hospital beds, support for recovering Covid-19 patients,
  - Enhanced care and increased acuity of patients across all sites,
  - On-going sickness and international recruitment costs,
  - vacancies, and
  - enhanced pay rates.

- Registered Nursing agency spend averaged c.£1.9m per month in 2021/22.

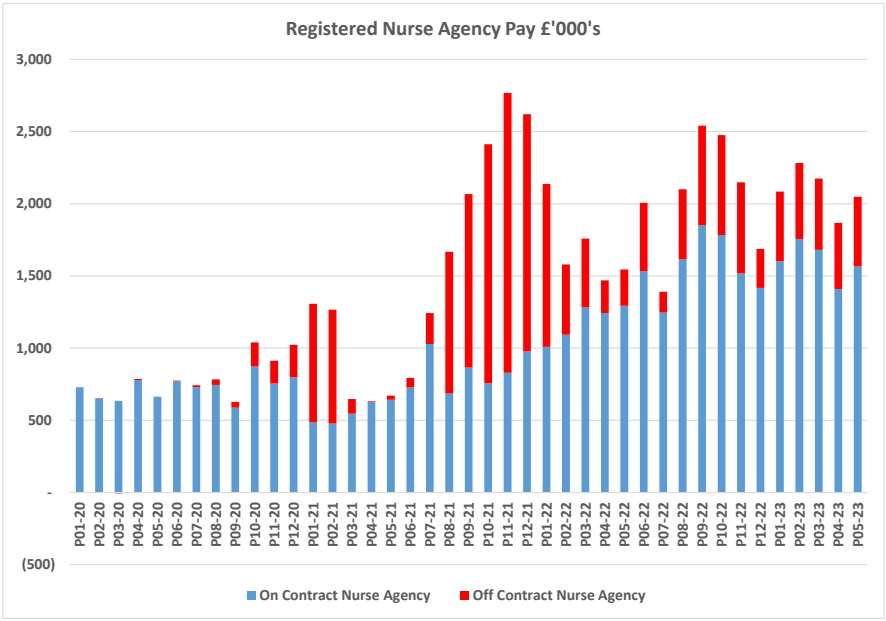


- In month spend of £0.7m on Estates & Ancillary (similar to July), which is primarily within GUH and related to Covid.
- Reasons for use of agency include:
  - Meeting enhanced cleaning standards,
  - Covid-19 and surge capacity
  - Enhanced care and increased acuity of patients,
  - Sickness,
  - Vacancies and
  - Supporting the Mass Vaccination Programme.
- Estates and Ancillary agency spend averaged c.£0.5m per month 2021/22.

Registered Nurse Agency

Registered nurse agency spend totalled £22.8m in 2021/22, £18.1m in 2020/21 and £10.2m in 2019/20.

Health Board spend for the year to date is £10m on nurse agency. If this level of use continues throughout the financial year it would cost c.£24m in 2022/23. The use of "off-contract" agency – not via a supplier on an approved procurement framework – usually incurs higher rates of pay. This has remained significant during the month.



The Health Board spent £0.5m on 'off' contract RN agency in August which is at a similar level to previous and reflects the on-going vacancy hours used and the usage of agency to cover enhanced care hours. The main reasons for its usage are:

- Enhanced care,
- Additional capacity,
- Nursing vacancies,
- Patient safety,
- Covid-19 responses (especially for recovering patients), and
- Increased sickness and cover for staff in isolation.

As part of the new Variable Pay savings programme for 2022/23, the Nurse Agency Reduction Plan will form a key part of delivering efficiencies.

Medical locum staff

Total locum spend in August was £0.23m which is at a similar level to July. GUH ED and Mental Health costs increased in August whilst radiology remains the area of highest expenditure relating to on-going operational pressures, elective recovery and substantive vacancies.

Enhanced Care

Enhanced Care, also known as 'specialling', can include a spectrum of reasons ranging from the provision of assistance to help a patient mobilise, through to one-to-one patient monitoring. Enhanced care is designed to ensure a patient centred safe approach for patients with additional care needs.

A review of the financial impact of 'enhanced care' – including the use of bank and agency staff – has identified the following use of nursing staff:

	2020/21	2021/22	2022/23 (forecast costs)	2022/23 increase
Average number of hours used per month	15,305	35,446	41,916	17%
Average monthly notional expenditure (£m)	0.24	0.70	0.93	
Increase in average notional cost per month compared to prior year				£0.2m
Estimated increase in the calculated annual cost based on average hours				£2.7m
Total annual costs (£m)	**2,826**	**8,413**	**11,155**	**2,742**

In August (P05-2023), enhanced care hours and associated costs remained high and increased significantly within the Primary Care and Community Division. Costs (& associated hours) increased in the Medicine as well as within Scheduled Care Divisions. It should be noted that the hours quoted are the number of bank and agency hours worked using 'enhanced care' as the reason for booking, notional costs are calculated using average registered/unregistered hourly rates incurred. These have been updated for 2022/23 using shift time, type and specialist rates where defined. Further updates will be completed to reflect the off-contract nature of many shifts which will inevitably increase the costs described. The E-Systems team within the Workforce and OD Division are undertaking a review of previously booked shifts. As a result it is likely that there will be further amendments in the next couple of months to reflect the review.

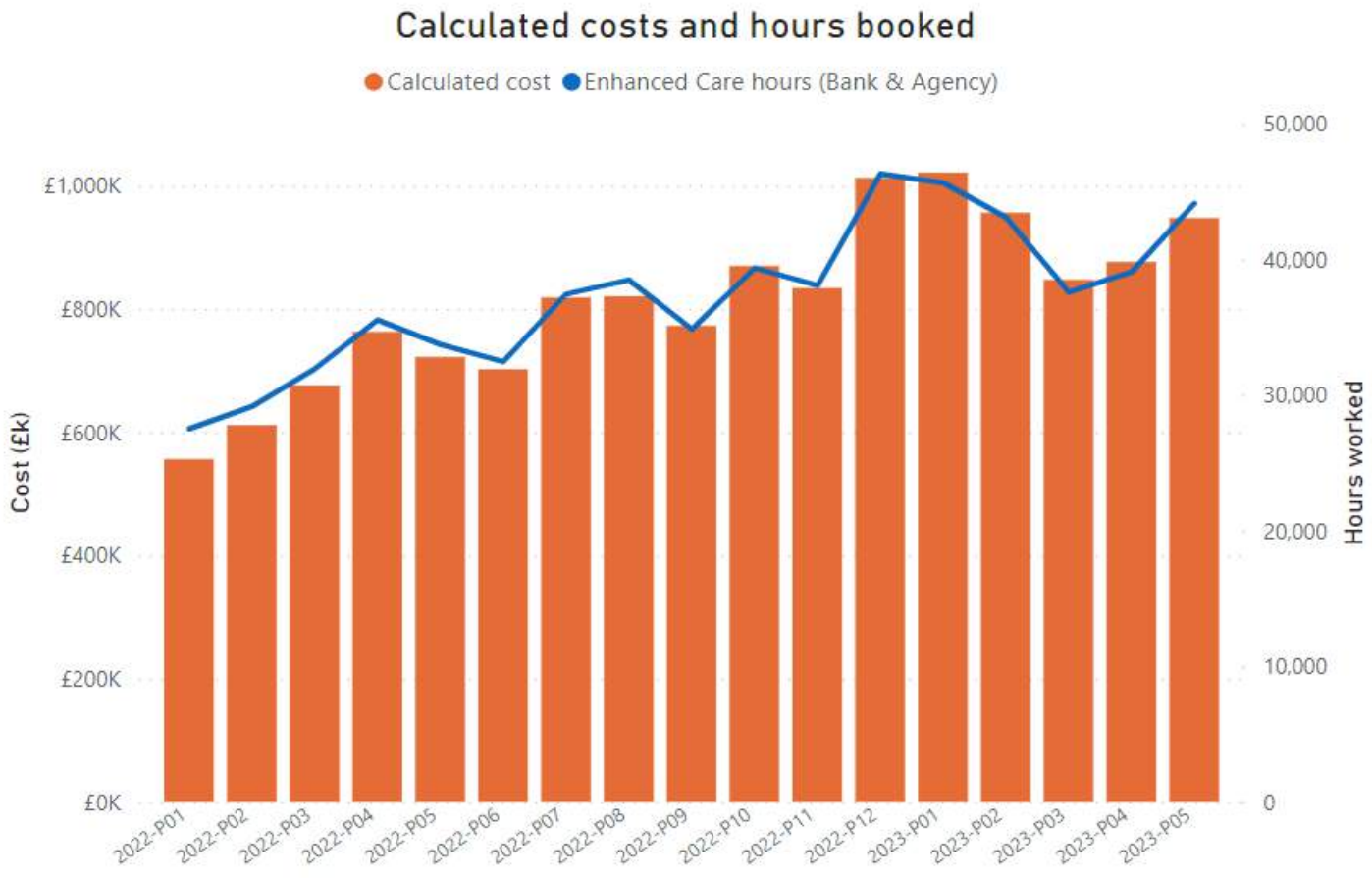
There is a distinct increase in enhanced care hours (and associated costs) from February 2022 (see graph below). The monthly average from April 2021 to February 2022 is approx. 34,400 hours and £0.68m cost. The August cost of £0.95m is an increase of £0.27m above that average and continues to indicate a step change which reflects the change in acuity of patients across the UHB.

The level of the provision of enhanced care on bed utilisation within Medicine for August 22 is shown below:

Enhanced Care (acuity EC4 & EC5) by Hospital Site as a percentage of total bed capacity	Month 4	Month 5
YYF		
Total no of Medicine beds	148	148
Monthl's average bed numbers occupied by EC4 & EC5 pts	46	35
%age of beds in receipt of Enh Care (EC4 & EC5)	**31%**	**24%**
RGH		
Total no of Medicine beds	192	192
July monthly average enh care patients	30	45
%age of beds in receipt of enh care	**16%**	**23%**
NHH		
Total no of Medicine beds	164	164
July monthly average enh care patients	39	35
%age of beds in receipt of enh care	**24%**	**21%**
GUH		
Total no of Medicine beds	91	91
July monthly average enh care patients	18	32
%age of beds in receipt of enh care	**20%**	**35%**

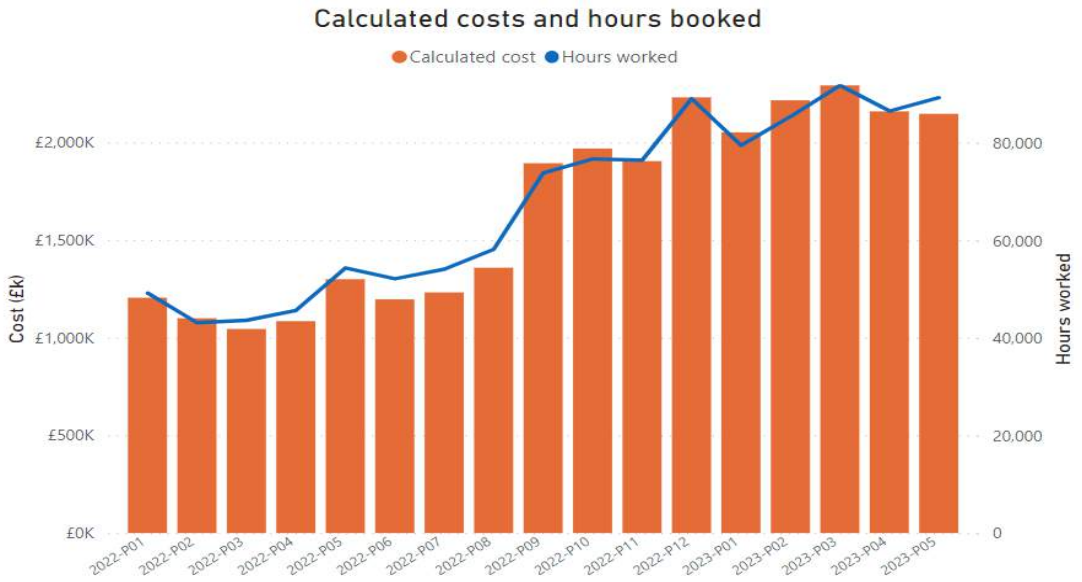
The following graph highlights the increase in hours attributed to enhanced care for the period April 2021 (P01-2022) to August 2022 (P05-2023) using bank and agency registered nurses and health care support workers.

Enhanced Care bank and agency calculated costs and hours booked



The graph below describes the bank and agency hours and costs relating to those booked to cover vacancies. The graph highlights that in July that variable pay relating to vacancies remains significant and over £2m of 'notional calculated' expenditure.

Calculated bank and agency costs / hours booked to cover shifts resulting from vacancies



Non-Pay

Spend (excluding capital) was £77.5m in August which is £0.3m increase in comparison with July. Increased Primary Care contract costs in line with profile were off-set by reduced CHC, Individual Patient Treatment Referral (IPTR) and out of area treatment costs. The in-month energy costs reflect the volatility in energy prices, which is regarded by Welsh Government as an exceptional cost pressure. Further additional funding has been anticipated for this volatile cost pressure now estimated at £33.9m (increase of £17.8m from July) and will continue to be adjusted in future months based on the latest data from NWSSP.

Other areas to note are:

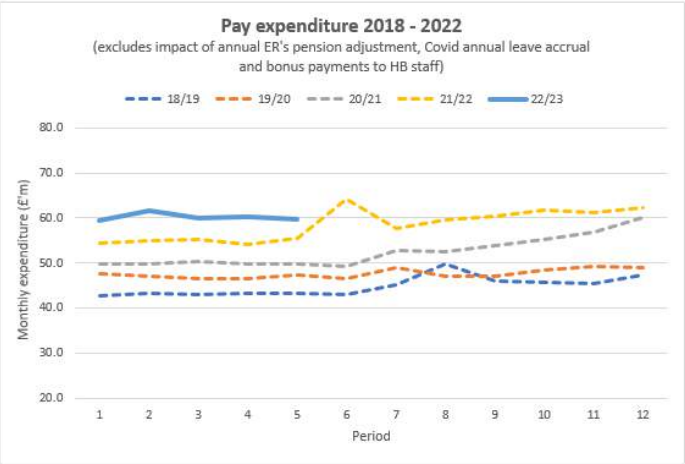
- CHC Mental Health – the current patient numbers at the end of August were 413 (at a cost of £3.8m in August) which is a net decrease of 2 MH&LD patients in month. The increase in LD patients included higher cost per packages resulting in an on-going cost pressure for the Division.
- CHC Adult / Complex Care - 668 active CHC and D2A placements (increase of 6 from July). There was a decrease of 5 D2A patients but an increase of 12 placements on the 'Step Closer to Home' pathway (47 total) in August. The 2022/23 forecast cost is £1.1m which assumes this pathway will cease in November 2022. The table below summarises the current position:

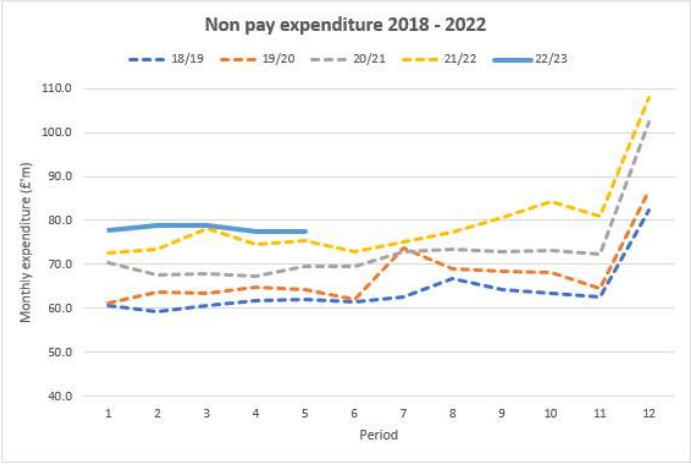
Activity	July 2022	August 2022	Movement
D2A	62	57	-5
Step Closer to Home	35	47	+12
All Other CHC	565	564	-1
Total	662	668	+6

- FNC - currently 887 active placements, which is an increase of 2 from end of July placements (expenditure of £36k in August).
- Primary Care medicines – the expenditure year to date is £44.4m. The August 2022 forecast is based on growth in items of 0.8% (using underlying growth estimate) with an average cost per item of £6.82, category M drugs prices continue to fluctuate but presents

an in-month pressure for August prices. Price increases compared with pre-Covid levels have not been mitigated through medicines management actions due to redeployment of pharmacy staff. Mitigating actions and resources to deliver cost reductions in prescribing costs are needed. NCSO drugs costs remain a pressure from July – September due to 2 drugs (one osteoporosis and one anti-depressant).

Pay and Non-Pay expenditure run-rates for the last four financial years are shown below to demonstrate the on-going step change in expenditure particularly for pay. If the service response to Covid-19 implications could be de-escalated it should result in cost reductions to some of the operational factors currently in place where funding is assumed.





Current operational forecasts based on March bed and activity plans, are assuming a similar level of spending through to the end of the year. These assumptions will now be subject to detailed review as part of financial recovery 'turnaround' work to re-assess the 22/23 operational service, workforce and financial plans. These plans will inform a revised, service, workforce and financial forecast for ABUHB.

Furthermore, the Executive requested that all budget-holders identify further cost reduction and savings opportunities during August as part of this focus on financial recovery and development of options and the associated implications. However, this did not result in any material changes to the forecast.

Service Pressures & Activity Performance

<u>Bed Capacity</u>

Additional medical beds have been opened as part of responding to the system pressures described previously. The level of additional capacity beds have reduced to 131 in August as described in the table below:

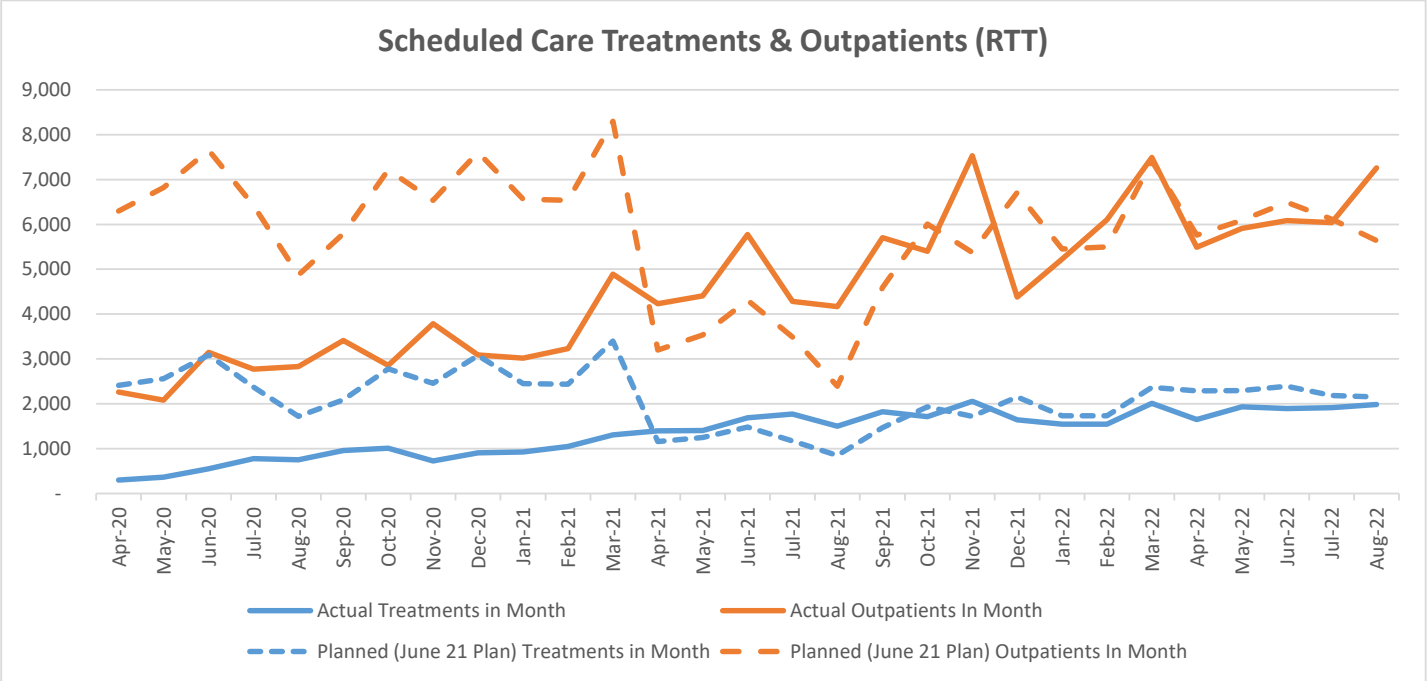
No. of Additional Beds							
Site	**Ward**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Description**
RGH	B3 Winter Ward	0	0	0	0	0	26 Additional Capacity
	C6E Med Additional Capacity from Oct	0	30	28	28	30	Old Resp Ward converted to Add Cap
	Other wards		6	0	0	0	
NHH	3rd Floor	7	8	11	11	11	32 (flexed up from 28)
	4th Floor	6	7	9	9	9	28 (flexed up from 30)
	4/1 winter	0	0	0	0	0	Winter ward from 27th Dec (flexed up from 28)
	AMU	0	0	0	6	2	
GUH	C4	0	0	0	0	0	2 Covid beds in March
	B4	8	8	8	8	8	
	A4	1	1	1	1	1	Using Ringfenced beds
	Fox Pod	8	8	8	8	8	Closed 18th August
	Other wards					13	Includes AMU chairs
YYF	MAU				27	0	Open for part of August
RGH AMU	AMU / D1W	18	0	8	16	10	D1W closed in July
Sub-total Medicine		**48**	**68**	**73**	**114**	**92**	
STW	Ruperra	24	24	24	24	24	
	Holly	10	10	10	10	0	
YAB	Tyleri	11	15	15	15	15	
Sub-total Community		45	49	49	49	39	
Total		**93**	**117**	**122**	**163**	**131**	

The number of medically fit patients and those delayed transfers of care remain at significant levels at 286 patients as at the end of August. Approximately 50% of these patients relate to social care delays with an estimated cost of £3.4m YTD (£8.2m for 2022/23). These patients are across multiple sites and are generally within the Medicine specialities. These delays affect flow and the level of additional capacity across the UHB resulting in significant additional costs. These levels were not factored into the IMTP for 2022/23. Further discharge support solutions have been implemented to mitigate the flow pressures but these continue to increase the financial pressure for the Health Board.

Scheduled Care treatments and outpatients

Elective activity in August was at a similar level to July and remains below planned levels (year to date 1,932 treatments under plan), activity remains below plan due to a range of operational reasons including vacancies, reduced theatre utilisation and a low uptake to provide additional sessions. T&O activity remains under plan due to long-term sickness alongside operational issues relating to WLIs but did increase in August compared with plan. Outpatient activity had a significant increase in-month mainly due to an increase in core General Surgery activity. The plan assumed reduced activity due to annual leave but activity was maintained, the year-to-date activity is now 689 appointments above plan although the profile is to come back in line with plan in future months. Virtual clinics are also being used as well as on-going review of clinic templates to potentially increase future activity with demand and capacity plans being updated for a number of specialities. Whilst most routine elective services have fully resumed, elective activity remains lower than pre-Covid-19 levels.

Activity plans are finalised linked to demand and capacity plans triangulated with service, workforce and financial affordability; however, the forecast plans are being reviewed.



- Elective Treatments for August '22 was 1,986 (July '22 was 1,913).
- Outpatient appointments for August '22 was 7,259 (July '22 was 6,041).

Medicine Outpatient Activity

Medicine Outpatient activity for August '22 was 1,311 attendances (July '22 was 1,522 attendances and 2021/22 activity 15,581, a monthly average of 1,298) the year to date activity is presented by specialty below:

Aug-22

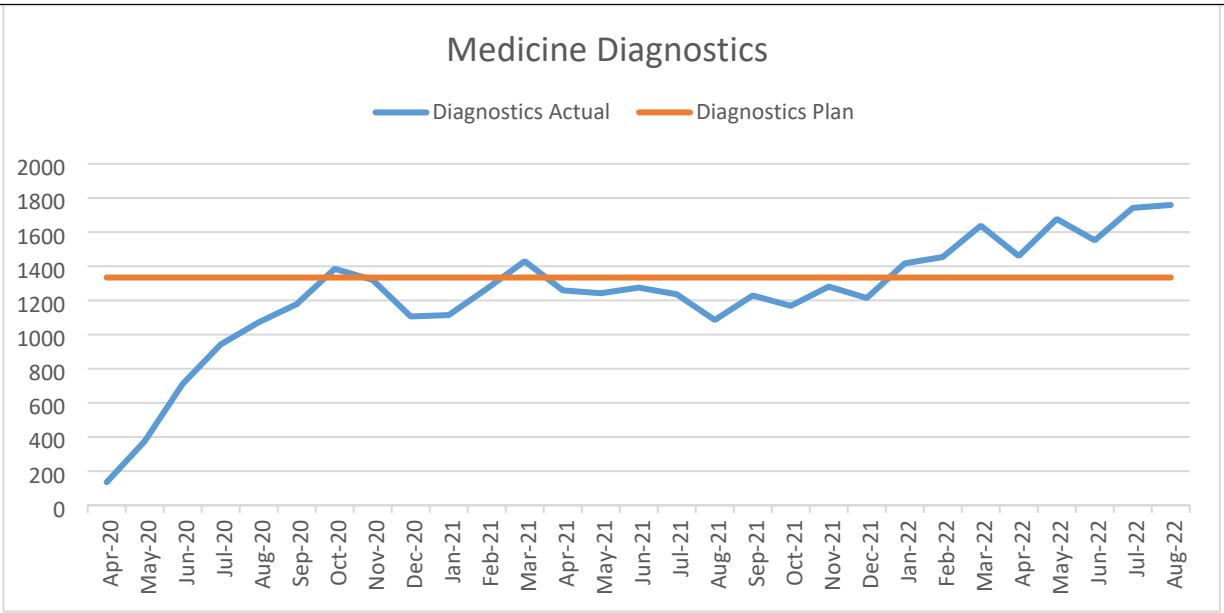
YTD Aug-22	PREVIOUS Assumed monthly activity	Actual activity	Variance
Gastroenterology	2550	1073	-1477
Cardiology	2765	1441	-1324
Respiratory (inc Sleep)	3030	1517	-1513
Neurology	1295	1191	-104
Endocrinology	1210	774	-436
Geriatric Medicine	1155	768	-387
Total	**12005**	**6764**	**-5241**

Demand and capacity plans are currently being revised by the Division and as a result an updated performance position will be provided in following reports.

Medicine Diagnostics (Endoscopy) Activity

Medicine endoscopy activity for August '22 was 1,759 procedures which is 425 cases more than plan.

The activity undertaken since April '20 is shown below;



Covid-19 – Revenue Financial Assessment

Total Covid-19 costs are shown as c.£73.6m and at this stage the Health Board is including matched funding. These are full year forecasts unless otherwise stated:

- Testing - £4.07m. It should be noted that the current forecast is c.£5.6m, the Director of Therapies is in discussions with WG regarding the level of funding and is committed to reducing this forecast as required (forecast reduction of £0.3m compared to previous month). This funding includes Testing Team and Pathology department testing costs.
- Tracing - £6m
- Mass Vaccination - £9m
- PPE - £3.3m
- Cleaning standards - £2.5m
- Long Covid - £0.9m
- Nosocomial investigation - £0.8m, and
- Other additional Covid-19 costs (now including dental income target reduction) - £44.9m.

The Health Board is reporting costs for additional capacity and maintaining Covid-19 safe and compliant operational service delivery across all sites, as part of the other additional Covid-19 costs section.

The cost impact of responding to Covid-19 and emergency system pressures along with increased patient acuity will be closely monitored and the implications for Q2 to Q4 will continue to be reviewed and appropriately reflected in future months reports.

Though a higher cost, the assumptions are in line with those used for the submitted IMTP, correspondence from WG and the IMTP financial assumptions letter sent in March 2022. In addition, forecast costs decreased for discharge support, facilities and enhanced cleaning. This is linked to revised workforce plans for later in the financial year. On-going review of the local schemes will be required to ensure forecasts and classifications remain in line with the assumptions described.

The Health Board is not including costs for Velindre Trust Covid-19 (recovery or outsourcing) within these figures, in line with the All Wales LTA agreement. The table below describes allocations which have been confirmed and received versus those which remain anticipated.

Type	Covid-19 Specific allocations - August 2022	£'000
HCHS	Tracing	2,867
HCHS	Extended flu	1,517
HCHS	Testing (inc Community Testing)	1,548
HCHS	PPE	695
HCHS	Mass COVID-19 Vaccination	1,331
GMS	Mass COVID-19 Vaccination	185
Dental	E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS income	2,308
HCHS	Nosocomial investigation and learning	753
	Total Confirmed Covid-19 Allocations	**11,204**
HCHS	Testing (inc Community Testing)	2,522
HCHS	Tracing	3,133
HCHS	Mass COVID-19 Vaccination	7,484
HCHS	PPE	2,630
HCHS	Cleaning standards	2,491
HCHS	Long Covid	887
HCHS	A2. Increased bed capacity specifically related to C-19	10,749
HCHS	A3. Other capacity & facilities costs	7,061
HCHS	B1. Prescribing charges directly related to COVID symptoms	50
HCHS	C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance	14,609
HCHS	D1. Discharge Support	8,309
HCHS	D4. Support for National Programmes through Shared Service	0
HCHS	D5. Other Services that support the ongoing COVID response	1,911
	Total Anticipated Covid-19 Allocations	**61,836**
	Total Covid-19 Allocations	**73,041**

The Health Board is expected to manage these costs downwards.

Exceptional Cost Pressures

The exceptional cost pressures recognised by Welsh Government for 22/23 includes energy prices, employers NI and the Real living wage costs for social care contracts. It has been agreed that these be managed with WG on a collective basis with funding assumed to cover costs, albeit the funding is not confirmed. The Health Board still has a duty to mitigate these costs within its financial plan to reduce the collective risk.

- Real living wage costs only relate to CHC; the agenda for change element will receive an allocation in line with wage award funding once confirmed.
- It should be noted that increased energy costs are based on forecasts provided by NWSSP adjusted for any local information. The energy prices increase was based using August information adjusted for local intelligence, early September information received will result in a further increase but was unable to be fully validated for month 5 reporting.

Type	Exceptional items allocations - August 2022	£'000
HCHS	Energy prices increase	33,945
HCHS	Employers NI increase	4,606
HCHS	Real living wage	2,154
	Total Exceptional items allocations (anticipated)	**40,705**

The Health Board is expected to manage these costs downwards.

Budget Setting / Delegation

In line with Health Board SFI's, budget delegation letters have been sent to Executive Directors, setting out the expectations to manage within the delegated budget levels.

Executive Directors are expected to issue delegation letters to Deputies and Divisional Directors, stating the level of budget and the expectations associated with managing that budget. **This should be cascaded to all budget holders.** A review is underway to determine how far the delegation letters have been delegated and what actions are in place for overspending areas.

A budget delegation paper for quarter 2 budgets including adjustments for Covid-19 and exceptional items was approved at July's Board. Funding was delegated to Divisions in month 4 with an on-going quarterly review thereafter.

- **Revenue Reserves**

Health Board reserves are held by the Board, until such time as they agree their use or delegate this responsibility to the Chief Executive as Accountable Officer. Agreed funding delegations per the Board Budget Setting paper have been actioned, however, some funding allocations are held in reserves, where their use is directed by Welsh Government or funding is allocated for a specific purpose.

The following reserves, relating to WG Funding, were approved for delegation by the CEO in Month 5.

£483k Outpatient Transformation funding – delegate to Director of Operations	£25k Outpatient Transformation funding – delegate to Director of Operations for specific post
£297k Value Based Healthcare – delegate funding to Medicine	£34k Value Based Healthcare – High risk surgical wound management delegation to Family & Therapies
£15k Cervical Screening income: Amend PHW income budget to reflect activity delegation to Scheduled Care and Family & Therapies	£72k SAS Advocacy implementation – delegation to Medical Director
£1.067m – Vertex funding - delegation to WHSSC	£60k Climate emergency National Prog Round 1 for Decarbonisation bids – delegation to Director of Planning
£144k – English contracts additional 1.3% inflation – delegate funding to contracting	£197k WHSSC English contracts additional 1.3% inflation – delegate to WHSSC
£904k (from 23/24 onwards) – PACU confirmed allocation	£1.4m Urgent Primary Care (23/24 recurrent element) – delegate to Primary Care
£119k Digital Priorities Investment Fund – Medicines Transformation – delegate to Director of Planning	(£228k) Recover VBH Heart Failure funding into reserves. Replaced by National Value bid funding.
(£17k) TEC Cymru funding recover funding into reserves to reflect recent WG confirmation	

There is no contingency reserve held by the Board in 22/23.

Long Term Agreements (LTA's)

LTA agreements have been signed with all Welsh providers/commissioners in accordance with the DOF LTA Financial Framework for 2022-23. Initial performance data shows significant variation from baselines levels (both under and over performance) depending on the provider / commissioner.

The £605k year to date variance reflects the NICE drugs growth in Velindre and pressure arising from the reduction in Powys income offset by underperformance on other Welsh and English agreements.

Further work is ongoing to understand the performance variation by provider/commissioner and to understand the financial risk that may crystallise in future. Velindre forecasting remains a particular risk due to the implementation of the new commissioning currencies in 2022-23 and the volatility in NICE forecasting based on limited data received to date. ABUHB is establishing a clinically led drugs review process with Velindre NHS Trust.

Underlying Financial Position (ULP)

The Underlying (U/L) forecast position is a brought forward value of £21m.

Financial sustainability is an on-going priority and focus for the Health Board.

The IMTP forecasts an improved closing 2022/23 underlying deficit of £8.1m. This is now at significant risk given the challenges of 22/23.

This is based on the IMTP assessment of available recurrent funding, savings and the recurrent financial impact of existing service and workforce commitments. It continues to exclude any potential recurrent impact of Covid-19 decisions or 2022/23 operational pressures outside of the IMTP.

The Health Board's 2022-25 IMTP identifies several key priorities where the application of Value-Based Health Care principles – improving patient outcomes along with better use of resources – should result in delivering greater service, workforce and financial sustainability whilst improving the health of the population. The actions being taken through transformation programmes to improve financial sustainability are integral to this approach.

The Board approved approach to the refreshed 22/23 IMTP financial plan is to focus on making previous investment decisions sustainable before new investments are committed to. The WG allocation funding 22/23 provided the Health Board with the opportunity to help address its historic underlying financial position and prioritise current challenges and commitments as part of the 2022/23 IMTP.

Health Board savings schemes for 2022/23 need to be implemented in full and on a recurrent basis both to manage future cost pressures and reduce the underlying deficit. This position is assumed at present but will require constant management and implementation of new schemes to mitigate new cost pressures and manage risks as they arise. The underlying position will be reviewed as part of the mid-year review.

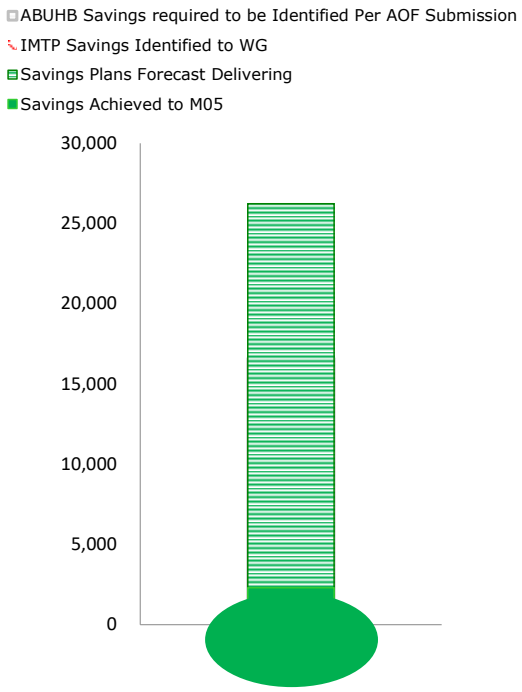
Savings delivery

As part of the IMTP submitted by the Board to Welsh Government (March 2022), the financial plan for 2022/23 identifies a core savings requirement of £26.2m and cost mitigation of £19m. As at Month 5 forecast savings achievement in 22/23 is £26.2m however this includes an extreme level of on-going risk to ensure full delivery of savings and cost avoidance from opportunities identified.

The ABUHB preferred approach to financial balance is to improve efficiency and sustainability through the agreed IMTP priority programmes. Current operational and service pressures are continuing to drive additional expenditure above IMTP planned levels and are affecting the level of savings achievement required.

Actual savings delivered to August amounted to £2.31m, now compared with month 5 planned delivery of £5.7m. The profile of savings has been amended to reflect current service challenges with delivery profile expected to be achieved significantly increased in later months.

Savings Progress: as at Year To Date Month 05



Month 5 Forecast Savings Plans

	Forecast	Non Recurrent	Recurrent	Full year effect of Recurring savings
Medicines Management (Primary and Secondary Care)	3,162	0	3,162	3,332
Pay	9,821	329	9,492	9,795
Non Pay	13,255	8,187	5,068	4,976
Total	**26,238**	**8,516**	**17,722**	**18,102**

Further scheme detail is provided in the appendices

Forecast savings by Division and RAG rating are shown below:-

Category	IMTP & Green/Amber (as at Month 3)	Forecast Savings Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Complex Care	IMTP													0
	Green													0
	Amber	-	-	-	-	-	-	-	-	-	83	83	84	250
Medicine	IMTP	42	42	42	251	251	251	251	251	251	251	251	251	2,388
	Green	8	12	18	15	13	12	12	12	14	14	14	14	158
	Amber	-	-	-	-	-	-	-	-	-	276	276	281	833
Urgent Care	IMTP	-	-	-	102	102	102	102	102	102	102	102	102	915
	Green	6	8	10	24	24	24	24	24	24	24	8	5	202
	Amber	-	-	-	-	-	-	129	129	129	129	129	129	774
Scheduled Care	IMTP	48	175	175	1,305	1,305	1,305	1,305	1,305	1,305	1,305	1,305	1,305	12,144
	Green	166	192	122	131	131	131	132	132	132	132	132	132	1,662
	Amber	-	-	- 0	-	-	-	543	543	543	3,158	3,158	3,143	11,088
Primary Care and Community	IMTP	54	54	54	54	54	54	54	54	54	54	54	54	646
	Green	219	150	192	202	233	242	247	255	257	256	266	274	2,795
	Amber													0
Mental Health and Learning Disabilities	IMTP	32	32	32	32	32	32	32	32	32	32	32	32	378
	Green	-	-				54	54	54	54	54	54	54	378
	Amber													0
Family & Therapies	IMTP	25	25	25	125	125	125	125	125	125	125	125	125	1,202
	Green	25	25	25	53	25	25	25	25	25	44	44	43	383
	Amber	-	-	-	-	-	-	-	-	-	217	217	218	652
Estates and Facilities	IMTP	29	29	29	84	84	84	101	101	101	101	101	101	947
	Green	29	29	29	55	55	55	55	55	55	55	55	55	579
	Amber	-	-	-	-	-	-	17	17	17	106	106	107	368
Corporate	IMTP	18	18	18	245	245	245	888	888	888	888	888	888	6,118
	Green	18	18	18	18	18	18	18	18	18	18	18	18	214
	Amber	-	-	-	-	-	-	-	-	1,426	1,493	1,493	1,491	5,903
Commissioning	IMTP				167	167	167	167	167	167	167	167	167	1,500
	Green													0
	Amber													0
Total	IMTP	247	374	374	2,365	2,365	2,365	3,025	3,025	3,025	3,025	3,025	3,025	26,238
	Green	471	434	414	497	498	560	566	573	578	595	590	594	6,370
	Amber	-	-	- 0	-	-	-	689	689	2,115	5,462	5,462	5,453	19,868

Green schemes are assumed to be fully deliverable. Amber schemes require either progression or equivalent alternative plans as soon as possible to mitigate this risk. The schemes remain amber, despite the WG requirement to classify schemes as green (deliverable) or red (not achievable) by the end of quarter 1 (M3).

Savings by WG monitoring return (MMR) and general category are shown as per the table below:-

		Forecast		
Category	Category	Green	Amber	Total
Medicines Management	Prescribing	2,148		2,148
	Scheduled Care rationalisation	70		70
	Scheduled Care Lenaliomide	944		944
Pay	Variable pay - sickness / overseas & medical agency	2,716	-	2,716
	CHC - agency mitigation	-	250	250
	MSK	83	-	83
	All others	177	6,595	6,772
Non-pay	Corporate / CHC review		3,657	3,657
	NR opps		2,047	2,047
	Facilities related	232	368	600
	Theatres		4,368	4,368
	Other non-pay / schemes		2,583	2,583
				0
Total		6,370	19,868	26,238

Savings classified as amber were required to be re-classified as green or red at month 3 reporting, the impact of not finalising plans to achieve these savings will put financial balance at risk. To achieve a balanced core financial plan, the Health Board needs to ensure that savings plans are achieved in line with IMTP. In addition, further cost avoidance plans are required to ensure that any other financial pressures are mitigated. The IMTP narrative notes potential risks that require mitigation either through additional savings plans or other solutions. These risks are emerging and are causing challenges to forecast financial balance.

Savings schemes straddle transformational, transactional, and operational plans. Aligned to progressing the savings and mitigating actions a value focussed pathway approach is being employed. The Health Board has agreed ten priority areas for focussed support using a programme management approach with MDT support through an Executive lead, value, performance, workforce, service, planning and finance representation. These now need to be accelerated.

In addition, further programmes have been added given the difficulty in obtaining 'traction' to progress these opportunities. Variable Pay, CHC, Procurement/Non-pay and Medicines Management programmes will need to drive savings delivery during 2022/23.

An organisational re-assessment of priorities and forecast service demand will be undertaken and considered by the Executive Team and the Board before finalising the re-profiled plan which will include these savings plans.

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 other sources where appropriate.

The Health Board will continue to pursue all available operational and transactional savings however this alone will no longer achieve the savings target.

To deliver greater levels of savings and to achieve better use of resources, which improves health outcomes – and doesn't adversely impact on safety and quality – a greater focus is required on savings and efficiency improvement related to:

- Eliminating unwarranted clinical variation
- Transformational service change
- Reducing waste

It is important to note that a number of Divisions are pursuing savings plans internally to mitigate local cost and underlying pressures.

The Executive have implemented an internal financial recovery 'turnaround' approach to accelerate financial cost reduction for 2022/23, this is a standing item at Executive Team meetings and reports will be provided through the FPC and to the Board.

Emerging programmes include:-

- System level working – reviewing DTOCs, updating bed capacity forecasts & additional capacity requirements
- Urgent care and elective care re-design,
- Demand and flow management, - reviewing the social care community actions,
- Workforce efficiency, reducing variable pay in particular HCSW agency and medical temporary pay costs,
- Review of Medicines management,
- Review of CHC pathways within Mental Health and Complex Care,

- Review of current savings plans, current investments made and service options across Divisions,
- Corporate opportunities and Executive Director options, and
- Other actions to improve the financial position e.g. review of income/allocations

Forecast

The Health Board is required to submit a forecast position to the WG on the fifth working day of each month, for month 5 the forecast was pending subject to Executive and Board confirmation. The reported WG MMR forecast is reported as break-even but **with extremely significant risk.**

Given the extremely significant risk to forecast break-even the CEO has commenced focussed sessions of the Executive team to review income opportunities and cost reduction opportunities and likely delivery levels for 22/23. This will provide the basis for consideration with the Board of an updated service, workforce and financial plan and forecast for 2022/23. Further mitigating actions are being developed by the Executive for Board consideration.

The Board meeting on the 28th July discussed, reviewed and noted the current financial forecast alongside the significant level of risk the HB needs to manage and mitigate to achieve break-even. Opportunities were shared for consideration and action.

The Chief Executive requested that all budget-holders identify further cost reduction and savings opportunities during August as part of this focus on financial recovery.

Welsh Government and Finance Delivery Unit met with ABUHB to undertake a deep dive in early August and have asked for further analysis and a further meeting following month 5 reporting.

Without changes being agreed and actioned, at pace, the Health Board will not be able to sustain and justify continuing to report a break-even position.

2022/23 IMTP revenue plan profile

The in month variance profile as submitted as part of the IMTP (@ M1) for 2022/23 is presented below:

£m Deficit (Surplus)	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total Year End Position
Forecast Monthly Position	1.67	1.27	1.01	- 0.39	- 0.39	- 0.39	- 0.45	- 0.45	- 0.45	- 0.45	- 0.45	- 0.52	0.00

This profile has now been updated for month five to reflect slippage in savings and cost reduction delivery profiles, however, this assumes the savings are still achievable, and is now shown as follows in the table below:-

£m Deficit (Surplus)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Forecast year-end position
Revised forecast position	1.67	3.21	3.48	5.97	3.10	2.69	0.20	0.01	(1.23)	(5.36)	(5.66)	(8.07)	0

Risks & Opportunities (2022/23)

There are serious, immediate and significant risks to managing the 2022/23 financial position, which include:

- Ensuring full delivery of the savings plans identified in the IMTP
- Identifying savings to mitigate any further financial risks identified outside of the IMTP,
- Quarter 2-4 additional Covid cost pressures (c.£8m),

- Workforce absence / self-isolation / vacancies, availability of staff for priority areas,
- Responding to any specific Covid-19 impacts e.g., new variants, outbreaks,
- Continued or increased delayed discharges of care / medically fit patients in hospital beds including delays in social services and packages of care, (c.£16m of which £8m relates to social care reasons),
- Unconfirmed levels of funding for exceptional cost pressures and the local covid responses, that the Health Board is currently assuming (c.£105m),
- Testing expenditure forecast above anticipated funding level (c.£1.5m),
- Additional operational pressures including increased managed practice, prescribing and nurse vacancy cover,
- Funding for any wage award or change in terms and conditions,
- Responding to the ongoing impact of Covid-19 and associated preventative and Public Health services,
- Addressing backlogs in waiting times for services, due to the Covid-19 pandemic,
- Specific economic factors/Ukraine conflict issues such as energy costs, supply chain issues, Monkey pox, and non-pay inflation including travel expense costs,
- Maximising the opportunity to change services resulting in improved health outcomes for the population,
- IFRS16 - implementation of IFRS16 (lease accounting) in NHS Wales will go live in April 2022. The Board assumes that any revenue or capital resource implications of implementation will be managed by Welsh Government, with no financial impact to Health Boards or Trusts across Wales,
- Additional costs of new trainee doctor and dentist contract,
- Additional Welsh Risk Pool and/or Litigation costs,
- Additional Bank Holiday costs,
- Cash availability, and
- Any potential industrial action in 2022/23.

The table below presents the risks reported to Welsh Government for month 5:

Risk narrative	Likelihood	£'000
Under delivery of Amber Schemes included in Outturn via Tracker	High	19,869
Operational pressures requiring mitigation actions	High	19,000
Additional Covid costs q2 -q4 not assumed in covid response	High	8,000
Funding for exceptional cost pressures	High	40,705
Funding for local Covid response	High	45,180
Funding for National Covid response	Low	16,656
Testing forecast above anticipated funding level	High	1,560
Total		**150,970**

Managing the financial risk is dependent on developing service and workforce plans that are sustainable during 2022/23 and in the future. These operational assumptions will be reviewed to inform revised forecasts for 2022/23.

Capital

The approved Capital Resource Limit (CRL) as at Month 5 totals £48.662m. In addition, grants totalling £32k have been received in month to fund works and R&D equipment requirements. The current forecast outturn is breakeven.

The GUH works to the Same Day Emergency Care Unit, Resus, and CAEU have all completed during August. All Laing O'Rourke works are now complete, and the final account is being agreed. Tenders for the Well-being works to Grange House have been received. The works are slightly delayed due to bat requirements (estimated completion April 2023). The additional works costs are being offset by the final VAT recovery claim (£3.5m) due in the last quarter of 2022/23 which is the reason for the credit budget allocation of (£394k). The Health Board's VAT advisors are currently working with HMRC and the external cost advisors to expedite the VAT recovery claim and mitigate the risk that an agreement is not reached in the current financial year.

A Chairs Action totalling £778k has been approved for the YYF Breast Centralisation Unit. This allows the renegotiated contract to be signed and works to recommence on site during October. Whilst the £778k in currently being underwritten by the Health Board (2023/24 DCP impact), an application for further AWCP funding has been submitted to Welsh Government for approval.

The works at Tredegar H&WBC are continuing. The handover of the building is now expected to be delayed to May 2023 due to the supplier cancellation of the brick order for the façade. There continues to be significant cost risks to the scheme including the re-design of the foundations (potential additional £750k), EV charging points (not a requirement at Design Stage), culvert diversion, Heart building stabilisation, brick supply cancellation and inflation. Any potential overspend is expected to impact in 2023/24.

The Newport East Health and Well-being Centre works have commenced. The old Multi Use Games Area has been removed and the replacement is being prepared. Groundworks are underway for the car park and surrounding area. The RGH Endoscopy scheme works commenced on site on 15th August 2022.

The FBC for the NHH Satellite Radiotherapy Centre has concluded and has been submitted to WG for approval. The Outline Business Case for the Mental Health SISU is on-going and expected to be submitted to Board for approval in November 2022.

The National Imaging Programme funding has been reduced by £491k to £4.195m because of savings generated on equipment purchases and works costs. The spend in the current year includes the replacement of two CT Scanners (NHH / RGH), the installation of three general rooms and the recently approved replacement of seven ultrasound machines.

The Health Board Discretionary Capital Programme (DCP) forecast outturn for 2022/23 is £6.589m funded by:

- 2022/23 DCP Funding - £8.227m (a reduction of 24% compared to 2021/22)
- RGH Endoscopy fees reimbursement - £207k
- Grant funding received (Sparkle and R&D) - £32k
- Less All Wales Capital Programme scheme brokerage & overspends – (£1.877m)

The unallocated contingency budget as at the end of August is £531k.

Correspondence has been received from Welsh Government to confirm an additional £10m across Wales to increase DCP allocations for 2023/24. The estimated ABUHB DCP funding for 2023/24 will be £9.521m (compared to £10.814m 21/22, £8.227m 22/23).

Cash

The cash balance at the 31st August is £4.097m, which is below the advisory figure set by Welsh Government of £6m.

Public Sector Payment Policy (PSPP)

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods in August and there has been an improvement in the cumulative target from the previous month. We are continuing to work with those departments where invoices are being processed outside of the 30 day payment terms.

Recommendation

The Committee is asked to note:

- The financial performance at the end of August 2022 and forecast position – against the statutory revenue and capital resource limits,
- The savings position for 2022/23,
- The 2022/23 forecast,
- The significant level of risk to the financial position,
- The revenue reserve position on the 31st of August 2022,
- The Health Board's underlying financial position,
- The Capital position, and
- The Month 5 WG Monthly Monitoring Return (MMR)

Appendices

ABUHB%20Finance%20board%20report

ABUHB MMR Commentary m5.pdf

ABUHB%20MMR%20Tables%20M5%202

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 IMTP priorities and opportunities to improve efficiency and effectiveness.
Equality and Diversity Impact Assessment (including child impact assessment)	The Assessment forms part of the IMTP 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 IMTP, which includes an assessment of how the plan complies with the Act.
Glossary of New Terms	See Below
Public Interest	Circulated to FPC 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	CEAU – Children's Emergency Assessment Unit	
D		
DHR – Digital Health Record	DNA – Did Not Attend	DOSA – Day of Surgery Admission
D2A – Discharge to Assess	DoLS - Deprivation of Liberty Safeguards	DoF – Director(s) of Finance
E		
EASC – Emergency Ambulance Services Committee	EDCIMS – Emergency Department Clinical Information Management System	eLGH – Enhanced Local general Hospital
ENT – Ear, Nose and Throat specialty	EoY – End of Year	ETTF – Enabling Through Technology Fund
F		
F&T – Family & Therapies (Division)	FBC – Full Business Case	FNC – Funded Nursing Care
G		

GMS – General Medical Services	GP – General Practitioner	GWICES – Gwent Wide Integrated Community Equipment Service
GUH – Grange University Hospital	GIRFT – Getting it Right First Time	
H		
HCHS – Health Care & Hospital Services	HCSW – Health Care Support Worker	HIV – Human Immunodeficiency Virus
HSDU – Hospital Sterilisation and Disinfection Unit	H&WBC – Health and Well-Being Centre	
I	IMTP – Integrated Medium Term Plan	INNU – Interventions not normally undertaken
IPTR – Individual Patient Treatment Referral	I&E – Income & Expenditure	ICF – Integrated Care Fund
L		
LoS – Length of Stay	LTA – Long Term Agreement	LD – Learning Disabilities
M		
MH **–** Mental Health	MSK - Musculoskeletal	Med – Medicine (Division)
MCA – Mental Capacity Act	MDT – Multi-disciplinary Team	
N		
NCN – Neighbourhood Care Network	NCSO – No Cheaper Stock Obtainable	NICE – National Institute for Clinical Excellence
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
ODTC – Optometric Diagnostic and Treatment Centre	OD – Organisation Development	
P		
PAR – Prescribing Audit Report	PCN – Primary Care Networks (Primary Care Division)	PER – Prescribing Incentive Scheme
PICU – Psychiatric Intensive Care Unit	PrEP – Pre-exposure prophylaxis	PSNC –Pharmaceutical Services Negotiating Committee
PSPP – Public Sector Payment Policy	PCR – Patient Charges Revenue	PPE – Personal Protective Equipment
PFI – Private Finance Initiative		
R		

RGH – Royal Gwent Hospital	RN – Registered Nursing	RRL – Revenue Resource Limit
RTT – Referral to Treatment	RPB – Regional Partnership Board	RIF – Regional Integration Fund
S		
SCCC – Specialist Critical Care Centre	SCH – Scheduled Care Division	SCP – Service Change Plan (reference IMTP)
SLF – Straight Line Forecast	SpR – Specialist Registrar	
T		
TCS – Transforming Cancer Services (Velindre programme)	T&O – Trauma & Orthopaedics	TAG – Technical Accounting Group
U		
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	VERS – Voluntary Early Release Scheme	
W		
WET AMD – Wet age-related macular degeneration	WG – Welsh Government	WHC – Welsh Health Circular
WHSSC – Welsh Health Specialised Services Committee	WLI – Waiting List Initiative	WLIMS – Welsh Laboratory Information Management System
WRP – Welsh Risk Pool		
Y		
YAB – Ysbyty Aneurin Bevan	YTD – Year to date	YYF – Ysbyty Ystrad Fawr

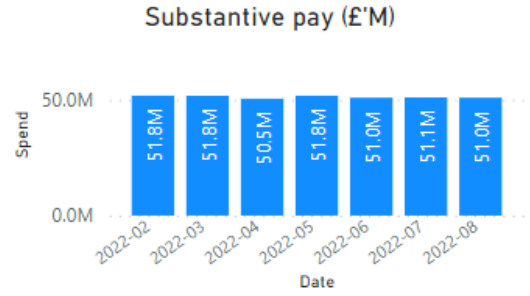
Aneurin Bevan University Health Board

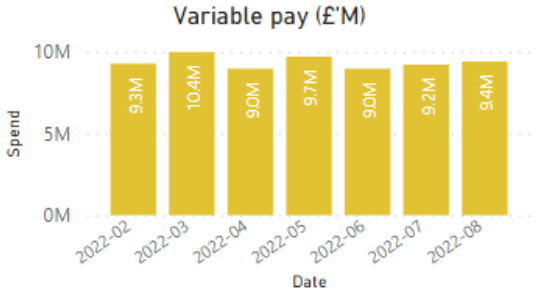
Finance Report – August (Month 5) 2022/23

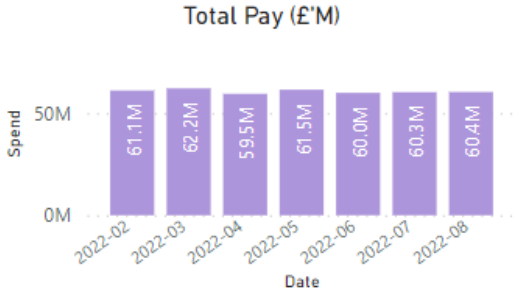
Appendices

Section	Page Number(s)
Pay Summary 1	2
Pay Summary 2 Substantive Pay	3
Pay Summary 3 Variable Pay	4
Non Pay Summary	5
RTT & Waiting List Initiatives	6-8
Covid-19 Funding Assumptions & Delegation	9
Savings	10 - 11
Reserves	12
Cash / Public Sector Payment Policy	13
External Contracts – LTA's	14
External Contracts – Specialised Services	15
Balance Sheet	16
Health Board Income	17
Capital Planning & Performance	18-19

Pay Summary (1) (subject to change excluding annual leave and Pension employer costs):







Substantive (£'000)

Pay category	22-P11	22-P12	23-P01	23-P02	23-P03	23-P04	23-P05	Change	%	Avg 21/22
ADD PROF SCIENTIFIC AND TECHNICAL	2,497	2,267	1,916	1,939	1,909	1,896	1,889	-7	-0.4%	2,219
ADDITIONAL CLINICAL SERVICES	6,595	6,486	6,352	6,693	6,504	6,561	6,519	-43	-0.6%	6,550
ADMINISTRATIVE & CLERICAL	8,747	8,597	8,593	8,655	8,710	8,562	8,792	229	2.7%	8,262
ALLIED HEALTH PROFESSIONALS	3,350	3,311	3,558	3,630	3,542	3,550	3,538	-13	-0.4%	3,249
ESTATES AND ANCILLIARY	2,631	2,758	2,529	2,704	2,520	2,594	2,578	-16	-0.6%	2,611
HEALTHCARE SCIENTISTS	961	1,011	977	1,000	996	989	975	-14	-1.5%	996
MEDICAL AND DENTAL	11,879	12,910	12,059	12,146	12,087	12,287	12,175	-112	-0.9%	11,744
NURSING AND MIDWIFERY REGISTERED	15,143	14,426	14,523	15,008	14,695	14,614	14,492	-122	-0.8%	15,021
STUDENTS	3	6	6	6	9	9	10	1	13.4%	3
Total	**51,805**	**51,771**	**50,512**	**51,781**	**50,972**	**51,064**	**50,967**	**-97**	**-0.2%**	**50,655**

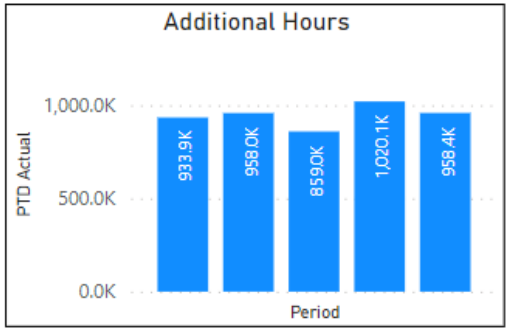
Variable pay (£'000)

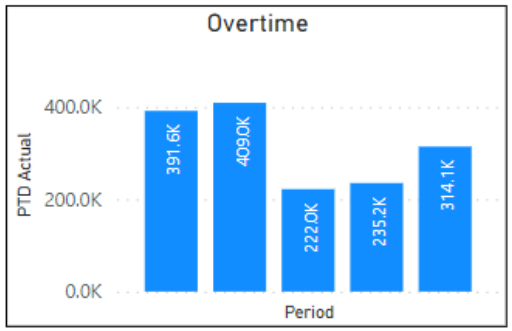
Pay category	22-P11	22-P12	23-P01	23-P02	23-P03	23-P04	23-P05	Change	%	Avg 21/22
Agency	5,395	5,958	5,301	5,968	5,384	5,538	5,430	-108	-1.9%	4,774
Bank	3,667	4,203	3,458	3,512	3,304	3,460	3,757	298	8.6%	2,812
Locum	227	229	226	238	294	228	232	5	2.0%	152
Total	**9,289**	**10,389**	**8,986**	**9,718**	**8,982**	**9,226**	**9,420**	**194**	**2.1%**	**7,738**

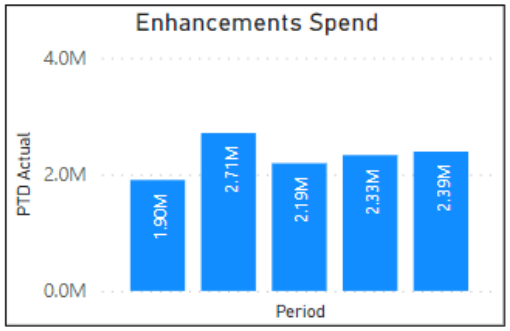
Total pay (£'000)

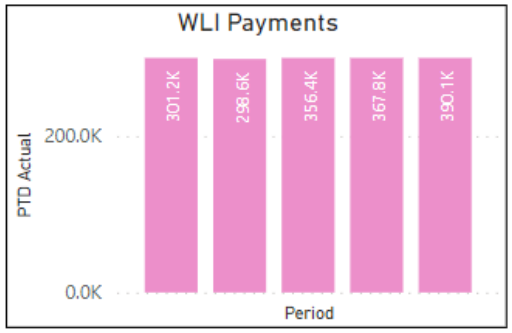
Pay category	22-P11	22-P12	23-P01	23-P02	23-P03	23-P04	23-P05	Change	%	Avg 21/22
Pay	**61,093**	**62,160**	**59,498**	**61,499**	**59,955**	**60,289**	**60,387**	**98**	**0.2%**	**58,392**

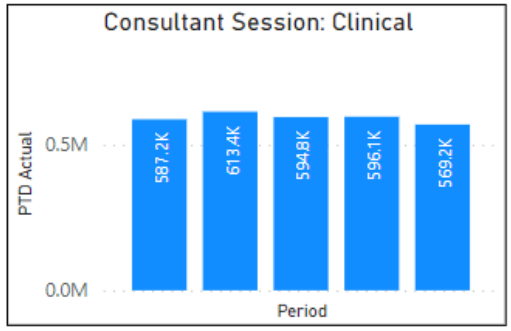
Pay Summary (2): Substantive Pay

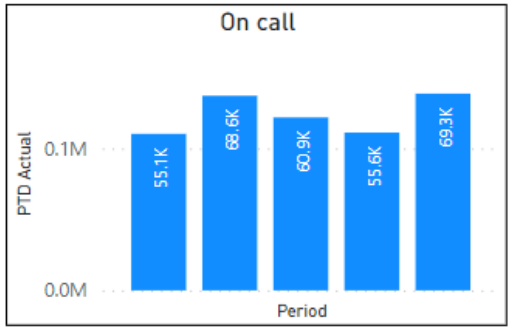










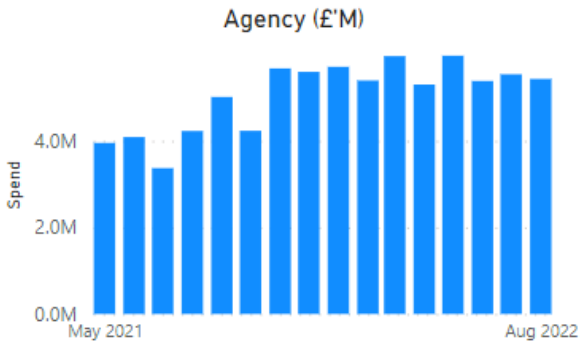


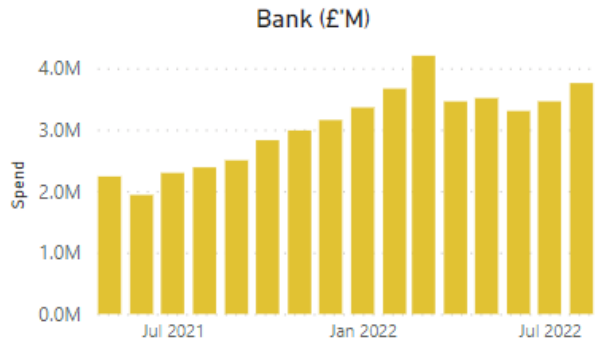
Analysis type by Division

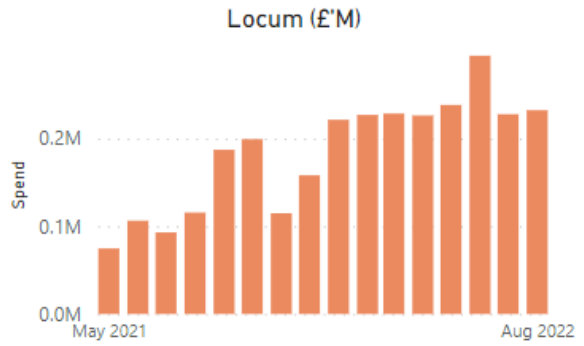
Analysis type	23-P01	23-P02	23-P03	23-P04	23-P05	Total
Enhancements						
Scheduled Care	373	525	425	449	482	**2,253**
Medicine	294	415	339	349	362	**1,759**
Estates and Facilities	284	396	303	331	334	**1,647**
Primary Care & Community	244	360	302	335	306	**1,547**
Family & Therapies	247	338	278	291	305	**1,458**
Mental Health	156	242	195	205	210	**1,008**
Urgent Care	152	213	171	189	201	**926**
CHC/FNC	82	117	94	99	109	**500**
Corporate	72	103	82	83	82	**423**
Total	**1,903**	**2,709**	**2,189**	**2,329**	**2,390**	**11,521**
ADDITIONAL HOURS						
Scheduled Care	306	351	422	357	419	**1,854**
Medicine	294	273	180	307	210	**1,263**
Urgent Care	216	256	195	218	221	**1,107**
Family & Therapies	121	51	38	117	63	**390**
Primary Care & Community	3	15	14	7	10	**50**
Mental Health	8	11	7	5	17	**47**
Corporate	-14	2	3	9	18	**19**
Total	**934**	**958**	**859**	**1,020**	**958**	**4,729**
CONSULTANTS SESSION: CLINICAL	**587**	**613**	**595**	**596**	**569**	**2,961**
WAITING LIST PAYMENTS: CONSULTANTS	**301**	**299**	**356**	**368**	**390**	**1,714**
Overtime	**392**	**409**	**222**	**235**	**314**	**1,572**
ON CALL	**55**	**69**	**61**	**56**	**69**	**309**
Total	**4,172**	**5,056**	**4,283**	**4,604**	**4,691**	**22,806**

Pay Summary (3): Variable Pay

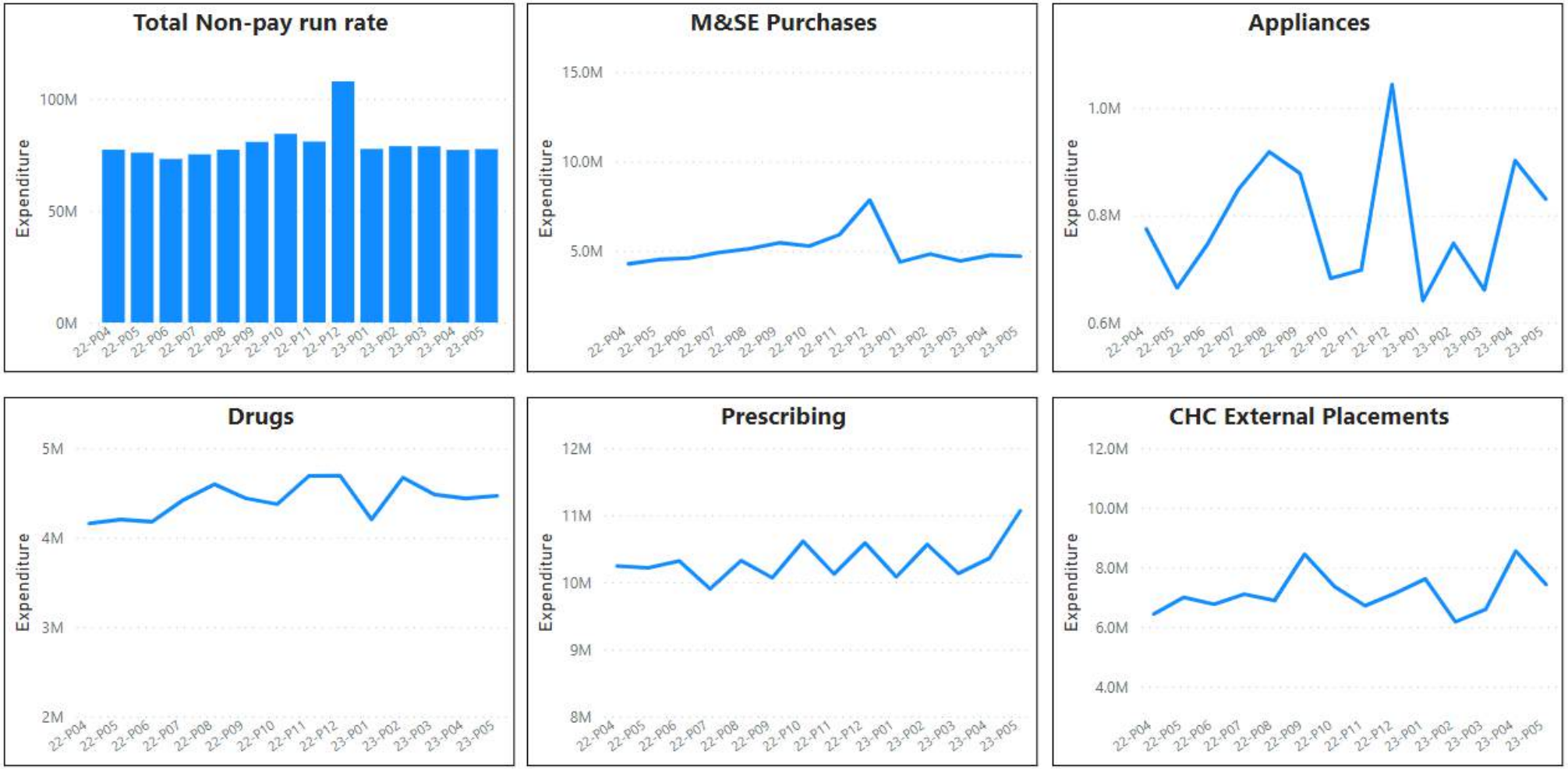
Pay category	22-P02	22-P03	22-P04	22-P05	22-P06	22-P07	22-P08	22-P09	22-P10	22-P11	22-P12	23-P01	23-P02	23-P03	23-P04	23-P05	Change	%
Agency																		
Admin & Clerical Agency	227	222	128	208	82	182	115	191	243	237	412	148	179	164	204	126	-77	-37.9%
Allied Health Prof Agency	3	-31	76	91	124	88	104	172	144	155	213	108	136	169	155	97	-58	-37.4%
Estates & Ancilliary Agency	726	643	483	465	717	422	428	807	474	44	544	413	622	677	663	669	6	0.9%
Medical Agency	1,043	1,027	531	1,272	1,238	1,318	1,920	1,704	1,278	1,688	1,693	1,448	1,602	927	1,439	1,265	-174	-12.1%
Nurse HCA/HCSW Agency	261	358	611	590	756	729	880	67	917	951	1,020	1,101	1,086	1,185	1,122	1,080	-42	-3.7%
Other Agency	114	110	71	59	92	103	128	114	180	170	390	-1	61	87	88	146	57	65.0%
Registered Nurse Agency	1,579	1,759	1,469	1,544	2,006	1,390	2,100	2,540	2,475	2,148	1,687	2,084	2,282	2,175	1,867	2,048	180	9.7%
Total	**3,953**	**4,088**	**3,369**	**4,228**	**5,015**	**4,232**	**5,674**	**5,594**	**5,711**	**5,395**	**5,958**	**5,301**	**5,968**	**5,384**	**5,538**	**5,430**	**-108**	**-1.9%**
Bank																		
Admin & Clerical Bank	97	132	129	120	111	134	111	108	131	102	117	104	111	102	101	105	4	4.3%
Estates & Ancilliary Bank	80	89	119	142	145	154	146	148	153	142	173	159	168	172	181	192	10	5.7%
Nurse HCA/HCSW Bank	1,013	812	1,005	1,079	1,102	1,185	1,114	1,193	1,217	1,397	1,427	1,276	1,313	1,140	1,243	1,408	165	13.3%
Other Bank	1	0	-2	2	-1	0	0	0	0	0	0	0	0	0	0	0	0	-1468.6%
Registered Nurse Bank	1,046	903	1,044	1,043	1,144	1,355	1,616	1,706	1,858	2,026	2,486	1,919	1,920	1,889	1,934	2,052	117	6.1%
Total	**2,238**	**1,936**	**2,295**	**2,386**	**2,500**	**2,828**	**2,987**	**3,155**	**3,359**	**3,667**	**4,203**	**3,458**	**3,512**	**3,304**	**3,460**	**3,757**	**298**	**8.6%**
Locum																		
Medical Locum	75	106	93	116	187	199	115	158	221	227	229	226	238	294	228	232	5	2.0%
Total	**75**	**106**	**93**	**116**	**187**	**199**	**115**	**158**	**221**	**227**	**229**	**226**	**238**	**294**	**228**	**232**	**5**	**2.0%**
Total	**6,265**	**6,130**	**5,757**	**6,729**	**7,702**	**7,259**	**8,775**	**8,907**	**9,292**	**9,289**	**10,389**	**8,986**	**9,718**	**8,982**	**9,226**	**9,420**	**194**	**2.1%**







Non-Pay Summary:



Referral to Treatment (RTT):

Elective activity has significantly reduced as part of the Health Board's Covid-19 planned response. Whilst routine elective services have resumed, elective activity is still lower than pre-Covid-19 levels.

- Elective Treatments for August '22 was 1,986.

Planned Treatments					
Treatment	Core	Backfill	WLI	Other	Total
Derm	163	0	25	56	244
ENT	138	0	38	0	176
GS	259	82	4	0	345
Max Fax	166	6	12	0	184
Ophth	211	24	6	0	241
Rheum	0	0	0	0	0
T&O	325	73	72	0	470
Urology	473	18	0	0	491
	1,735	203	157	56	2,151

Actual Treatments					
Treatment	Core	Backfill	WLI	Other	Total
Derm	182	19	0	0	201
ENT	69	4	0	0	73
GS	253	112	0	0	365
Max Fax	223	0	0	0	223
Ophth	271	10	6	0	287
Rheum	0	0	0	0	0
T&O	370	86	47	0	503
Urology	305	25	4	0	334
	1,673	256	57	0	1,986

Treatment Variance					
Treatment	Core	Backfill	WLI	Other	Total
Derm	19	19	(25)	(56)	(43)
ENT	(69)	4	(38)	0	(103)
GS	(6)	30	(4)	0	20
Max Fax	57	(6)	(12)	0	39
Ophth	60	(14)	0	0	46
Rheum	0	0	0	0	0
T&O	45	13	(25)	0	33
Urology	(168)	7	4	0	(157)
	(62)	53	(100)	(56)	(165)

- Outpatient activity for August '22 was 7,259.

Planned Outpatients					
Outpatient	Core	Backfill	WLI	Other	Total
Derm	1,411	0	36	0	1,447
ENT	471	0	80	0	551
GS	1,092	3	10	0	1,105
Max Fax	271	0	10	0	281
Ophth	703	0	100	0	803
Rheum	159	0	0	0	159
T&O	709	0	100	0	809
Urology	452	0	30	0	482
	5,268	3	366	0	5,637

Actual Outpatients					
Outpatient	Core	Backfill	WLI	Other	Total
Derm	1,862	0	0	0	1,862
ENT	363	0	0	0	363
GS	1,825	64	61	0	1,950
Max Fax	251	0	0	0	251
Ophth	964	92	44	0	1,100
Rheum	330	0	0	0	330
T&O	722	0	286	0	1,008
Urology	384	0	11	0	395
	6,701	156	402	0	7,259

Outpatient Variance					
Outpatient	Core	Backfill	WLI	Other	Total
Derm	451	0	(36)	0	415
ENT	(108)	0	(80)	0	(188)
GS	733	61	51	0	845
Max Fax	(20)	0	(10)	0	(30)
Ophth	261	92	(56)	0	297
Rheum	171	0	0	0	171
T&O	13	0	186	0	199
Urology	(68)	0	(19)	0	(87)
	1,433	153	36	0	1,622

- Medicine Outpatients activity for August '22 was 1,311:

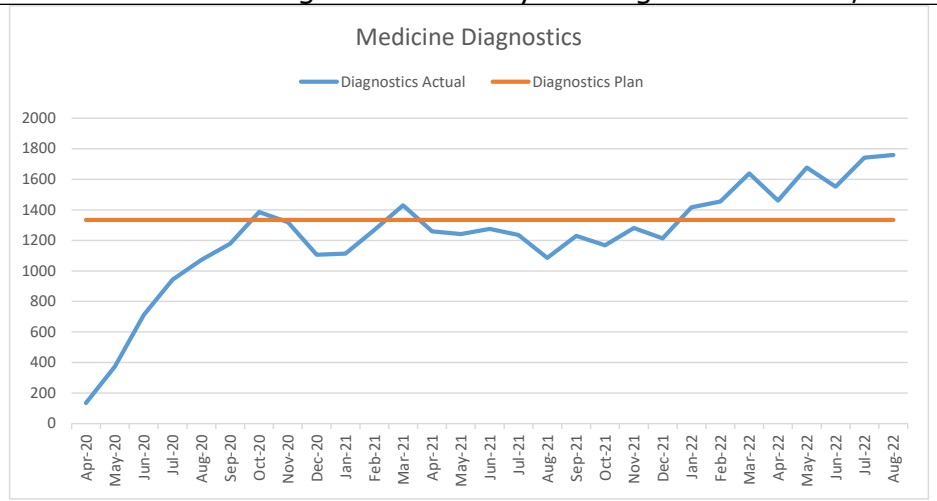
Updated demand and capacity figures are being completed and therefore revised graphs will be provided for future months.

Aug-22

	Previous assumed monthly activity	Actual activity	Variance
Gastroenterology	510	201	-309
Cardiology	553	272	-281
Respiratory (inc Sleep)	606	281	-325
Neurology	259	243	-16
Endocrinology	242	173	-69
Geriatric Medicine	231	141	-90
Total	**2401**	**1311**	**-1090**

Outpatients	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**
Gastroenterology	198	235	194	245	201
Cardiology	140	385	311	333	272
Respiratory (inc Sleep)	232	355	319	330	281
Neurology	193	193	244	318	243
Endocrinology	121	171	133	176	173
Geriatric Medicine	151	185	171	120	141
Total	**1035**	**1524**	**1372**	**1522**	**1311**

- Medicine Diagnostics activity for August '22 was 1,759:



YTD August 22	**Assumed monthly activity**	**Actual activity**	**Variance**
Endoscopy	6670	8190	1520
Total	**6670**	**8190**	**1520**

Waiting List Initiatives:

Medicine have spent £87k in August 22:

- Gastroenterology (£58k): the number of endoscopy lists undertaken was 83 (92 in July). Patients seen in August 2022 was 501 (656 in July)
- Cardiology (£16k): for 7 clinic sessions including virtual, telephone, Tilt, and Echo (25 in July) seeing 103 patients (303 in July), plus 14 Cath lab sessions treating 42 patients (15 sessions and 39 patients in July).
- Diabetes (£13k): for 15 clinic sessions including telephone, face to face, virtual and audit (2 in July seeing 16 patients) seeing 97 patients.

Scheduled Care Division have spent £280k in August:

- Radiology (£129k)
- Pathology (£11k)
- Trauma & Orthopaedics (£75k)
- Anaesthetics (£20k)
- General Surgery (£12k)
- Urology (£22k)
- Dermatology (£5k)
- Oral Surgery (£2k), PAC/ISU (£3k), ENT (£3k)

Mental Health Division have spent £20k in August within Older Adult Mental Health Services. Family & Therapies spent £2k in Gynaecology.

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 - August 2022	£'000
HCHS	Tracing	2,867
HCHS	Extended flu	1,517
HCHS	Testing (inc Community Testing)	1,548
HCHS	PPE	695
HCHS	Mass COVID-19 Vaccination	1,331
GMS	Mass COVID-19 Vaccination	185
Dental	E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS income	2,308
HCHS	Nosocomial investigation and learning	753
	Total Confirmed Covid-19 Allocations	**11,204**
HCHS	Testing (inc Community Testing)	2,522
HCHS	Tracing	3,133
HCHS	Mass COVID-19 Vaccination	7,484
HCHS	PPE	2,630
HCHS	Cleaning standards	2,491
HCHS	Long Covid	887
HCHS	A2. Increased bed capacity specifically related to C-19	10,749
HCHS	A3. Other capacity & facilities costs	7,061
HCHS	B1. Prescribing charges directly related to COVID symptoms	50
HCHS	C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance	14,609
HCHS	D1. Discharge Support	8,309
HCHS	D4. Support for National Programmes through Shared Service	0
HCHS	D5. Other Services that support the ongoing COVID response	1,911
	Total Anticipated Covid-19 Allocations	**61,836**
	Total Covid-19 Allocations	**73,041**

Type	Exceptional items allocations - August 2022	£'000
HCHS	Energy prices increase	33,945
HCHS	Employers NI increase	4,606
HCHS	Real living wage	2,154
	Total Exceptional items allocations (anticipated)	**40,705**

Covid-19 Funding & Delegation

The UHB has assumed Covid funding totalling £73m. £11.2m of this has been confirmed with the remaining £61.8m anticipated. The UHB has anticipated funding of £40.7m for exceptional items listed in the WG letter dated 14th March.

Only funding for specific Covid-19 Programmes has been delegated at this stage with some schemes having funding for Q1 delegated only.

It should be noted that a review of local Covid schemes continues to be undertaken to ensure assumptions link with WG guidance. Costs decreased in month 5 (c.£0.6m) linked Covid prescribing and estates/facilities costs.

Savings – list of schemes tracker

Division	Savings Scheme Number	Scheme / Opportunity	Recurrent / Non Recurrent	Current Year Annual Plan £'000	Plan FYE £'000	Current Year Forecast	Scheme RAG rating
Commissioning	COMM01	GUH OOA cost reduction	R	1,500	1,500	0	Amber
Complex Care	CHC01	Reduction of RN Agency (RJ)	R	250	250	250	Amber
Corporate	CORP01	Workforce and OD	NR	3,657	0	3,657	Amber
Corporate	CORP02	Workforce variable pay	R	214	214	214	Green
Corporate	CORP03	R&D savings	R	200	200	200	Amber
Corporate	CORP04	Non-recurrent opportunities	NR	2,047	0	2,047	Amber
Estates and Facilities	EF01	Minor works	NR	138	0	138	Green
Estates and Facilities	EF02	Agency (non-contract)	NR	268	0	268	Amber
Estates and Facilities	EF03	Park Square car park	NR	94	0	94	Green
Estates and Facilities	EF04	Agile working related opportunities	NR	100	0	100	Amber
Estates and Facilities	EF05	Workforce variable pay	R	347	347	347	Green
Family & Therapies	FT01	Family & Therapies non-pay	NR	652	0	652	Amber
Family & Therapies	FT02	MSK	R	250	250	83	Green
Family & Therapies	FT03	Workforce variable pay	R	300	300	300	Green
Medicine	MED01	Medicine non-pay	NR	500	0	731	Amber
Medicine	MED02	Medical staffing roster	R	140	140	102	Amber
Medicine	MED03	LoS bed reduction - GUH plan	R	1,242	1,242	0	Amber
Medicine	MED04	Workforce variable pay	R	506	506	0	Amber
Medicine	MED05	Endoscopy Backfill Cost Reduction	R	100	120	100	Green
Medicine	MED06	Retinue Savings	NR	8	0	57	Green
Mental Health and Learning Disabilities	MH01	Workforce variable pay	R	378	378	378	Green
Primary Care and Community	PCC01	Workforce variable pay	R	646	646	646	Green
Primary Care and Community	PCC02	Prescribing support dieticians (Prescribing)	R	100	100	100	Green
Primary Care and Community	PCC03	Waste reduction scheme (Prescribing)	R	168	168	168	Green
Primary Care and Community	PCC04	Pharmacy led savings (Prescribing)	R	50	50	31	Green
Primary Care and Community	PCC05	Scriptswitch (acute) (Prescribing)	R	180	180	180	Green
Primary Care and Community	PCC06	Scriptswitch (repeat) (Prescribing)	R	390	390	390	Green
Primary Care and Community	PCC07	Darifenacin to Solifenacin switch	R	80	80	70	Green
Primary Care and Community	PCC08	Respiratory Inhaler Switches	R	349	349	209	Green
Primary Care and Community	PCC09	Rebate - total (Prescribing)	R	1,000	1,000	1,000	Green
Scheduled Care	SCH01	Anaesthetics-POCU temporary staffing	NR	180	0	180	Amber
Scheduled Care	SCH02	Scheduled Care non-pay	NR	500	0	500	Amber
Scheduled Care	SCH03	Vascular mitigation opportunity	R	1,150	1,150	1,137	Amber
Scheduled Care	SCH04	Theatres overall opportunity	R	3,949	3,949	3,949	Amber
Scheduled Care	SCH05	GUH Theatre establishment	R	419	419	419	Amber
Scheduled Care	SCH06	Eye Care / Cataracts	R	500	500	500	Amber
Scheduled Care	SCH07	Medical staffing roster	R	140	140	140	Amber
Scheduled Care	SCH08	Enhanced Care	R	1,400	1,400	1,005	Amber
Scheduled Care	SCH09	SACU / POCU	R	77	77	77	Green
Scheduled Care	SCH10	LoS bed reduction - Scheduled Care / Family	R	864	864	864	Amber
Scheduled Care	SCH11	Outpatient transformation (DNA & Follow-up)	R	2,394	2,394	2,394	Amber
Scheduled Care	SCH12	Workforce variable pay	R	571	571	571	Green
Scheduled Care	MM SCD1	Antibiotic savings	R	3	3	0	Amber
Scheduled Care	MM SCD2	Lenalidomide Price Reduction	R	944	944	944	Green
Scheduled Care	MM SCD3	Bortezomib rationalisation	R	70	72	70	Green
Urgent Care	URG01	Medical staffing roster	R	141	141	110	Green
Urgent Care	URG02	SDEC / Ambulatory Care	R	774	774	774	Amber
Urgent Care	URG03	Retinue	NR	6	0	92	Green

Savings – summary by Division and PMO programme

Division	£'000		
	IMTP - Green	IMTP - Amber	Total
Primary Care and Community	646		646
Prescribing	2,148		2,148
Community CHC & FNC		250	250
Mental Health	378		378
Scheduled Care	1,662	11,088	12,750
Medicine	158	833	991
Urgent Care	202	774	976
Family & Therapies	383	652	1,035
Estates and Facilities	579	368	947
Director of Operations			-
Corporate	214	5,903	6,117
Total	**6,370**	**19,868**	**26,238**

PMO programme	£'000		
	IMTP - Green	IMTP - Amber	Total
Urgent Care Transformation		774	774
Redesigning Services for Older Peopl (COTE) incl. CoPD, HF			-
Enhanced Local Hospital Network		864	864
Planned Care - MSK	83		83
Planned Care - Regional Planning and Ophthalmology		1,137	1,137
Planned Care - Outpatient Transformation		2,394	2,394
Planned Care - Diagnostics			-
Planned Care - Maximising Elective Capacity	177	5,048	5,225
Health Protection			-
Cancer Services			-
Accelerated Cluster Development incl. HRAC, Diabetes			-
Mental Health & Learning Disabilities			-
Decarbonisation			-
Agile Workforce		100	100
Variable Pay	2,716	1,514	4,230
Continuing Health Care (CHC)		250	250
Procurement / non-pay	232	7,787	8,019
Medicines Management	3,162		3,162
Total	**6,370**	**19,868**	**26,238**

- There are currently no savings / efficiencies arising from the prioritisation programmes, many are focussing on transformation which may increase costs in the first instance.

Reserves

7769-ALLOCATIONS TO BE DELEGATED

Confirmed or Anticipated	R / NR	Description	22/23
Anticipated	NR	Training Grade salary adjustments as HEIW schedule	9,045
Confirmed	R	Lead nurse for Primary and Community Care	80,000
Anticipated	NR	Six goals for Urgent and Emergency Care programme	4,529,000
Confirmed	NR	Bereavement support	60,000
Anticipated	NR	Exceptional-Incremental National Insurance	4,606,000
Anticipated	NR	Exceptional-Energy cost increase at M5	17,845,000
Anticipated	NR	C19-Reduction in prescribing anticipated funding M5	(230,000)
		Confirmed Allocations to be apportioned	**26,899,045**

7788-COMMITMENTS TO BE DELEGATED

Description	22/23
Value Based Recovery (balance of funding)	1,083,000
Value Based Recovery - funding recovered	369,000
Recovery of pay budget relating to VERS	56,421
Other (inc.B1&2 enhancement alloc)	187,215
Total Commitments	**1,695,636**

Reserves Delegation:

The UHB Board approved the quarter 2 budget delegation paper on the 28th July. As a result, the majority of anticipated allocations for Covid-19, exceptional items, mental health and other primary care elements were delegated based on quarter 1 estimates. A small number of other committed reserves are held which are due to be delegated once values and plans are finalised.

Any residual reserve leftover will be used to help manage national anticipated funding adjustments rather than claw back from delegated budgets.

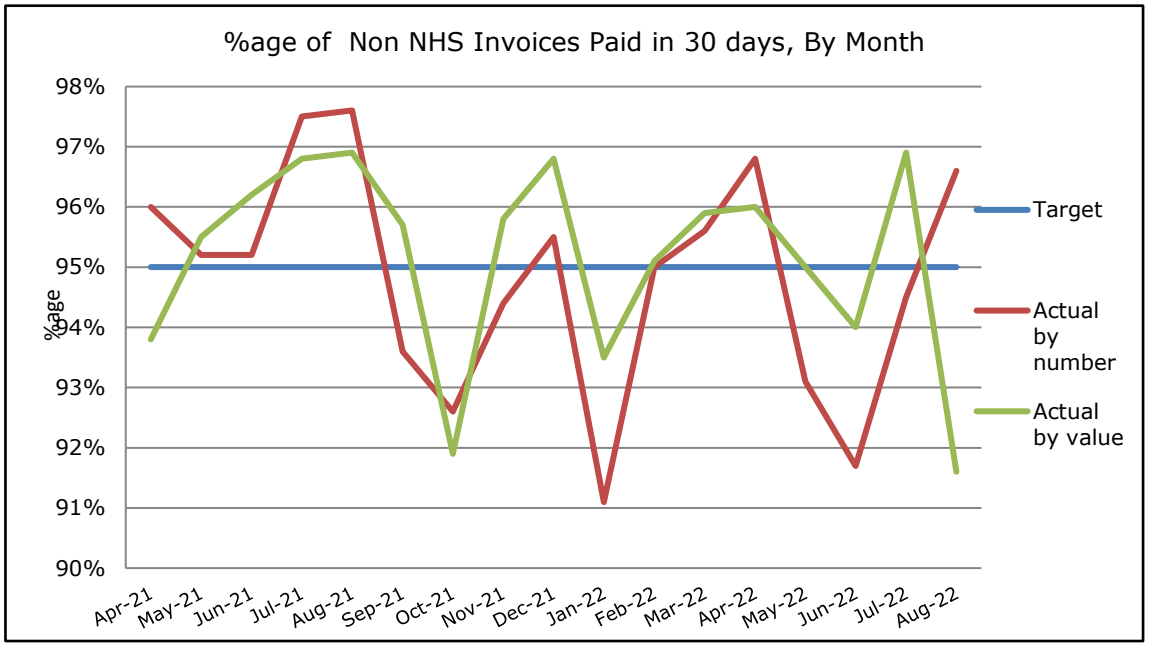
The funding for Covid-19 and exceptional costs has been anticipated at risk and will be monitored quarterly.

Cash Position

- The cash balance at the 31st August is £4.097m, which is below the advisory figure set by Welsh Government of £6m.

Public Sector Payment Policy (PSPP)

- The Health Board has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods in August and there has been an improvement in the cumulative target from the previous month. We are continuing to work with those departments where invoices are being processed outside of the 30 day payment terms.

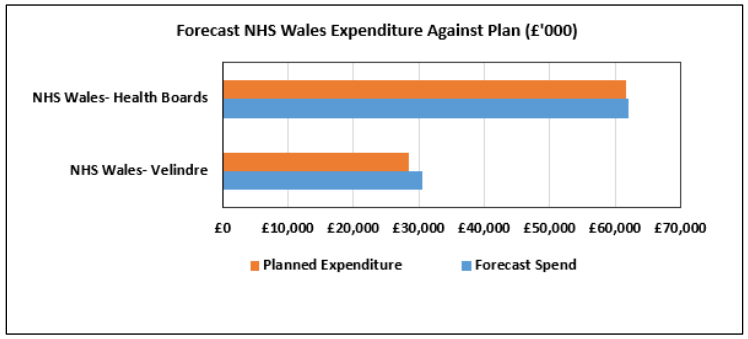


Contracting & Commissioning – LTA Spend & Income

Month/Financial Year:- Month 5 (August) 2022-23

At Month 5 the financial performance for Contracting and Commissioning is a YTD adverse variance of £605k (forecast var. £3.064m).

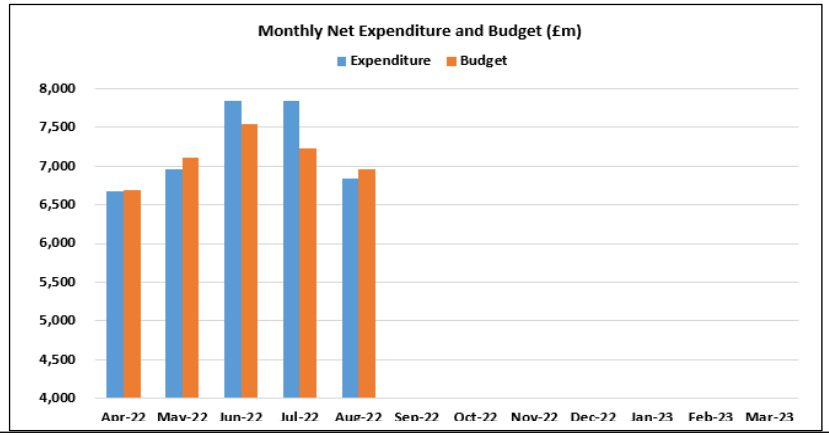
The key elements contributing to this position at Month 5 are as follows:

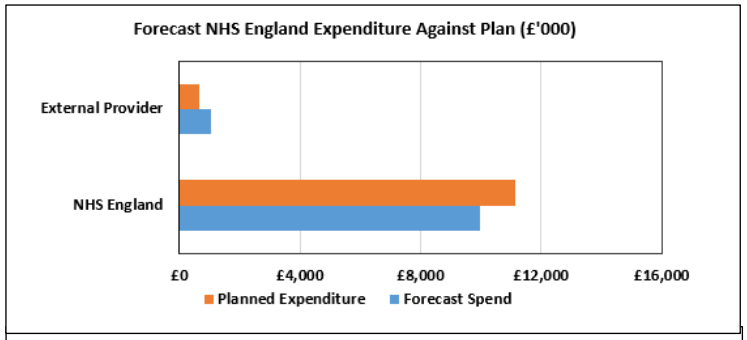


NHS Wales Expenditure

There is increased activity (£550k) and drug spend (£1.65m) being forecast at Velindre for ABUHB patients receiving cancer treatment.

ABUHB are, however, forecast to recover c£500k in underperfomance due to less activity being delivered by Cwm Taf.

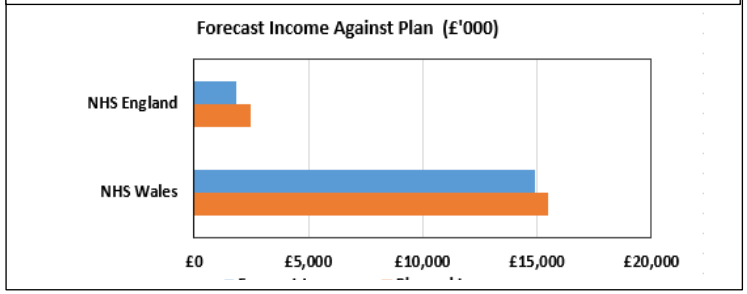




NHS England Expenditure

Contract Expenditure with NHS England organisations has to move away from Block agreements in 2022-23

There is a risk of increased expenditure if English providers deliver additional activity in 2022/23.



Provider Income

There is a c£2.3m cost pressure expected from the reduced activity being delivered for Powys LHB following the opening of the GUH hospital.

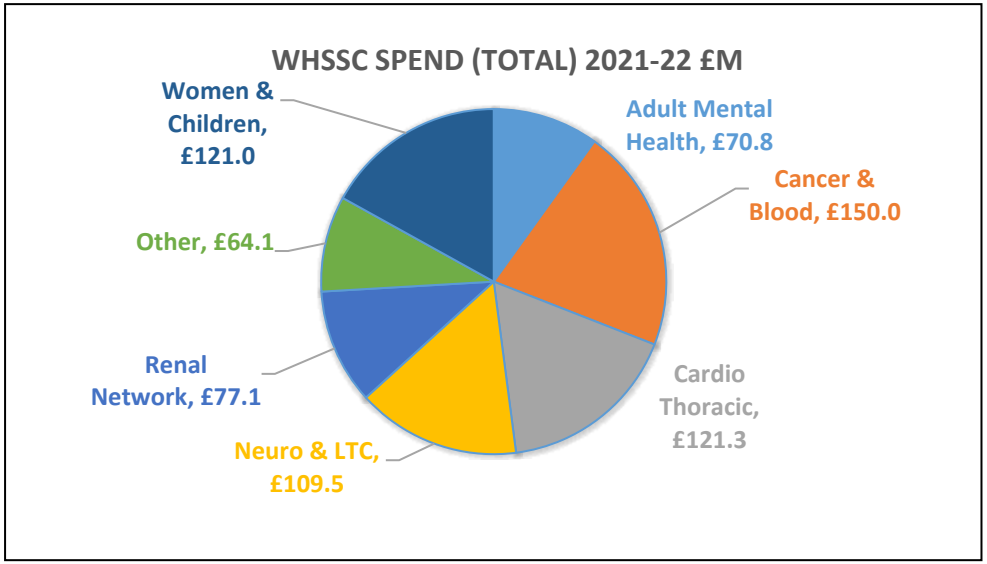
This has been partly funded by £1.6m budget delegated.

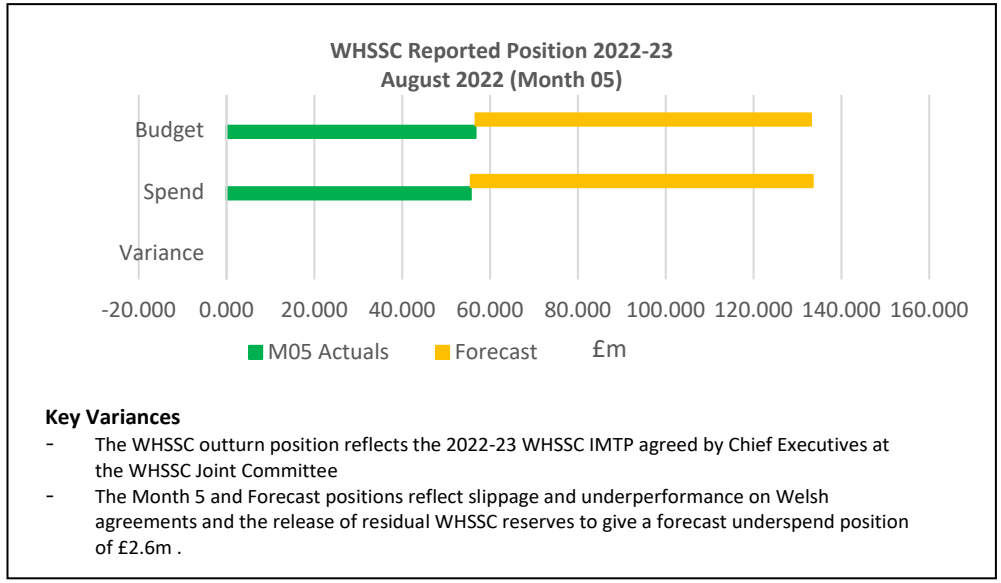
Key Issues 2022-23

- All LTAs signed and agreed in compliance with 30 June 2022 deadline.
- 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 £2.3m cost pressure from the reduced activity being delivered for Powys LHB following the opening of the GUH hospital partly funded by c.£1.6m budget delegated in year.
- There is a c£800k cost pressure expected from outsourcing activity to St Josephs hospital to support endoscopy and MRI (c£958k expenditure partly offset by £160k funding allocated in year)
- The position reflects £0.145m of anticipated funding to cover the inflationary uplift agreed with NHS England for English Providers.

WHSSC & EASC Financial Performance Period: Month 05 2022-23

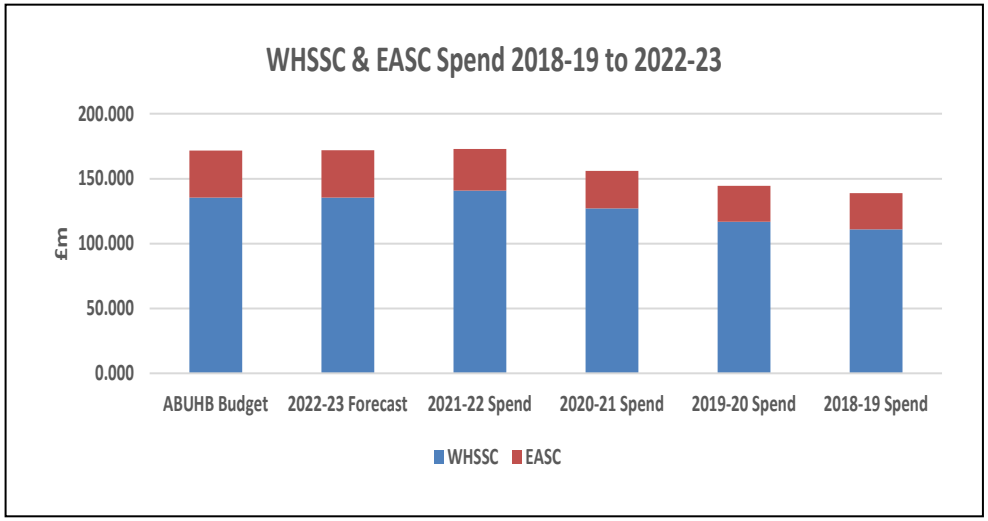
The Month 05 financial performance for WHSSC & EASC is a YTD underspend of £0.957m with a forecast underspend of £2.301m. The Month 05 position reflects the agreed IMTP & LTA agreements with providers.

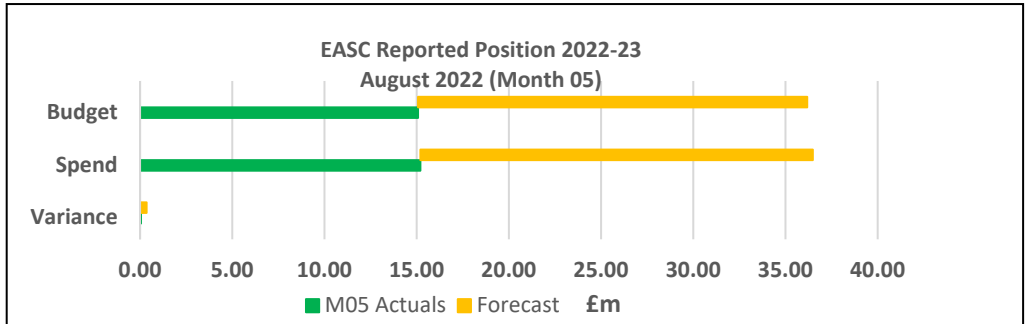




Key Variances

- The WHSSC outturn position reflects the 2022-23 WHSSC IMTP agreed by Chief Executives at the WHSSC Joint Committee
- The Month 5 and Forecast positions reflect slippage and underperformance on Welsh agreements and the release of residual WHSSC reserves to give a forecast underspend position of £2.6m .





Key Variances

- The EASC outturn position reflects the 2022-23 EASC IMTP agreed by Chief Executives at the EASC Joint Committee.
- The variance reflects the HB's contribution share of £1.8m non recurring support to Welsh Ambulance Services Trust in 2022-23 to support ongoing recruitment and service pressures.
-

Balance Sheet

Balance sheet as at 31st August 2022	2022/23 Opening balance £000s	31st August 2022 £000s	Movement £000s
Fixed Assets	810,479	818,554	8,075
Other Non current assets	131,429	127,975	-3,454
Current Assets			
Inventories	8,726	8,871	145
Trade and other receivables	133,807	120,710	-13,097
Cash	1,720	4,119	2,399
Non-current assets 'Held for Sale'	0	0	0
Total Current Assets	144,253	133,700	-10,553
Liabilities			
Trade and other payables	226,999	233,810	6,811
Provisions	195,707	189,977	-5,730
	422,706	423,787	1,081
	663,455	**656,442**	**-7,013**
Financed by:-			
General Fund	530,429	523,423	-7,006
Revaluation Reserve	133,026	133,019	-7
	663,455	**656,442**	**-7,013**

Fixed Assets:
- An increase of £8.282m in relation to new 2022/23 capital expenditure incurred.
- A reduction of £18.049m for depreciation charges to August period.
- An increase of £17.842m in relation to IFRS16 lease assets.

Other Non-Current Assets:
- This relates to a decrease in Welsh Risk Pool claims due in more than one year £2.3m and a decrease in intangible assets £1.2m since the end of 2021/22.

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 August £2.5m. A decrease in the value of both NHS & Non-NHS accruals of £18.8m, of which £4.9m relates to a decrease of Welsh Risk Pool claims due in less than one year and £12.7m relates to a decrease in NHS & Non NHS accruals and £1.2m relates to VAT/other debtors decrease.
- An increase in the value of prepayments held of £3.2m.

Cash:
- The cash balance held in month 5 is £4.119m.

Liabilities, Provisions:
- The movement since the end of 2021/22 relates to a number of issues the most significant of which are:- a decrease in Capital accruals (£8.4m), an increase in NHS Creditor accruals (£7.6m), a decrease in the level of invoices held for payment from the year end (£16.4m), an increase in non NHS accruals (£11.6m), an increase in Tax & Superannuation (£7.1m), a decrease in other creditors (£11.5m), an increase in liability for lease payment (£17.9m).
- Due to the decrease in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £5.2m and the decrease in pensions & other provisions £0.5m.

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: £1.57bn

Confirmed Allocations as at August 2022 (M5 2021/22)

	£'000
HCHS	1,293,992
GMS	105,091
Pharmacy	32,831
Dental	33,249
Total Confirmed Allocations - August 2022	**1,465,163**
Plus Anticipated Allocation - August 2022	**105,834**
Total Allocations - August 2022	**1,570,997**

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 £104.7m. (£109m for 21/22). The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Estimated funding (allocations & income) for the UHB totals £1.68bn for 22/23.

WG Anticipated allocations: £105.83m

	STATUS OF ISSUED RESOURCE LIMIT ITEMS				Total Revenue Resource Limit
	HCHS £'000	Pharmacy £'000	Dental £'000	GMS £'000	£'000
DEL Non Cash Depreciation - Accelerated	483				483
DEL Non Cash Depreciation - IFRS 16 Leases	2,956				2,956
AME Non Cash Depreciation - Donated Assets	342				342
AME Non Cash Depreciation - Impairment	(13,929)				(13,929)
Removal of Donated Assets / Government Grant Receipts	(150)				(150)
Total COVID-19 (see below analysis)	61,836	0	0	0	61,836
Removal of IFRS-16 Leases (Revenue)	(2,933)				(2,933)
Energy (Price Increase)	33,945				33,945
Employers NI Increase (1.25%)	4,606				4,606
Real Living Wage	2,154				2,154
(Provider) SPR's	112				112
(Provider) Clinical Excellence Awards (CDA's)	298				298
Technology Enabled Care National Programme (ETTF)	1,800				1,800
Informatics - Virtual Consultations	2,532				2,532
National Nursing Lead Community & Primary Care	53				53
National Clinical Lead for Falls & Frailty	26				26
AHW:Prevention & Early Years allocation	1,041				1,041
Healthy Weight-Obesity Pathway funding 21-22	550				550
WHSSC - National Specialist CAMHS improvements	139				139
Same Day Emergency Care (SDEC)	1,560				1,560
PSA Self-management Programme (Phase 1 & 2)	114				114
OP Transformation-Dermatology Specialist Advice and Guidance	22				22
OP Transformation-Dermatology Nurses Surgical Skills Study Day	4				4
Digital Priority investment fund (DPIF)	500				500
Strategic programme Primary Care within A Healthier Wales (additional p	113				113
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
Memory Assessment Services - Gwent RPB (ANEHFS 37 21/22)	565				565
EASC/WAST Improvements in MH Emergency Calls (ANEHFS 54 21/22)	51				51
WHSSC - Impl of National Specialist CAMHS Improv. (ANEHFS 90 21/22)	131				131
NHS Pay enhancement Band 1 to 2 - 3% uplift 21-22 (ANEHFS 21/22)	152				152
Urgent Primary Care	1,400				1,400
Primary Care 111 service	623				623
End of Life Care Board	112				112
Welsh Risk Pool	(4,212)				(4,212)
GMS Refresh				1,603	1,603
PSA self-management Programme Platform development	465				465
Real Living Wage Bands 1 & 2	658				658
Dementia Action Plan-Age Cymru National advocacy project	445				445
VBH: Heart Failure and Rehab in the Community	297				297
VBH: High risk surgical wound management	34				34
Digital Medicines transformation team	119				119
Mental Capacity Act prep for Liberty Protection Safeguards (Phase 2)	326				326
Six Goals Urgent and Emergency Care Prog	4,529				4,529
Total Anticipated Funding	**104,230**	**0**	**0**	**1,603**	**105,833**

Capital Planning & Performance

Summary Capital Plan Month 5 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
Grant Income Received	0	32		32
NBV of Assets Disposed	0	0		0
Total Approved Discretionary Funding	6,693	6,400		6,400
All Wales Capital Programme Funding: -				
AWCP Approved Funding	24,615	42,262		42,262
Total Approved AWCP Funding	24,615	42,262		42,262
Total Capital Funding / Capital Resource Limit (CRL)	**31,308**	**48,662**		**48,662**
Applications:				
Discretionary Capital:-				
Commitments B/f From 2021/22	1,317	1,498	90	1,324
Statutory Allocations	576	576	242	605
Divisional Priorities	587	1,120	532	1,117
Corporate Priorities	2,182	670	321	670
Informatics National Priority & Sustainability	1,800	2,342	551	2,342
Remaining DCP Contingency	231	195	0	531
Total Discretionary Capital	**6,693**	**6,400**	**1,736**	**6,589**
All Wales Capital Programme:-				
Grange University Hospital Remaining works	-1,408	-394	968	-394
Tredegar Health & Wellbeing Centre Development	10,023	9,934	1,334	9,934
Fees for NHH Satellite Radiotherapy Centre Development	198	257	109	257
YYF Breast Centralisation Unit	8,989	8,978	214	8,978
Newport East Health & Wellbeing Centre Development	0	9,287	1,366	9,287
Fees for MH SISU	258	263	104	263
Covid Recovery Funding	1,400	1,620	1,620	1,636
National Programme - Imaging	4,700	4,195	311	4,195
Digital Eyecare	0	66	43	66
National Programme - Infrastructure	12	12	15	15
NHH SRU Enabling Works	400	403	414	403
SDEC Equipment	0	79	52	79
ICF Discretionary Fund Schemes	43	153	-4	153
RGH Endoscopy Unit	0	7,395	0	7,188
DPIF - Digital Medicines Transformation Portfolio	0	14	0	14
Total AWCP Capital	**24,615**	**42,262**	**6,546**	**42,073**
Total Programme Allocation and Expenditure	**31,308**	**48,662**	**8,282**	**48,662**
Forecast Overspend / (Underspend) against Overall Capital Resource Limit				**0**

The approved Capital Resource Limit (CRL) as at Month 5 totals £48.630m. In addition, grants totalling £32k have been received in month to fund works and R&D equipment requirements. The current forecast outturn is breakeven.

The GUH works to the Same Day Emergency Care Unit, Resus, and CAEU have all completed during August. All Laing O'Rourke works are now complete, and the final account is being agreed. Tenders for the Well-being works to Grange House have been received. The works are slightly delayed due to bat requirements (estimated completion April 2023). The additional works costs are being offset by the final VAT recovery claim (£3.5m) due in the last quarter of 2022/23 which is the reason for the credit budget allocation of (£394k). The Health Board's VAT advisors are currently working with HMRC and the external cost advisors to expedite the VAT recovery claim and mitigate the risk that an agreement is not reached in the current financial year.

The YYF Breast Centralisation Unit scheme is currently delayed due to contractual issues with the main contractor (inflationary pressures). The issues are being worked through with the external cost advisors, NWSSP-Estates and Welsh Government to allow the scheme to progress.

The works at Tredegar H&WBC are continuing. The handover of the building is now expected to be delayed to May 2023 due to the supplier cancellation of the brick order for the façade. There continues to be significant cost risks to the scheme including the re-design of the foundations (potential additional £750k), EV charging points (not a requirement at Design Stage), culvert diversion, Heart building stabilisation, brick supply cancellation and inflation. Any potential overspend is expected to impact in 2023/24.

The Newport East Health and Well-being Centre works have commenced. The old Multi Use Games Area has been removed and the replacement is being prepared. Groundworks are underway for the car park and surrounding area. The RGH Endoscopy scheme works commenced on site on 15th August 2022.

The FBC for the NHH Satellite Radiotherapy Centre has concluded and has been submitted to WG for approval. The Outline Business Case for the Mental Health SISU is on-going and expected to be submitted to Board for approval in November 2022.

The National Imaging Programme funding has been reduced by £491k to £4.195m because of savings generated on equipment purchases and works costs. The spend in the current year includes the replacement of two CT Scanners (NHH / RGH), the installation of three general rooms and the recently approved replacement of seven ultrasound machines.

The Health Board Discretionary Capital Programme (DCP) forecast outturn for 2022/23 is £6.589m funded by:

- 2022/23 DCP Funding - £8.227m (a reduction of 24% compared to 2021/22)
- RGH Endoscopy fees reimbursement - £207k
- Grant funding received (Sparkle and R&D) - £32k
- Less All Wales Capital Programme scheme brokerage & overspends – (£1.877m)

The unallocated contingency budget as at the end of August is £531k. Correspondence has been received from Welsh Government to confirm an additional £10m across Wales to increase DCP allocations for 2023/24. The estimated ABUHB DCP funding for 2023/24 will be £9.521m (compared to £10.814m 21/22, £8.227m 22/23).

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

MONITORING RETURN FOR MONTH 05 2022/23

Director of Finance Commentary for the Period Ended 31st August 2022

Introduction

The purpose of this narrative is to provide a commentary on the financial monitoring returns being submitted to the Welsh Government (WG) by the Aneurin Bevan University Health Board (ABUHB) for the period to 31st August 2022 (Month 05, 2022/23). This commentary will provide an overview of the financial position and performance of the Health Board as at month five of the 2022/23 financial year. It will also provide a detailed narrative, where required, on each of the tables within the accompanying returns, in the format prescribed by WG.

This commentary will also respond, as far as is possible, to the issues highlighted in the WG response letter, the Health Board's response is recorded in the action log included as an Annex 1 to this commentary.

It is important to note that the uncertainty of Covid-19 continues with operational impacts for the Health Board's response. National priority schemes have been determined depending on WG guidance for 2022/23. A range of local Covid-19 transitional schemes have been estimated and funding anticipated for varying time profiles during the financial year. Exceptional cost pressures are included with anticipated income assumed. These are being actively managed to minimise the financial impact as per the IMTP financial assumptions letter dated 14th March 2022 and is in line with the ABUHB IMTP submitted to WG.

The Health Board is working to increase activity in areas that have suffered during Covid peak periods but there continues to be additional surge beds open on all sites and the workforce demands remain a significant risk to delivering services in the urgent and emergency care system.

Pay award costs are excluded from the Health Board financial plan on the assumption that this will have nil impact due to funding from WG. The cost impact of the recent WG pay circulars (Pay Letter Face(W) 03/2022 and M&D(W) 02/2022 Pay Circular) will be modelled to determine the impact for ABUHB with anticipated funding included for month 6 reporting.

Energy costs have been revised based on latest data from NWSSP, this has resulted in a significant increase compared to the IMTP submission. These will continue to be monitored and updated for revised information from Shared Services. The estimates provided by NWSSP are shown as an average, this doesn't reflect the profile of actual spend, therefore, the HB's spend profile is adjusted to take account of usage patterns.

As at Month 05, ABUHB is reporting a deficit of £17.441m and is holding a forecast position of break-even as directed by the Board, this will be subject to further Board and Executive decisions. There is **extremely high risk** to reaching this break-even forecast, in particular the achievement of the full level of savings required within the IMTP. A briefing on the high risk areas was discussed on the 9th June and Executive Director discussions were held on the 13th June, the purpose of this was to reinforce the need to manage the financial risk to the Health Board to achieve the break-even forecast position. The Finance and Performance Committee were provided with a full financial update including risks to break-even on the 6th July. A further Executive session on the 11th July reviewed a number of mitigating actions which will need Board approval. This is now a standing item on weekly Executive meetings. These risks are in line with those identified in the IMTP and were expected to be managed. These risks have been further raised at each Executive meeting.

The Board meeting on the 28th July discussed, reviewed and noted the current significant level of risk to the financial forecast alongside discussing how to manage and mitigate costs to achieve break-even. Opportunities were shared for consideration.

In response to **Action Point 4.1** all budget-holders were asked to review their current forecasts and other potential opportunities. The resulting forecasts are being analysed with the viable opportunities considered. Some options have been rejected based on risk to patient safety, optimal flow or performance. The Board meeting in September will review the current risks to the position with a view to amending the forecast if appropriate.

The Executive Team meet on a weekly basis with financial recovery 'Turnaround' being a standing item. A number of short-term actions are being discussed but not yet agreed noting the possible implications to performance and services if implemented. The Chief Executive has asked all budget-holders across the UHB to consider and develop further short-term measures. Any actions are being approved at Divisional levels. Further transformational opportunities with their implications are being discussed at weekly Executive meetings to agree and prioritise any decisions. The UHB Board meeting on the 28th July noted the year to date financial position along with the significant level of risk to the forecast. The next Board meeting will consider amending the forecast given the list of actions and options required to achieve break-even, with consideration to the impact on delivery, safety and performance.

The programme of work is identifying options and actions for reducing costs and assess patient, target and financial impact. An organisational re-assessment of priorities and forecast service demand will be regularly undertaken and considered by the Executive and the Board as part of financial recovery.

Given the extreme risk to forecast break-even the CEO will be establishing additional focussed sessions of the Executive team to review income opportunities and cost reduction opportunities and likely delivery levels for 22/23. This will provide the basis for consideration with the Board of an updated service, workforce and financial plan

and forecast for 2022/23. The Board will consider, during its September meeting, a revised financial forecast for ABUHB for 2022/23 as part of the mid-year review process.

In response to **Action Point 4.2** Covid and exceptional items costs are undergoing constant review but remain high and in a similar region to previous months. Discharge support and facilities costs may reduce further upon on-going review of the schemes, de-escalation measures and proposed options for the Executive Team to consider. This is off-set by on-going costs relating to surge capacity and associated nursing costs linked to acuity resulting from Covid-19. The Clinical futures strategy including the GUH should have resulted in a lower and more cost-effective bed base than previous years but this has not been achieved, Covid-19 and delays in discharge (with social care delays accounting for c.50%) being the most significant of several factors.

Actual YTD

The month five reported financial position shows a **£17.441m overspend position;** this is presented as such on the face of ***Table B – Monthly Positions***. The table below details the outturn financial position analysed across the Health Board's organisational structure of Divisions and Corporate Directorates, funding has been delegated following Board approval and subsequent Chief Executive agreement: -

Summary Reported position - August 2022 (M05)	Full Year Budget £000s	YTD Reported Variance £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	271,231	(944)	(1,334)	390
Prescribing	99,190	3,101	2,050	1,051
Community CHC & FNC	71,296	(1,844)	(1,170)	(675)
Mental Health	104,853	3,960	2,562	1,398
Director of Primary Community and Mental Health	311	(63)	22	(85)
Total Primary Care, Community and Mental Health	**546,881**	**4,210**	**2,131**	**2,079**
Scheduled Care	226,287	10,097	7,470	2,627
Medicine	106,819	9,250	7,996	1,254
Urgent Care	41,204	2,676	2,358	319
Family & Therapies	119,405	(346)	13	(358)
Estates and Facilities	104,043	588	(37)	625
Director of Operations	7,634	392	311	81
Total Director of Operations	**605,392**	**22,659**	**18,112**	**4,547**
Total Operational Divisions	**1,152,273**	**26,869**	**20,242**	**6,626**
Corporate Divisions	111,486	(6,406)	(4,513)	(1,893)
Specialist Services	172,248	(957)	(499)	(458)
External Contracts	83,965	605	732	(126)
Capital Charges	34,734	(159)	(67)	(92)
Total Delegated Position	**1,554,706**	**19,952**	**15,895**	**4,057**
Total Reserves	28,595	(2,511)	(1,559)	(952)
Total Allocations	(1,570,997)	0	0	0
Other Corporate Income	(12,304)	0	0	0
Total Reported Position	**0**	**17,441**	**14,336**	**3,105**

Key messages for Month 05

The financial position at the 31st August 2022 shows a £17.441m deficit position, with the key issues in the month being:

- The number of Covid-19 positive patients in hospital has decreased throughout August. The total number of patients (positive, suspected and recovering) is 157 (31st August 2022) which is now at similar levels to August 2021 (153 as at 31st August 2021). There are a considerable number of patients recovering from Covid-19 across several wards in the Health Board. The temporary staffing cost to operate these areas, some of which are surge capacity, remains significant.

- Pay expenditure decreased compared to month four partly due to a review of Nursing agency booked shifts not filled in 2022. There was an increase in Registered nursing and HCSW bank (related to on-going enhanced care) as well as additional hours across all staff groups off-set by the reduction for the annual leave provision release.
- Expenditure in the Health Board for non-pay increased slightly due to Primary Care contract (Pharmacy and Dental) off-set by decreased costs in CHC costs (linked to young persons and some EMI packages). Costs for out of area treatments, litigation and IPTR also decreased in-month.
- Surge capacity remains at significant levels. The level of recovering patients coupled with the increased acuity of all patients is impacting on efficient bed utilisation and ability to rationalise the bed-base.

The number of medically fit and delayed transfers of care remain at significant levels, in the region of 286 patients as at the end of August. Approximately 50% of these patients relate to social care delays. These patients are across multiple sites and are generally within the Medicine and Community specialities. These delays affect patient flow, increasing the level of additional capacity across the HB resulting in significant additional costs. This is above any level factored into the IMTP for 2022/23. Further discharge support solutions have been implemented to mitigate the flow pressures which increases the financial pressure for the Health Board.

Covid-19 related staff sickness cover remains substantial resulting in direct and indirect increased variable pay costs across the Health Board. In addition, costs

continue to be incurred to cover medical staff who are unable to return to front-line clinical work due to Occupational Health advice. The operational functions of ABUHB continue to operate to 'Covid-19 safe' standards. These include Covid-19 service cost drivers for:

- 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.

There is a continued reliance on premium rate variable pay (agency & enhanced bank rates). Variable pay remains at a significantly higher level compared to historical spend. In particular the consistent increase in patient acuity resulting in the need to provide enhanced care at levels 4 and 5. Current enhanced care is being provided to c.30% of patients in ABUHB beds.

The inability to effectively and efficiently cohort patients and implement sustainable solutions continues to provide a service, workforce and financial pressure throughout the Health Board. It was expected that this situation would improve as Covid-19 restrictions were lifted, however, this return to 'business as usual' has not transpired.

A continued focus on variable pay using a programme management approach is being led by the Director of Workforce and OD, the aim is to create a more sustainable best value workforce model.

Outside of workforce, prescribing costs increased due to volume & price increases as well as significant non Category-M drug costs and NCSO's. Mental Health CHC costs increased due to additional fee costs due to the increased rates paid by some Local Authorities which is the start point of the uplift formula for the HB, as well as on-going growth in patient numbers. Velindre NICE drug growth above the HB's IMTP, litigation provisions and IPTR costs have all increased in-month.

1. Actual YTD and Forecast Under / Overspend 2021/22 (Tables A, B, B2 & B3)

Table A – Movement of Opening Financial Plan to Outturn

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.

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 IMTP submitted to Welsh Government in March 2022 identified a break-even core position, assuming funding for the three areas of exceptional cost pressures as well as for the on-going transitional and National costs relating to Covid-19. It should be noted that there are on-going financial risks for 2022/23. A break-down of the submitted IMTP for 2022/23 is summarised below:

- Underlying deficit brought forward of £20.9m
- Cost pressures identified of £89.3m
- Anticipated WG recurrent funding of £84m
- Savings of £26.2m
- Other cost pressures (c.£19m) and new pressures will be mitigated and managed in year.

Going into 2023/24 the position was planned to be an underlying deficit to carry forward of £8.1m, this is a result of the level of in year non recurrent savings. However, in light if the in year pressures this needs to be reviewed as part of the mid-year review process.

Opportunities to make efficiencies have been identified as c.£26m, included in the core plan, and the Health Board is working to translate these into meaningful savings. The Board and the Finance & Perofrmance Committee (FPC) have been presented with further efficiency opportunities to consider as part of cost reduction, mitigation and transformation including the use of benchmarking, GIRFT, Carter review and the FDU 'VAULT'. A list of these opportunities was provided in the IMTP, these have been reviewed resulting in some presentational changes which is causing the presentational movement between IMTP and in year savings in the movement table.

The achievement of the core break-even IMTP position is at risk.

This MMR table has been completed based on updated, current operational plans and will be updated to reflect transitional Covid-19 costs, achievement of savings, further local/exceptional cost pressures and Board / Executive decisions.

In response to **Action Point 3.3** the £0.094m updated WRP risk position increase has been reflected as an anticipated allocation reduction.

In response to **Action Point 3.4** the additional cost pressures of £19m are described as follows:-

Item	IMTP Risks / Choices Not Included in the B/E Position	IMTP Risks / Choices Not Included in the B/E Position @ M5	How the IMTP Risks are recorded at Month 5			
			M5 - forecast	M5 - Covid or Exceptional funded	M5 - risk	M5 - mitigated
	£'000	£'000	£'000	£'000	£'000	£'000
GUH IT - additional costs of staffing and non-pay consumables	851	851	973			(122)
Additional Covid de-contamination costs	338	338		338		
Sustainable Palliative Care - additional staffing costs	251	251	251			
Diabetes Pump Service	1,216	1,216			1,216	
Right-sizing communities project	750	750			750	
Pharmacy developments in Emergency Department	340	306		306		
Speech and Language Therapy (SaLT) - additional staffing	276	237		237		
Health Courier Services (HCS) - additional transport costs (E&F)	375	375		141		234
Additional RIF costs - awaiting confirmation within Regional Integration Funds	1,924	1,924				1,924
GUH Excess Travel	156	156	156			
Streamlining (F&T)	2,768	2,775	429			2,346
Additional bed capacity (Community)	1,001	1,001		1,001		
Medicine (& other Divisional) non-pay	2,500	2,500	2,500			
Increase to specialist nursing rates	304	304		304		
Medical Director and other Corporate non-pay	314	314	-	34		280
Powys additional risk	2,000	2,000	1,000			1,000
Sub-total	**15,364**	**15,298**	**5,309**	**2,361**	**1,966**	**5,662**
Psychological Well-being Practitioners (PWP) Covid programme	1,365			1,365		-
Energy prices further increase	2,000			2,000		-
Total - as at IMTP	**18,729**	**15,298**	**5,309**	**5,726**	**1,966**	**5,662**

In response to **Action Point 3.5** the WHSSC movement and Velindre drugs pressure are now shown in Table A to reflect these issues.

In continued response to **Action Point 1.3** the Health Board will aim to adjust the RRL profile once 'turn-around' mitigating actions are approved with a revised profile in terms of these actions.

Table B - Monthly Positions

The year to date reported position is a £17.441m deficit position.

The 31st August position assumes that costs for exceptional cost pressures as well as both Covid-19 National and Local pressures are fully funded.

The table below indicates changes made to the SoCNE since Month 4 in terms of forecast and movements.

	A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Revenue Resource Limit	Actual/F'cast	(676)	0	3,069	3,476	4,670	4,497	4,951	4,811	[illegible]	[illegible]
7	**Income Total**		**(448)**	**0**	**3,069**	**3,476**	**4,670**	**4,497**	**4,951**	**4,811**	[illegible]	[illegible]
8	Primary Care Contractor (excluding drugs, including non resource limited expen	Actual/F'cast	328	0	0	48	0	0	0	0	[illegible]	[illegible]
10	Provided Services - Pay	Actual/F'cast	(600)	0	755	755	1,250	1,250	1,250	1,250	[illegible]	[illegible]
11	Provider Services - Non Pay (excluding drugs & depreciation)	Actual/F'cast	(670)	0	2,314	2,721	3,420	3,247	3,701	3,562	[illegible]	[illegible]
12	Secondary Care - Drugs	Actual/F'cast	504	0	0	0	0	0	0	0	[illegible]	[illegible]
13	Healthcare Services Provided by Other NHS Bodies	Actual/F'cast	(861)	(200)	(200)	(200)	(200)	(200)	(200)	(151)	[illegible]	[illegible]
15	Continuing Care and Funded Nursing Care	Actual/F'cast	(120)	0	0	0	(300)	0	(200)	0	[illegible]	[illegible]
22	DEL Depreciation/Accelerated Depreciation/Impairments	Actual/F'cast	1,411	246	246	246	246	246	246	67	[illegible]	[illegible]
25	Profit/Loss Disposal of Assets	Actual/F'cast	(93)	0	0	0	0	0	0	(57)	[illegible]	[illegible]
26	**Cost - Total**	Actual/F'cast	**(134)**	**46**	**3,115**	**3,570**	**4,416**	**4,543**	**4,797**	**4,671**	[illegible]	[illegible]
27	**Net surplus/ (deficit)**	Actual/F'cast	**(315)**	**(46)**	**(46)**	**(94)**	**254**	**(46)**	**154**	**140**	[illegible]	[illegible]

Material movements of actual expenditure from Month 4 are as follows:

- *RRL* – this reflects the increased anticipated allocations mainly due to increased energy prices but also to 6 goals hosted funding with the anticipated allocations aligned to Divisional expenditure budgets phasing.

- *Provider Services – Pay* – costs lower than forecast for month 5 due to reduced agency costs. Pay costs are assumed to increase linked to anticipated allocations (e.g. hosted 6 goals funding).

- *Provider Services – Non-Pay* – costs lower than forecast for month 5 due to utilities in-month costs. Assumption that further costs for energy and other costs linked to anticipated allocations will be forecast in quarter 4.

- *Secondary care - drugs* – in month 5 WP10 and Ophthalmology drugs costs were higher than forecast.

- *Healthcare Services Provided by Other NHS Bodies* – costs were lower than forecast for month 5 due to reduced costs linked to some specific LTA under-performance. There is a risk regarding other LTA over-performance in particular with C&V.

- *Continuing Care and Funded Nursing Care* – forecast costs in month 5 were lower than plan given a review of details of expected packages of care included on the CHC databases. The forecast for the remainder of the year has decreased to reflect specific case reviews in Mental Health and Adults later in the financial year.

- Other categories such as DEL depreciation have been adjusted due to IFRS 16 adjustments. The impact on this on delegated budgets is to be worked through.

In regards the Annual leave accrual (**Action Point 1.13/3.7**) the Health Board can confirm the following:-

- The b/fwd accrual from 2021/22 was £19.603m
- The remaining Annual Leave Accrual after 'Sell Back' payments were made in months 1 - 5 (totalling £0.949m) is £18.654m.
- It is expected that costs have been incurred by the Health Board where staff have taken some of the carried forward annual leave. Therefore, for the year to date a total provision release of £7.898m has been reflected in the month 5 position.

In response to **Action Point 4.3** it is assumed that backfill costs will be required on a consistent basis and therefore the annual leave accrual release will cover these elements in addition to the sell back costs. In addition, the level of vacancies across the UHB requires further cover which will include a level annual leave.

The forecast assumes full release of the annual leave provision for 2022/23.

Section B has been completed from month 2 indicating costs by Directorate/Division on a forecast and actual basis.

Section D shows the year-to-date and forecast depreciation position for the Health Board based on the final asset values for 2021/22 and the 2022/23 capital schemes approved in the CRL issued on 7th September 2022. The figures are currently based on indices previously supplied by the Valuation Office Agency. As 2022/23 is a quinquennial valuation year, these figures will change when the Valuation Office Agency report is finalised (the draft report has been received and queries are near to being resolved), and the confirmed land and buildings revaluations are processed.

The DEL requirements set out in the table below agree to the DEL Non-Cash Return submitted on 30th June 2022. The AME Depreciation charges, and anticipated funding requirements shown in the table will be finalised in the November 2022 Non-Cash Return. The IFRS16 funding requirements for DEL leases have been agreed with WG and are now included in the table below. Any changes to these will be finalised alongside the AME lease depreciation requirements and confirmed for the November Non-Cash Return.

It is currently assumed that the IFRS 16 funding requirements are treated as non-cash. A query has been submitted to Welsh Government colleagues to confirm this is the correct treatment and the relevant tables and adjustments will be made in future months if necessary.

AME Impairments have been included as per the updated project completion dates that we have been notified of. The reversals of impairment funding required is currently based on the existing indices as described above, so will be subject to change following the processing of the quinquennial valuations. The revised requirements will be confirmed in future monitoring and non-cash returns accordingly.

	Anticipated	Confirmed	Total
Allocations M05	**£000**	**£000**	**£000**
DEL - Baseline Depreciation Shortfall	0	298	298
DEL Strategic depreciation Support Required	0	21,122	21,122
DEL Accelerated Depreciation Required	483	0	483
DEL IFRS16 Leases Depreciation	2,956	0	2,956
Total DEL Anticipated Funding	**3,439**	**21,420**	**24,859**
AME Forecast Donated Asset Depreciation	342	0	342
AME Impairment Funding	1,350	0	1,350
AME Reversals of Impairment Funding	(15,279)	0	(15,279)
Total AME Anticipated Funding	**(13,587)**	**0**	**(13,587)**
Donated Granted Assets Credit	**(150)**	**0**	**(150)**
Total Forecast Anticipated Allocations	**(10,298)**	**21,420**	**11,122**

Table B2 – Pay & Agency (Section A)

This table has been completed in line with the guidance.

Table B3 – Covid-19

Total Covid-19 costs are shown as £73m and at this stage the Health Board is including expenditure with equivalent funding, these are full year forecasts unless otherwise stated:

- Testing - £4.070 in line with WG correspondence. The Health Board remains in discussion both internally and externally to clarify the potential level of funding. There is a financial risk of c.£1.56m, on top of this £4.070m, if the service continues at current forecast with the level of funding noted. This has been included as a risk but should be read in conjunction with the Testing return.
- Tracing - £6m
- Mass Vaccination - £9m
- PPE - £3.325m
- Extended Flu - £1.517m
- Cleaning standards - £2.491m
- Long Covid - £0.9m
- Nosocomial investigation - £0.8m, and,
- Other additional Covid-19 costs including those relating to emergency, patient acuity associated workforce pressures - £45m.

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 future months especially Q3 and Q4 will be reflected in future 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 as a result of covid, at this stage an amount is included for quarter 1, it is worth noting that following a lifting of the covid restrictions the Health Board has decreased the costs of Covid to reflect the change in visitors to the sites and therefore to the retail outlets within the sites, but, as stated above, this will be reviewed and updated. During month 5 the HB has reduced the forecast for covid prescribing costs based on the latest data.

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 additional costs for Velindre Covid (recovery or outsourcing) within these figures, this in line with the All Wales LTA agreement.

The Health Board continues to try to manage these costs downwards.

FDU Exceptional/Covid Template

This template has been completed in line with guidance. In response to **Action Point 4.5** energy costs have been updated linked to the NWSSP estimates. There was a delay in the month 4 forecast being received by the relevant Division which requires various checks and further analysis since some changes are required. To note NWSSP estimates do not cover the whole of the energy costs of the HB.

Estates & Facilities energy forecast is based on projections supplied by NWSSP along with actual costs incurred year to date (which vary slightly to estimates supplied by NWSSP). The forecast is made up of three components, the commodity element for British Gas contracted sites, which is provided by NWSSP and split out monthly. The non-commodity element for British Gas contracted sites, also provided by NWSSP, but only provided as an annual figure which requires some manual apportioning where we use the British Gas business intelligence tool in conjunction with the local energy manager.

Ringfenced & Other Template

In response to **Action Point 4.6** the template has been reviewed and is subject to further review. There are none or limited uncommitted spend plans. The Regional Partnership Board had instigated a process for the utilisation of its funding this is well under way and the funding is fully committed.

Committed plans have been received and are progressing for all other funding. It should be noted that Planned/Unscheduled Care sustainability are fully committed for a number of schemes whereby the majority of costs are either through fixed pay costs and/or commissioning/contractual expenditure.

All Regional Integration Fund (RIF) funding has now been committed due to the further development of the RPB strategic programmes that will utilise the previously

unallocated funding, specifically responding to the ministerial directive and national initiative to provide 1000 alternative beds. This means our Improving System Flow and Graduated Care Programmes have increased. It is intended that the capacity within these programmes will be implemented in time to generate some impact over the winter period and will therefore be reflected within Winter Plans.

2. Underlying Position (Tables A1)

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. This needs to be updated to reflect the substantial challenges materialising during the year.

Financial sustainability is an on-going priority and focus for the Health Board.

3. Risk Management (Table A2)

There are several significant challenges to the financial forecast for 2022/23, which include:

- Ensuring full delivery of the savings plans identified in the IMTP. The level of amber savings remains at £20m which are a significant risk and require firm plans,
- Identifying savings to mitigate any further financial risks identified outside of the IMTP and driven by operational pressures in urgent and emergency care, CHC and delayed transfer of care,
- Delayed Transfers of Care (DTOC) and delayed discharges related to social care delays,
- Quarter 2-4 additional Covid cost pressures, these relate to the likelihood of continued surge capacity, discharge support measures and increased enhanced care,
- Workforce absence / self-isolation / vacancies, availability of staff for priority areas,
- Responding to any specific Covid-19 impacts e.g., new variants, outbreaks,
- Anticipated levels of funding for exceptional cost pressures and covid responses, that the Health Board is currently assuming (£89m),
- Specific risk regarding forecast costs for testing above anticipated level of funding, the service leads and Senior Responsible Officer have been asked to review this forecast as a matter of urgency in liaison with WG as necessary (£1.56m),
- Funding for any wage award or change in terms and conditions,
- Responding to the ongoing impact of Covid-19 and associated preventative and public health services,
- Addressing backlogs in waiting times for services, due to the Covid-19 pandemic,

- Specific economic factors/Ukraine conflict issues such as energy costs, Monkey Pox, supply chain issues and non-pay inflation including travel expense costs, and
- Maximising the opportunity to transform services resulting in improved health outcomes for the population,
- Additional Welsh Risk Pool and/or litigation costs,
- Additional bank holiday costs,
- Potential industrial action,
- Availability of cash.

Managing the 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.

The level of risk to the position remains of extreme concern and the Health Board has initiated a process of financial recovery and 'turnaround' to assist the Health Board to de-escalate financial risks as well as mitigating as many operational and service risks as possible. Inevitably some risk will remain for issues relating to anticipated funding and specific areas such as expenditure linked to Ukraine re-settlement, monkey-pox and the action of social care partners to support earlier discharge.

The Board had its meeting on the 28th July stated its expectation for the organisation to take action to mitigate the financial risk, adopt a financial recovery turnaround approach with rigour and achieve break-even. The Board will again discuss the forecast position on the 28th September 2022.

4. Ring Fenced Allocations (Tables B, N & O)

The Health Board plans to fully utilise the ring-fenced funding in line with the requirements for each element.

Tables N (GMS) and O (Dental) will be completed from month 6.

5. Agency / Locum (Premium) Expenditure (Tables B2 Sections B & C)

Agency expenditure continues at the high level of previous months, it remains significantly higher than the average for 2021/22 and historical levels.

Agency expenditure across nursing and additional clinical services is predominantly linked to covering Covid absence, enhanced care as well as to cover additional service demands including ED, opening surge beds and step-down hospital beds linked to DTOC's. Medical agency expenditure is due to on-going elective recovery activity, vacancies, shielding and service pressures. The medical cover relating to Care of the Elderly consultants is a pressure which is now forecast to continue in the short to medium term. It is expected as part of mitigating actions that agency expenditure will decrease significantly in quarter 4 given the reduction in off-contract agency coupled

with conversion to substantive posts as part of the variable pay cost reduction programme and switching back to on contract agencies. This is in line with savings opportunities and Covid de-escalation.

6. Savings (inc Accountancy Gains & Income Generation) (Tables C, C1, C2 & C3)

As part of the IMTP submitted by the Board to Welsh Government (March 2022), the financial plan for 2022/23 identified a core savings requirement of £26.2m. As at Month 5 forecast achievement in 22/23 is £26.2m, however, this contains an extremely significant level of on-going risk to ensure full or part delivery.

Actual savings delivered to August amounted to £2.312m, compared with year to date planned delivery of £5.73m. The profile of savings expected to be achieved is significantly increased in later months.

To achieve a balanced core financial plan, the Health Board needs to ensure that savings 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. These risks appear to be emerging and are causing difficulties in converting opportunities to confirmed savings plans.

Savings schemes straddle transformational, transactional, and operational plans. Aligned to progressing the savings and mitigating actions a value focussed pathway approach is being employed. The Health Board has agreed priority areas for focussed support using a programme management approach with MDT support through an Executive lead, value, performance, workforce, service, planning and finance representation. These now need to be accelerated.

Further service initiatives are being developed to support upstream patient management and reduce pressure on acute services, aligned to the Clinical Futures 'Level 1' strategy. The Value Based Health Care team as part of the "AB Connect" function 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.

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. Furthermore, the Health Board is proceeding with a number of 'turnaround' actions which may result in additional savings plan to mitigate the extreme levels of risk. In addition to transformational changes are being sought.

The Chief Executive requested that all budget-holders to identify further cost reduction and savings opportunities during August as part of this focus on financial recovery. The list of these opportunities is being discussed which aims to prioritise and urgently agree key actions.

7. Income Assumptions 2021/22 (Tables D, E & E1)

Table D – Welsh NHS Assumptions

This table has been completed in line with the guidance. LTAs have been agreed and signed off by the 30th June deadline.

Table E - Revenue Resource Limit

The Month 05 financial position is based on total allocations of £1,571.0m, of which £1,465.1m are received and £105.8m are anticipated.

Allocations are anticipated on receipt of a notification from WG, including Policy Leads and finance colleagues. It should be noted that anticipated allocations have been made for 'Think 111' and End of life Care board based on 2021/22 correspondence. These will need to be confirmed with the relevant policy leads and in line with WG correspondence relating to Urgent Emergency Care allocations. The anticipated allocations include £40.7m for exceptional cost pressures as per those listed and a further £61.8m for Covid-19 pressures as listed below. A compiled list of anticipated allocations is included in Table E.

Type	Covid-19 Specific allocations - August 2022	£'000
HCHS	Tracing	2,867
HCHS	Extended flu	1,517
HCHS	Testing (inc Community Testing)	1,548
HCHS	PPE	695
HCHS	Mass COVID-19 Vaccination	1,331
GMS	Mass COVID-19 Vaccination	185
Dental	E1. Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS income	2,308
HCHS	Nosocomial investigation and learning	753
	Total Confirmed Covid-19 Allocations	**11,204**
HCHS	Testing (inc Community Testing)	2,522
HCHS	Tracing	3,133
HCHS	Mass COVID-19 Vaccination	7,484
HCHS	PPE	2,630
HCHS	Cleaning standards	2,491
HCHS	Long Covid	887
HCHS	A2. Increased bed capacity specifically related to C-19	10,749
HCHS	A3. Other capacity & facilities costs	7,061
HCHS	B1. Prescribing charges directly related to COVID symptoms	50
HCHS	C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance	14,609
HCHS	D1. Discharge Support	8,309
HCHS	D4. Support for National Programmes through Shared Service	0
HCHS	D5. Other Services that support the ongoing COVID response	1,911
	Total Anticipated Covid-19 Allocations	**61,836**
	Total Covid-19 Allocations	**73,041**

Type	Exceptional items allocations - August 2022	£'000
HCHS	Energy prices increase	33,945
HCHS	Employers NI increase	4,606
HCHS	Real living wage	2,154
	Total Exceptional items allocations (anticipated)	**40,705**

The anticipated allocation for testing has been reduced in line with correspondence but remains in discussion in WG given the UHB/WG assumptions differ.

In addition the CEO is expecting additional funding for WCCIS but is yet to receive confirmation of this, please can this be confirmed?

It is noted and appreciated that the Health Board is anticipating a material level of allocations and will work with WG colleagues to confirm as soon as possible. It would be helpful to receive a full list of anticipated allocations for NHS Wales as well as the expected issue date as a month 5 update.

8. Healthcare Agreements and Major Contracts

LTA agreements have been signed with all Welsh providers/commissioners in accordance with the DOF LTA Financial Framework for 2022-23. Initial performance data shows significant variation from baselines levels (both under and over performance) depending on the provider / commissioner.

Further work is ongoing to understand the performance variation by provider/commissioner and to understand the financial risk that may crystallise in future. Velindre forecasting remains a particular risk due to the implementation of the new commissioning currencies in 2022-23 and the volatility in NICE forecasting based on limited data received to date.

9. Statement of Financial Position and Aged Welsh NHS Debtors (Tables F & M)

Table F – Statement of Financial Position

This table has been completed for month 5. The main changes in the balance sheet from the previous month relate to:

- An increase in Clinical Negligence provisions in month based on the information provided in the quantum report with an associated increase in the income anticipated from the Welsh Risk pool.

- An increase in trade and other payables mainly due to the liability for IFRS 16 lease payments partially offset by a decrease in Non-NHS accruals.

Table M - AGED WELSH NHS DEBTORS

At the end of August 2022, the Health Board had 3 invoices outstanding with other Welsh Health Bodies over 11 weeks old, totalling £8,928.

Cardiff & Vale University Health Board – 1 invoice with a value of £4,158. We have been liaising with Cardiff to ascertain a confirmed payment date.

Health Education and Improvement Wales - 2 invoices outstanding totalling £4,770. We have provided the additional information requested in relation to these 2 outstanding invoices and are liaising with HEIW to ascertain for a confirmed payment date.

10. Cash Flow Forecast (Table G)

The cash balance held at the end of August is £4.119m which was made up of £1.862m relating to revenue and £2.257m relating to Capital. The balance held is within the advisory figure set by Welsh Government of £6m.

In response to **Action-point 4.4** we have updated the presentation of the amounts reported in Table K, so that they match the amounts reported in Table G.

Table K previously only reflected the Net Sales Receipts figure but has been updated to reflect the Gross amounts for both Sales Receipts and Cost of Disposals in each month.

The same figures are reported in Table G by the amounts shown on Line 9 – Sale of Assets and Line 22 – Other items (Line 22 is the cost of disposal amount).

The net forecast total of Line 9 and Line 22 (£498k - £98k = £400k) matches the total forecast Gain reported in Table K (£400k).

11. Public Sector Payment Compliance (Table H)

This table is not required for month 5.

12. Capital Schemes & Other Developments (Tables I, J & K)

Table I has been completed in line with the latest CRL issued on 7th September 2022.

AWCP Schemes

Table J indicates a validation error against Grange University Hospital and NHH Enabling works minimum in year forecast. This is due to the current YTD spend being more than the minimum spend forecast. The GUH scheme is expecting a large VAT recovery in the final quarter of 2022/23 which will offset the expenditure during the first three quarters. As the budget is a credit allocation of £394k, this validation error will remain until the VAT recovery is achieved in Q4. The VAT recoveries expected for the NHH SRU scheme will be actioned in September.

Grange University Hospital Remaining Works

The works to the Same Day Emergency Care Unit, Resus, and CAEU have all completed during August. All Laing O'Rourke works are now complete, and the final account is being agreed. Tenders for the Well-being works to Grange House have been received. The works are slightly delayed due to bat requirements (estimated completion April 2023). The additional works costs are being offset by the final VAT recovery claim (£3.5m) due in the last quarter of 2022/23. The Health Board's VAT advisors are currently working with HMRC and the external cost advisors to expedite the VAT recovery claim and mitigate the risk that an agreement is not reached in the current financial year.

Tredegar HWBC

The works at Tredegar H&WBC are continuing. The handover of the building is now expected to be delayed to May 2023 due to the supplier cancellation of the brick order for the façade. There continues to be significant cost risks to the scheme including the re-design of the foundations (potential additional £750k), EV charging points (not a requirement at Design Stage), culvert diversion, Heart building stabilisation, brick supply cancellation and SCP market price escalation. This position is being monitored carefully with a view to managing from within the existing approved budget. A further funding bid may be required in future if the price escalation costs cannot be managed from within the current sum approved. Any potential overspend is expected to impact in 2023/24.

2022/23 actual expenditure is consistently behind the revised cash flow profile submitted by the contractor in June. This is in part due to the cost advisor withholding £612k plus VAT from the August valuation. A meeting will need to be convened in September to resolve the issues concerning the disputed sums within the August application. A revised cashflow for 2022/23 will also be requested to reconfirm the forecast outturn position.

NHH Satellite Radiotherapy Centre

The FBC is complete and has been submitted to Welsh Government capital colleagues for scrutiny and approval.

YYF Unified Breast Unit

Site set up works were stopped because of the contractor not signing the originally proposed fixed price contract that had been developed (concerns around the current inflationary pressures). Several months of discussions between relevant stakeholders reached a conclusion during August following the resolution of the final outstanding issues by the contractor. The Cost Advisors have reviewed and agreed the revised proposed Target Cost with the contractor and are now developing the expenditure profile for this financial year. The additional cost requirement over and above what is already approved has been calculated as £778k; it has been agreed in principle that WG will provide funding for this, subject to Ministerial approval (which is currently awaited). It is proposed that works re-commence on site as soon as possible, hopefully before the end of September.

Newport East HWBC

Works are ongoing, with the old MUGA already removed and the groundworks for the replacement MUGA currently in progress. Other works and infrastructure for the external areas including the car park and access roads are progressing well. A revised cash flow profile for the current year will be provided by the Cost Advisors in September, once the contractor has provided their detailed analysis. At this stage it is anticipated that the full allocation for 2022/23 will be spent by 31st March. The credit in the MMR tables for August was due to an over accrual in month 4 which has now been corrected.

Fees for MH SISU

The OBC preparation has been delayed due to work pressures on the operational staff involved in the project. The OBC is now anticipated to be submitted in November 2022 for Board approval.

Covid-19 Recovery Schemes

Most of the Covid Recovery allocation relates to the on-going SDEC works at the Grange University Hospital which are now complete. The remaining allocations relate to equipment and IT allocations that could not be delivered before 31st March 2022 for which final costs are awaited.

Imaging National Programme

The National Imaging Programme funding has been reduced by £491k in month to £4.195m because of savings generated on equipment purchases and works costs. The spend in the current year includes the replacement of two CT Scanners (NHH / RGH), the installation of three general rooms and the recently approved replacement of essential ultrasound equipment. All schemes are on track to achieve the forecast outturn before the end of March 2023.

Digital Eye-Care

All orders have been raised in relation to this slippage allocation, with most deliveries complete. Full spend is expected to be achieved. A further funding allocation is expected in relation to the 2022/23 implementation costs.

EFAB – National Programme Infrastructure

The small slippage allocation in relation to the lift replacement scheme is expected to be fully spent during quarter three, with a small amount of fees outstanding currently. A small overspend is anticipated due to an increase in project management costs.

NHH SRU Enabling Works

Scheme completion was achieved in May. The final account is being agreed with the contractor. The credit expected in September to bring the project expenditure back within budget relates to VAT recoveries.

SDEC Equipment Funding

The allocation of £79k relates to equipment that could not be delivered prior to 31st March 2022. Most of the remaining items have now been received with a small amount expected by September.

ICF Discretionary Funded Schemes
Full spend is expected to be achieved on these small schemes during the year.

RGH Endoscopy Unit
The RGH Endoscopy scheme works commenced on site on 15th August 2022. An updated cashflow has been requested from the contractor to reconfirm the 2022/23 expected outturn position.

DPIF - Digital Medicines Transformation Portfolio
Full spend is expected to be achieved in the current financial year.

Discretionary Capital Programme (DCP)

The Health Board Discretionary Capital Programme (DCP) forecast outturn for 2022/23 is £6.589m funded by:

- 2022/23 DCP Funding - £8.227m (a reduction of 24% compared to 2021/22)
- RGH Endoscopy fees reimbursement - £207k
- Grant funding received (Sparkle and R&D) - £32k
- Less AWCP scheme brokerage & 2022/23 overspends – (£1.877m)

The opening 2022/23 DCP was approved at the March board meeting. Expenditure has now commenced against these schemes. It should be noted that £715k in relation to RGH reconfiguration works (originally planned for the 2021/22 Covid Recovery allocation) has been approved into the UHB's 2022/23 DCP to allow the works to complete in the current financial year.

In addition, the current approved programme includes allocations for:

- Statutory, Asbestos & Fire Safety Works - £676k
- Duct works at St Cadoc's - £175k
- Refurbishment of Clinical Rooms at Pengam HC -£107k
- Mental Health Estates improvements (including anti-ligature works and compliance with Smoking legislation) - £341k
- Digital Priorities and Sustainability - £2,733k
- Replacement Equipment - £387k
- Funding contributions to AWCP schemes (e.g., NHH Cancer Centre Development and RGH Decontamination) - £658k

The unallocated contingency budget as at the end of August is £531k.

Risks of Capital Constraints 2022/23

The significant pressures on capital funding for 2022/23, in the context of the high demands for capital, has required a more robust prioritisation and risk management approach. The following risks were identified in the Opening Capital Programme Board report in March 2022:

- Statutory requirements in Asbestos Management and MH&LD smoking shelters/areas have been phased over a 2-year affordable period. This ensures that the Health Board commits to commencing the works, meeting its obligation of compliance. It should be noted that plans were in place to increase funding for backlog maintenance to £820k which has not been possible due to the reduced DCP funding available and therefore will delay addressing the risks associated with the existing condition of the estate.

- The delay in replacement of equipment which is past its manufacturer's life expectancy will increases the risk of failure or breakdown with possible impact or difficulties to efficient service provision.

- The lift replacement programme will need to be delayed, requiring the lifts to work further past their expected life span. This will possibly impose delays to the efficiency of the service and additional cost to the day-to-day revenue costs depending on breakdown and maintenance callouts.

- The informatics programme will need to be prioritised based on maintaining a safe and reliable ICT service to the Health Board which includes cyber security risks/vulnerability, legal and regulatory compliance risks. This will result in reduced funding for refresh of key infrastructure potentially reducing the reliability of IT across the Health Board. This also limits the opportunity for any further projects and transformation programmes that require capital investment. Alternative funding opportunities to help address the shortfall in capital will need to be reviewed to reduce the risk.

- The reduced funding position also limits the opportunities for service improvement and transformation that supports the Health Board strategic programmes.

Increased capital availability later in the financial year, whilst supporting the significant demand for capital, is also restrictive in terms of addressing priorities due to planning timescales for key projects and increased supplier lead times.

13. Other Issues

Risk Management

Claims submitted to the Welsh Risk Pool at the end of August 2022 total £4.422m. Claims paid out at the end of August equate to £3.107m leaving a balance of £1.315m to be reimbursed.

Creditors

Attached to the returns is a separate file containing the following information in relation to outstanding creditors:-

- All outstanding creditors we currently have identified with other Welsh Health bodies as of 9th September 2022.

- Response to the month 04 list of creditors circulated as part of the monthly reply letter.

14. Authorisation

Financial Performance is reported consistently in Board papers and external reporting including the MMR, however, internally these are presented in a more user-friendly way. The MMR Narrative and key tables are submitted for review to Finance and Performance Committee, as a sub-committee of the Board.

The dates for the Finance and Performance Committee meetings are:

- 5th October, and
- 11th January 2023.

In accordance with the MMR guidance, the Health Board will endeavour to ensure that the MMR submission is agreed, and the narrative signed by two parties, by the Chief Executive and the Director of Finance. Where timescales and availability prevent this the Deputy Chief Executive will sign on behalf of the Chief Executive and the Deputy / Assistant Director of Finance (Financial Planning) will sign on behalf of the Director of Finance.

Robert Holcombe
Interim Director of Finance, Procurement and Value
Cyfarwyddwr cyllid a chaffael dros dro

Nicola Prygodzicz
Chief Executive Officer
Prif Weithredwr

Submitted with this report are:

- Monthly Monitoring return Tables
- Test, Trace & Protect Pro-Forma
- Mass Vaccination Pro-Forma
- All outstanding creditors we currently have identified with other Welsh Health bodies as of 9th September 2022, and the
- Response to the month 04 list of creditors circulated as part of the monthly reply letter.

Appendix 1

Aneurin Bevan Health Board

Monthly Monitoring Returns – Current Period Action Points 2022/23

Month	Action Point	How responded to
2021/22 Month 12		
12.1	It is noted however, that the NHS payment performance fell below the best practice at 87.0%. I trust that solutions will be implemented which will result in 95% being achieved in 2022/23.	See Commentary
12.2	In respect of outstanding NHS invoices, Organisations are being reminded that payment for fully agreed invoices should be received within 4 weeks following the AOB exercise or sooner, if they exceed 17 weeks before the 4-week deadline.	Noted
Month 1		
1.1	You are requested to review and ensure that your costs align to the criteria set out in the IMTP Planning Assumption letter dated 14th March 2022 and at Month 2, reflect the recent guidance issued under the 'Covid De-escalation' letter dated 20th March 2022. The FDU will also be undertaking further challenge on your assumptions in due course.	See Commentary
1.2	Also of concern, is the significant level further potential risks of £25.392m and I note that you have reported a further 11 risks with a 'TBC' value. It is important that you take a balanced approach to the reporting and quantification of Risks, noting that it is expected that the organisation would be required to identify mitigating Opportunities. This area of your submission requires an urgent review in order to drive down the level of risk to your position from the very beginning of this new financial year.	See Commentary
1.3	Please adjust the phasing of your Revenue Resource Limit (RRL) to smooth the impact of the Savings Plan profile (line 8) to ensure the total Opening Plan (line 14) is balanced to zero on a YTD basis at Month 2 and also each future month. Only net pressures above the Plan should be reflected in the YTD position (e.g., line 26) and the organisation will need to reflect on the delivery and recovery profile, of additional mitigating actions to offset these pressures.	See Commentary
1.4	The Identified Savings Plans are already reporting nil delivery against five schemes yet these have already been replaced with alternative 'In Year' schemes in April with the same total value. The original schemes have start dates recorded; therefore, please clarify if these are potentially available, in addition, this year. Alternatively, if this is simply a completion issue (you wished to record the original schemes to maintain a link to Plan but the alternative schemes are a reflection of the finalised schemes) you can either 1) remove the original schemes and change the 'In year' schemes marker to 'Month 1'; or 2) continue to report the material movement for the rest of the year.	Noted
1.5	I note that you are choosing to record the recurrent savings of £18.102m and new unmitigated recurring cost pressures of £5.324m to arrive at the forecast	See Commentary

	position of £8.136m. This could be intentional, and you wish to report that you have invested without a source of funding (full details will then be sought); or perhaps, it is more applicable to show the net improvement in the recurrent savings column only. Please review for Month 2 and increase the level of supporting detail in your narrative, as this may have provided greater clarity on the above. The narrative should discuss the current year to date achievement and future delivery assumptions.	
1.6	The Savings Plans at Month 1 are assessed as 78% Amber and you are reporting a material Risk of Non Delivery of £6.932m. The movement to a Green assessment within the 3-month deadline should significantly reduce your assessment of risk; however, in the meantime, please continue to review and revise this assessment.	See Commentary
1.7	Please ensure that any Risks reported in Table A2 at Month 2 (after your review) are separately listed, please do not use one line to consolidate numerous material risks.	Noted
1.8	There are four Amber schemes in the Savings Tracker, with a forecast delivery of £4.207m, that have a 'go green' date in October 2022. Please be reminded that the WHC requires Amber schemes to move to the Green status within 3 months of first being included within the Tracker (Table C3). The 'Go Green' date must therefore fall within that requirement. Please take this opportunity to review and if applicable amend the 'Go Green' date' before Month 2.	See Commentary
1.9	I note that you are anticipating funding of £2.812m on line 17 of Table E for Real Living Wage. The FDU Template shows the Social Care element as £2.154m and this is the value we would expect to see recorded, at this stage on line 17. The 22/23 NHS associated pay award costs and corresponding funding assumptions should be excluded until the outcome of the pay negotiation exercise. Therefore, please leave this section of the FDU form blank for the time being.	Noted
1.10	In relation to the unpaid invoices listed on Table M; the deadline for receiving payment for any invoices raised pre-April 22, was May 20th. I trust therefore at M2, that there will be no 21/22 invoices included in Table M.	See Commentary
1.11	All organisations are being requested to provide the following information on the Annual Leave Accrual within the Month 2 narrative: 1) b/f Opening Annual Leave Accrual value 2) remaining Annual Leave Accrual balance after 'Sell Back'	See Commentary
1.12	As you are aware, the costs of the Extended Flu Programme (for all applicable age groups) should be included in your Table B3 in 2022/23 and you can anticipate Covid funding (the allocations will be confirmed in due course and therefore this is not anticipated at risk). During this year, should any funding for policy areas be confirmed as recurrent from 23/24, please continue to record them as non-recurrent this year; when issued recurrently, they become Operational in 23/24.	Noted
1.13	Please be advised that the non recurrent Dental Income target funding should be treated as Covid-19 and the corresponding expenditure included in table B3.	Noted
1.14	The 21/22 Bands 1 & 2 uplift (which will be issued in due course) of £0.152m, can be included on a sperate line on Table E.	Noted
1.15	In order to better align non-programme Covid-19 funding assumptions against the 'Other' analysis reported within the FDU template; all organisations are being requested to split their income assumptions across the below categories within the Covid-19 section of Table E/Table E1. The lines below will be linked to consolidation tables in our internal systems; therefore, please do not use these lines for any other income items. To reduce error, we suggest you add the narrative descriptions below in your Table E/E1 at M2 and if there is no corresponding funding request, then simply leave the value cell blank.	Noted
1.16	I refer to the email dated 26th May from Richard Dudley, which advises the removal of the R&D uplift from Table E, as this is being issued via the Grants process.	Noted
1.17	Thank you for providing the additional Appendix setting out all of the Anticipated Income items (due to limitation of lines on Table E). Until the number of items reduce, please may I request that you only set out in Appendix 2 the items that you have consolidated under one line on Table E, rather than replicate the entire list.	Noted
Month 2		

2.1	I acknowledge the update provided in relation to the internal discussions and look forward to receiving a comprehensive update at Month 3, including clarification of the status of the Plans and mitigating actions.	See Commentary
2.2	All organisations have been requested to fully review and re-evaluate the forecast Covid expenditure (Table B3) in line with the de-escalation guidance and to ensure they are compliant with the additional guidance, shared at the June Directors of Finance Meeting, in relation to the expected categorisation between Covid & Operational spend.	See Commentary
1.3	The issues raised at Month 1 (Action Point 1.3) in relation to the phasing of your planned monthly deficits, remain outstanding. I note your comments that you will address this and look forward to seeing this being actioned for Month 3, so that focus is moved to delivery.	See Commentary
1.13	I note the release of £2.778m (in addition to the sell back value) from the Annual Leave Accrual at Month 2, you confirm this reflects the costs in M1-2 of covering staff who have taken leave c/f from 21/22. Please confirm in your narrative if you release the provision further, in the coming months, so we can update our records.	See Commentary
2.3	The table below shows an extract of the changes made to your SoCNE since Month 1, with the material values highlighted. A number of Health Boards generate similar information in table format and provide supporting explanations for all material movements (in month, future profile and forecasts) as a matter of routine in their narrative, to reduce the number of queries. This may be something you wish to consider and is likely already used to inform your internal reports and discussions. Please provide a supporting explanation for the profile and forecast movements (below) in the following areas: o Primary care contractor (Action Point 2.3a) o Provider services - Pay (Action Point 2.3b) o Provider Services – Non-Pay (Action Point 2.3c) o Secondary Care – Drugs (Action Point 2.3d)	See Commentary
2.4	Following a further review of the 'Month 1' Amber schemes with a forecast delivery, there are now only 3 schemes which are not due to 'go green' until the period of October. There is also 1 'in-year' scheme with an October date. Please again review these schemes and provide an explanation.	See Commentary
2.5	I note that you are recording the YTD Loss of Dental Income to be £0.516m on Table B3 but a higher value is recorded on the Covid Other Template (£0.664m). The future month profile is also inconsistently reported across the two templates.	See Commentary
3.1	Whilst I note that you are continuing to forecast financial balance, the additional requirement reported this month to mitigate further annual pressures of £19.0m (currently reported as non-recurring) above the IMTP, is a significant concern. The balanced outturn is also reliant on the original 'finalised' Savings Plan of £26.2m which has a revised delivery profile weighted towards the last quarter of the year, with c £20m of those schemes currently assessed as 'Amber', which presents a material risk. The Health Board also has, by far, the highest assessment of 'local' Covid costs, for which funding is assumed at Risk. Your supporting narrative on the actions being taken is acknowledged and I look forward to receiving a full update at Month 4.	See Commentary
3.2	Whilst I note the movements of spend between Covid categories at Month 4, all organisations are again requested to fully review the forecast Covid expenditure (Table B3) for Month 4.	See Commentary
3.3	Please reflect the impact of the movement to the latest WRP risk sharing position in your Table A at Month 4.	Noted
3.4	In relation to the additional annual cost pressures of £19.0m; whilst I note the broad headings described in the narrative, please separately quantity each of the pressures for Month 4. This will enable greater clarity on which lines the costs are recorded in the SoCNE and where you have reflected the mitigating actions still to be finalised (we have assumed this is temporarily within your Non-Pay line).	See Commentary
1.3	The issues raised at Month 1 (Action Point 1.3) in relation to the phasing of your 'Planned' monthly deficits, remain outstanding. I note your comments that you will address this issue and I look forward to seeing this being actioned for Month 4, so that focus is moved to the delivery and the new issue this month of the £19m.	See Commentary

3.5	Following WHSSC increasing the risk sharing surplus from c. £.0.500m to c. £8.400m at Month 3; please confirm how your share of this surplus has been reflected within your forecast outturn.	See Commentary
3.6	It is disappointing to note that payment performance is below expectations for both NHS & Non NHS invoices. Your supporting narrative is noted, and I look forward to seeing you deliver an improvement next quarter.	Noted
3.7	Thank you for providing an update on the Annual Leave Accrual balance at Month 3; please continue to provide this as a standard item in your main narrative going forward.	See Commentary
Month 4		
4.1	...significant concerns have been raised at the recent 'Deep Dive' session in August. These, in summary, relate to the additional in year Operational Pressures of £19m for which there are currently no finalised plans to mitigate; the extent of the additional risks reported, and the revised delivery profile of your original 'finalised' Savings Plan of £26.2m which is weighted towards the last quarter of the year, with c £20m of those schemes currently assessed as 'Amber'. Your supporting narrative, on the actions being taken via the Board, is acknowledged. Significant evidence of deliverable actions is required, to support the continued balanced outturn. I look forward to seeing the results from the Divisional\Directorate savings exercise, in the Month 5 submission.	See Commentary
4.2	The outturn is also based on your assumed receipt of Welsh Government funding totalling £66.190m for Covid-19 Expenditure and £22.860m for Operational Exceptional costs (Energy, Employers NIC increase and the Real Living Wage). The funding for Covid non-programme areas and Operational Exceptional costs, is anticipated at risk (via Table A2). The funding for Q1 Covid Programme areas, has since been issued. Whilst I acknowledge the movements reported since Month1, your Health Board remains a material outlier regards the extent of your Covid expenditure. As discussed at the recent DoFs/DDoFs meeting, all organisations are again requested to fully review the forecast Covid expenditure (Table B3) for Month 5.	See Commentary
4.3	Whilst discussions progress on the Annual Leave Principles for 22/23, organisations are requested to consider if their accrual values contain any possible opportunity (gain) – this may be because new information suggests that the original accrual was perhaps generous or because new information suggests that elements will not require backfill costs to be incurred. The Provision should only be released to mitigate the sell back costs or to mitigate any true backfill costs of staff taking back the leave c/f. Please provide a statement in your narrative each month to confirm that the releases to date (c £6m) are to mitigate only those costs. I look forward to receiving a further update at Month 5.	See Commentary
3.3	I note you have included the impact of the updated WRP risk sharing value in Table A, and you state the value in Table E will be updated at Month 5.	Noted
3.4	In relation to the c£19m additional Operational Pressures; I acknowledge the high level summary provided this month. Please include the further detailed analysis (which you recognise would be provided after the Deep Dive session in August) in the narrative going forward.	See Commentary
1.3	Whilst I acknowledge that you continually reference the outstanding action from AP 1.3 in your narrative, it will be referenced in this reply letter until addressed	Noted
3.5	I note your response to AP 3.5 which quotes 'WHSSC risk sharing surplus has been recognised in the forecast at month 4, however, the UHB has also recognised an increased Velindre NICE drugs forecast which largely offsets said benefit, this is reflective of the approach to risk and opportunity management of the UHB'. The WHSSC movement was a material item (£0.885m) and therefore it is appropriate that both this benefit and the new Velindre Drugs pressure, are shown on Table A in separate free text lines (this also provides greater clarity of the profile of material issues).	See Commentary
4.4	Please review the asset sales receipts values of £0.306m reported in Table G and £0.249m reported in Table K; and ensure consistency going forward.	Noted
4.5	I note that your exceptional energy costs value remained unchanged at c16.100m (all other organisations materially increased their forecast in line with the latest data from NWSSP). Your narrative states your value was updated at Month 4 but that you have taken into account actuals, whereas the NWSSP estimate was based on averages. Please review and quote the value in the narrative each	See Commentary

	month (as part of your paragraph supporting this issue) so that we can easily ascertain if no movement in the template means there is an error or is deliberate.	
4.6	...For Month 5, Health Boards are again requested to review the data being presented and to ensure that sufficient supporting information is provided in the narrative i.e., comments are required for all committed spend detailing why it is categorised as such (fixed e.g., Contracts in place etc).	See Commentary
4.7	Please include the IFRS 16 Depreciation for agreed Transitioning Leases (£2.933m) and the Recovery (£2.956m) in the applicable tables for Month 5.	See Commentary

Welsh Government Month 5 Monthly Monitoring Return (MMR) extract tables

Aneurin Bevan ULHB

Period : Aug 22

Summary Of Main Financial Performance

Revenue Performance

		Actual YTD £'000	Annual Forecast £'000
1	Under / (Over) Performance	(17,440)	(0)

Aneurin Bevan ULHB **Period : Aug 22**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 14 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG
Lines 1 - 14 should not be adjusted after Month 1

		In Year Effect	Non Recurring	Recurring	FYE of Recurring
		£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-20,914	0	-20,914	-20,914
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-89,820	0	-89,820	-89,820
3	Planned Expenditure For Covid-19 (Negative Value)	-73,978	-73,978		
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	83,996	0	83,996	83,996
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	73,978	73,978		
6	Planned Provider Income (Positive Value)	500	0	500	500
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0
8	Planned (Finalised) Savings Plan	26,238	8,136	18,102	18,102
9	Planned (Finalised) Net Income Generation	0	0	0	0
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
12		0	0		
13	Planning Assumptions still to be finalised at Month 1	0	0		
14	**Opening IMTP / Annual Operating Plan**	**0**	**8,136**	**-8,136**	**-8,136**
15	Reversal of Planning Assumptions still to be finalised at Month 1	0	0	0	0
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)	0	0		
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	400	400		
18	Other Movement in Month 1 Planned & In Year Net Income Generation	0	0	0	0
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-3,661	231	-3,892	-3,682
20	Additional In Year Identified Savings - Forecast	3,661	149	3,512	3,681
21	Variance to Planned RRL & Other Income	0	0		
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 (Positive Value - additional)	-938	-938		
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0		
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	938	938		
25	In Year Accountancy Gains (Positive Value)	0	0	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	0	0		
27	Savings plans / mitigating actions to be finalised	21,198	21,198		
28	In-month operating pressures	-21,505	-21,505		
29	WRP updated risk share position (Month 4)	-94	-94		
30	WHSSC performance	-885	-885		
31	Velindre NICE increased expenditure	885	885		
32		0	0		
33		0	0		
34		0	0		
35		0	0		
36	**Forecast Outturn (- Deficit / + Surplus)**	**0**	**8,516**	**-8,516**	**-8,136**
37	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**			
38	**Operational - Forecast Outturn (- Deficit / + Surplus)**	**0**			

Aneurin Bevan ULHB **Period : Aug 22**

Table A1 - Underlying Position

This Table is currently showing 0 errors

	Section A - By Spend Area	IMTP Underlying Position b/f £'000	Full Year Effect of Actions: Recurring Savings (+ve) £'000	Full Year Effect of Actions: Recurring Allocations / Income (+ve) £'000	Subtotal £'000	New, Recurring, Full Year Effect of Unmitigated Pressures (-ve) £'000	IMTP Underlying Position c/f £'000
1	Pay - Administrative, Clerical & Board Members	(185)	85		(100)		(100)
2	Pay - Medical & Dental	(8,793)	7,598		(1,195)		(1,195)
3	Pay - Nursing & Midwifery Registered	(5,238)	3,772		(1,466)		(1,466)
4	Pay - Prof Scientific & Technical	(257)	126		(131)		(131)
5	Pay - Additional Clinical Services	(500)	300		(200)		(200)
6	Pay - Allied Health Professionals	(0)			(0)		(0)
7	Pay - Healthcare Scientists	(115)	111		(4)		(4)
8	Pay - Estates & Ancillary	(513)	347		(166)		(166)
9	Pay - Students	0			0		0
10	Non Pay - Supplies and services - clinical	(1,937)	200		(1,737)		(1,737)
11	Non Pay - Supplies and services - general	(740)	240		(500)		(500)
12	Non Pay - Consultancy Services	0			0		0
13	Non Pay - Establishment	0			0		0
14	Non Pay - Transport	0			0		0
15	Non Pay - Premises	(0)			(0)		(0)
16	Non Pay - External Contractors	0			0		0
17	Health Care Provided by other Orgs – Welsh LHBs	(1,400)	0		(1,400)		(1,400)
18	Health Care Provided by other Orgs – Welsh Trusts	0			0		0
19	Health Care Provided by other Orgs – WHSSC	(1,979)			(1,979)		(1,979)
20	Health Care Provided by other Orgs – English	0			0		0
21	Health Care Provided by other Orgs – Private / Other	744	0		744		744
22	**Total**	**(20,914)**	**12,779**	**0**	**(8,135)**	**0**	**(8,135)**

	Section B - By Directorate	IMTP Underlying Position b/f £'000	Full Year Effect of Actions: Recurring Savings (+ve) £'000	Full Year Effect of Actions: Recurring Allocations / Income (+ve) £'000	Subtotal £'000	New, Recurring, Full Year Effect of Unmitigated Pressures (-ve) £'000	IMTP Underlying Position c/f £'000
1	Primary Care	(3,152)	138		(3,014)		(3,014)
2	Mental Health	508	0		508		508
3	Continuing HealthCare	5,915			5,915		5,915
4	Commissioned Services	(1,400)	0		(1,400)		(1,400)
5	Scheduled Care	(14,418)	10,366		(4,052)		(4,052)
6	Unscheduled Care	(4,700)	1,203		(3,497)		(3,497)
7	Children & Women's	(1,977)	764		(1,213)		(1,213)
8	Community Services	0			0		0
9	Specialised Services	(1,979)			(1,979)		(1,979)
10	Executive / Corporate Areas	597			597		597
11	Support Services (inc. Estates & Facilities)	(308)	308		0		0
12	**Total**	**(20,914)**	**12,779**	**0**	**(8,135)**	**0**	**(8,135)**

Aneurin Bevan ULHB

Period : Aug 22

	Table A2 - Overview Of Key Risks & Opportunities	FORECAST YEAR END £'000	Likelihood
1			
2			
3			
	Risks (negative values)		
4	Under delivery of Amber Schemes included in Outturn via Tracker	(19,869)	High
5	Continuing Healthcare		
6	Prescribing		
7	Pharmacy Contract		
8	WHSSC Performance		
9	Other Contract Performance		
10	GMS Ring Fenced Allocation Underspend Potential Claw back		
11	Dental Ring Fenced Allocation Underspend Potential Claw back		
12	Operational pressures requiring mitigation actions	(19,000)	High
13	Additional Covid costs q3 -q4 not assumed in covid response	(8,000)	High
14	Addressing backlogs		
15	Funding for exceptional cost pressures	(40,705)	High
16	Funding for local Covid response	(45,180)	High
17	Funding for National Covid response	(16,656)	Low
18	Wage award / terms & conditions changes	TBC	Low
19	Further inflationary impacts	TBC	High
20	CHC rates for Domcilliary care	TBC	High
21	Supply chain issues	TBC	High
22	Costs relating to conflict in Ukraine	TBC	High
23	Testing forecast above assumed funding level	(1,560)	High
24			
25			
26	**Total Risks**	**(150,970)**	
	Further Opportunities (positive values)		
33			
34	**Total Further Opportunities**	**0**	
35	**Current Reported Forecast Outturn**	**(0)**	
36		**(0)**	
37	**Worst Case Outturn Scenario**	**(150,970)**	
38	**Best Case Outturn Scenario**	**(0)**	

Aneurin Bevan ULHB

Table B - Monthly Positions — **Period :**

This Table is currently showing 0 errors

	A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income		1 Apr £000	2 May £000	3 Jun £000	4 Jul £000	5 Aug £000	6 Sep £000	7 Oct £000	8 Nov £000	9 Dec £000	10 Jan £000	11 Feb £000	12 Mar £000	Total YTD £000	Forecast year-end position £000
1	Revenue Resource Limit	Actual/Forcast	129,487	131,258	127,894	124,832	128,566	117,469	133,092	133,486	134,765	136,685	136,329	138,164	642,606	1,570,997
2	Capital Donation / Government Grant Income (Health Board only)	Actual/Forcast	0	0	0	0	150	0	0	0	0	0	0	0	150	150
3	Welsh NHS Local Health Boards & Trusts Income	Actual/Forcast	1,857	1,808	1,728	1,786	1,950	2,000	2,000	2,000	2,000	2,000	2,000	2,000	9,110	23,110
4	WHSSC Income	Actual/Forcast	621	659	840	813	1,119	833	833	833	833	833	833	837	4,490	10,325
5	Welsh Government Income (Non RRL)	Actual/Forcast	(28)	214	727	187	21	67	67	67	67	67	67	7,278	1,129	8,800
6	Other Income	Actual/Forcast	6,139	4,919	5,897	6,029	6,889	6,200	6,200	6,200	6,200	6,200	6,200	6,200	29,963	62,362
7	**Income Total**		**137,203**	**138,958**	**137,084**	**132,648**	**136,883**	**125,569**	**141,192**	**141,586**	**142,865**	**143,765**	**144,429**	**153,479**	**682,857**	**1,675,743**
8	Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Actual/Forcast	14,731	15,648	15,694	14,239	15,588	15,260	15,260	15,058	15,058	14,010	14,010	16,055	75,900	180,602
9	Primary Care - Drugs & Appliances	Actual/Forcast	8,733	8,767	8,845	8,783	9,320	8,848	8,848	8,848	8,848	8,324	8,348	8,348	44,440	104,955
10	Provided Services - Pay	Actual/Forcast	55,828	57,512	56,156	55,972	55,212	55,817	56,659	56,659	57,154	55,864	55,943	55,872	283,680	674,649
11	Provider Services - Non Pay (excluding drugs & depreciation)	Actual/Forcast	11,736	10,945	12,076	10,090	10,968	11,516	12,042	12,449	12,739	12,596	12,963	12,886	55,819	142,910
12	Secondary Care - Drugs	Actual/Forcast	4,527	5,283	4,943	4,937	5,196	4,859	4,859	4,859	4,259	4,259	4,259	4,259	24,886	55,890
13	Healthcare Services Provided by Other NHS Bodies	Actual/Forcast	26,003	26,107	25,764	26,588	25,129	25,790	25,790	25,790	25,790	25,790	25,790	25,790	129,591	310,910
14	Non Healthcare Services Provided by Other NHS Bodies	Actual/Forcast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15	Continuing Care and Funded Nursing Care	Actual/Forcast	9,497	8,176	8,512	10,526	9,329	9,449	9,449	9,449	9,149	8,849	8,749	8,883	46,040	109,818
16	Other Private & Voluntary Sector	Actual/Forcast	1,113	1,076	1,164	974	1,092	842	842	842	842	842	842	8,853	5,413	18,618
17	Joint Financing and Other	Actual/Forcast	2,723	4,591	3,543	2,804	2,878	3,500	3,500	3,500	3,500	3,500	3,500	3,566	16,639	41,039
18	Losses, Special Payments and Irrecoverable Debts	Actual/Forcast	197	247	34	198	141	275	275	275	275	275	275	274	807	2,731
19	Exceptional (Income) / Costs - (Trust Only)	Actual/Forcast													0	0
20	Total Interest Receivable - (Trust Only)	Actual/Forcast													0	0
21	Total Interest Payable - (Trust Only)	Actual/Forcast													0	0
22	DEL Depreciation/Accelerated Depreciation/Impairments	Actual/Forcast	3,840	3,792	3,831	3,645	5,190	4,834	4,836	4,836	4,036	4,057	4,057	4,826	20,306	48,584
23	AME Donated Depreciation/Impairments	Actual/Forcast	28	28	28	28	28	(11,733)	28	28	28	29	29	(2,139)	141	(10,587)
24	Uncommitted Reserves & Contingencies	Actual/Forcast													0	0
25	Profit/Loss Disposal of Assets	Actual/Forcast	0	0	(26)	(155)	(60)	0	0	0	0	0	0	(127)	(271)	(450)
26	**Cost - Total**		**138,956**	**142,176**	**140,565**	**138,619**	**139,987**	**128,250**	**141,389**	**141,594**	**141,625**	**138,405**	**138,764**	**145,409**	**700,297**	**1,675,743**
27	**Net surplus/ (deficit)**	Actual/Forcast	(1,753)	(3,211)	(3,481)	(5,971)	(3,104)	(2,680)	(197)	(8)	1,234	5,360	5,664	8,071	(17,440)	(0)

	B. Cost Total by Directorate		1 Apr £000	2 May £000	3 Jun £000	4 Jul £000	5 Aug £000	6 Sep £000	7 Oct £000	8 Nov £000	9 Dec £000	10 Jan £000	11 Feb £000	12 Mar £000	Total YTD £000	Forecast year-end position £000
28	Primary Care	Actual/Forcast	32,356	33,535	33,524	32,088	34,953	33,338	33,600	33,948	33,000	32,599	32,599	34,163	165,636	397,027
29	Mental Health	Actual/Forcast	9,793	8,127	9,656	10,309	10,287	10,860	10,800	10,800	9,700	9,700	9,700	9,788	48,172	116,972
30	Continuing HealthCare	Actual/Forcast	5,758	6,336	4,934	6,211	5,497	5,717	5,717	5,717	5,717	5,695	5,695	5,649	28,596	68,405
31	Commissioned Services	Actual/Forcast	8,467	8,731	8,590	9,145	8,260	8,750	8,600	8,600	8,600	8,600	8,600	8,600	43,133	103,488
32	Scheduled Care	Actual/Forcast	21,347	21,517	20,887	21,545	22,615	21,441	21,361	21,438	21,438	21,095	20,995	20,853	107,311	255,873
33	Unscheduled Care	Actual/Forcast	15,022	15,096	14,916	15,409	14,360	15,060	14,700	14,550	14,936	14,399	14,500	14,788	75,623	179,369
34	Children & Women's	Actual/Forcast	10,436	10,579	10,399	10,516	10,247	10,360	10,300	10,300	10,109	9,600	9,600	9,568	52,177	125,757
35	Community Services	Actual/Forcast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
36	Specialised Services	Actual/Forcast	15,076	15,077	15,076	14,517	15,172	14,927	14,777	14,777	14,777	14,727	14,728	14,727	74,918	178,256
37	Executive / Corporate Areas	Actual/Forcast	8,609	11,259	9,896	7,298	6,176	8,560	9,155	8,978	8,978	8,455	8,455	15,663	43,148	111,251
38	Support Services (inc. Estates & Facilities)	Actual/Forcast	8,268	7,289	8,916	7,928	8,828	8,860	9,716	10,121	10,320	9,747	10,291	10,962	41,236	199,401
39	Reserves	Actual/Forcast	0	0											0	0
40	**Cost - Total (Excluding DEL & AME Non-Cash Charges)**	Actual/Forcast	**135,668**	**138,356**	**136,796**	**134,946**	**134,760**	**135,955**	**137,326**	**137,529**	**137,596**	**134,319**	**134,676**	**143,527**	**679,850**	**1,640,747**

C. Assessment of Financial Forecast Positions

Year-to-date (YTD)	£000	
28. Actual YTD surplus/ (deficit)	(17,440)	
29. Actual YTD surplus/ (deficit) last month	(14,336)	
30. Current month actual surplus/ (deficit)	(3,104)	
		Trend
31. Average monthly surplus/ (deficit) YTD	(3,488)	▲
32. YTD remaining months	(2,431)	

Full year surplus/ (deficit) scenarios	£000
33. Extrapolated Scenario	(39,105)
34. Year to Date Trend Scenario	(41,851)

D. DEL/AME Depreciation & Impairments

			1 Apr £000	2 May £000	3 Jun £000	4 Jul £000	5 Aug £000	6 Sep £000	7 Oct £000	8 Nov £000	9 Dec £000	10 Jan £000	11 Feb £000	12 Mar £000	Total YTD £000	Forecast year-end position £000
	DEL															
41	Baseline Provider Depreciation	Actual/Forcast	2,009	2,051	2,058	1,835	2,156	1,977	1,979	1,979	1,979	1,981	1,981	1,995	10,191	24,023
42	Strategic Depreciation	Actual/Forcast	1,741	1,741	1,741	1,760	1,760	1,760	1,760	1,760	1,760	1,779	1,779	1,779	8,743	21,122
43	Accelerated Depreciation	Actual/Forcast	0	0	40	50	51	51	51	51	51	51	51	48	141	483
44	Impairments	Actual/Forcast					1,231	246	246	246	246	246	246	247	0 1,231	0 2,956
45	IFRS 16 Leases	Actual/Forcast														
46	**Total**		**3,840**	**3,792**	**3,831**	**3,645**	**5,190**	**4,834**	**4,836**	**4,836**	**4,036**	**4,057**	**4,057**	**4,826**	**20,306**	**48,584**
	AME															
47	Donated Asset Depreciation	Actual/Forcast	28	28	28	28	28	28	28	28	28	29	29	29	141	342
48	Impairments (including Reversals)	Actual/Forcast	0	0	0	0	0	(11,762)	0	0	0	0	0	(2,167)	0	(10,929)
49	IFRS 16 Leases (Peppercorn)	Actual/Forcast													0	0
50	**Total**		**28**	**28**	**28**	**28**	**28**	**(11,733)**	**28**	**28**	**28**	**29**	**29**	**(2,138)**	**141**	**(10,587)**

Aneurin Bevan ULHB

Period : Aug 22

This Table is currently showing 0 errors

Table B2 - Pay Expenditure Analysis

A - Pay Expenditure		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	*TYPE*	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	8,657	8,598	8,788	8,614	8,769	8,500	8,705	8,705	8,800	8,571	8,571	8,570	43,426	103,848
2	Medical & Dental	13,160	13,581	12,736	13,187	12,929	13,150	13,301	13,301	13,451	13,250	13,278	13,250	65,593	158,574
3	Nursing & Midwifery Registered	18,220	18,922	18,453	17,992	17,677	18,350	18,550	18,550	18,700	18,550	18,600	18,550	91,264	221,114
4	Prof Scientific & Technical	2,202	2,215	2,189	2,146	2,139	2,250	2,250	2,250	2,250	2,090	2,090	2,090	10,891	26,161
5	Additional Clinical Services	8,591	8,990	8,701	8,747	8,661	8,600	8,850	8,850	8,950	8,600	8,600	8,600	43,690	104,740
6	Allied Health Professionals	3,290	3,367	3,335	3,308	3,245	3,300	3,300	3,300	3,300	3,150	3,150	3,150	16,545	39,195
7	Healthcare Scientists	939	1,025	1,043	1,038	1,079	963	1,000	1,000	1,000	950	950	950	5,124	11,937
8	Estates & Ancillary	3,044	3,406	3,312	3,360	3,361	3,300	3,300	3,300	3,300	3,300	3,300	3,300	16,483	39,583
9	Students	6	7	9	9	9	5	5	5	5	5	5	5	40	75
10	TOTAL PAY EXPENDITURE	58,109	60,111	58,566	58,401	57,869	58,418	59,261	59,261	59,756	58,466	58,544	58,465	293,056	705,227
	Analysis of Pay Expenditure														
11	**LHB Provided Services - Pay**	55,828	57,512	56,156	55,972	55,212	55,817	56,659	56,659	57,154	55,864	55,943	55,872	280,680	674,649
12	**Other Services (incl. Primary Care) - Pay**	2,281	2,599	2,410	2,429	2,657	2,601	2,601	2,601	2,601	2,601	2,601	2,592	12,376	30,577
13	**Total - Pay**	58,109	60,111	58,566	58,401	57,869	58,418	59,261	59,261	59,756	58,466	58,544	58,465	293,056	705,225

B - Agency / Locum (premium) Expenditure - Analysed by Type of Staff		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	*TYPE*	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	148	179	164	204	126	180	180	180	180	180	180	180	821	2,081
2	Medical & Dental	1,471	1,629	952	1,467	1,286	1,500	1,500	1,500	1,500	1,250	1,250	1,250	6,805	16,555
3	Nursing & Midwifery Registered	2,084	2,282	2,175	1,867	1,546	1,900	1,900	1,900	1,900	1,700	1,750	1,700	9,954	22,704
4	Prof Scientific & Technical	26	15	20	12	15	40	40	40	40	40	40	40	88	368
5	Additional Clinical Services	1,092	1,086	1,185	1,122	908	750	750	750	750	450	450	450	5,393	9,743
6	Allied Health Professionals	108	136	169	155	97	100	100	100	100	100	100	100	665	1,365
7	Healthcare Scientists	(18)	46	67	76	131	75	75	75	75	75	75	75	302	827
8	Estates & Ancillary	413	622	677	663	669	400	400	400	400	400	400	400	3,044	5,844
9	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE	5,324	5,995	5,409	5,566	4,778	4,945	4,945	4,945	4,945	4,195	4,245	4,195	27,072	59,487
11	**Agency/Locum (premium) % of pay**	9.2%	10.0%	9.2%	9.5%	8.3%	8.5%	8.3%	8.3%	8.3%	7.2%	7.3%	7.2%	9.2%	8.4%

C - Agency / Locum (premium) Expenditure - Analysed by Reason for Using Agency/Locum (premium)		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	*REASON*	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Vacancy	2,645	2,978	2,687	2,765	2,374	2,457	2,457	2,457	2,457	2,084	2,109	2,084	13,450	29,554
2	Maternity/Paternity/Adoption Leave	5	6	5	5	4	5	5	5	5	4	4	4	25	56
3	Special Leave (Paid) – inc. compassionate leave, interview	5	6	5	5	4	5	5	5	5	4	4	4	25	56
4	Special Leave (Unpaid)	3	3	3	3	3	3	3	3	3	2	2	2	15	34
5	Study Leave/Examinations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	Additional Activity (Winter Pressures/Site Pressures)	1,695	1,909	1,722	1,772	1,521	1,574	1,574	1,574	1,574	1,336	1,351	1,336	8,619	18,939
7	Annual Leave	20	23	20	21	18	19	19	19	19	16	16	16	102	223
8	Sickness	290	327	295	303	260	269	269	269	269	229	231	229	1,475	3,240
9	Restricted Duties	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	Jury Service	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	WLI	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	Exclusion (Suspension)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	COVID-19	661	744	672	691	593	614	614	614	614	521	527	521	3,361	7,386
14	TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE	5,324	5,995	5,409	5,566	4,778	4,945	4,945	4,945	4,945	4,195	4,245	4,195	27,072	59,487

Aneurin Bevan ULHB

Period : Aug 22

This Table is currently showing 0 errors

Table B3 - COVID-19 Analysis

A - Additional Expenditure

		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
A1	*Enter as positive values*	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	**Testing (Additional costs due to C19) enter as positive values - actual/forecast**														
2	**Provider Pay (Establishment, Temp & Agency)**														
3	Administrative, Clerical & Board Members	136	157	121	117	86	56	56	56	56	56	56	56	617	1,007
4	Medical & Dental	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5	Nursing & Midwifery Registered	12	16	14	13	16	16	16	16	16	16	16	16	71	183
6	Prof Scientific & Technical	0	12	15	23	20	20	20	20	20	20	20	20	70	210
7	Additional Clinical Services	58	62	58	41	27	24	21	21	21	21	21	21	245	395
8	Allied Health Professionals	90	99	78	79	66	63	66	66	66	66	66	65	411	869
9	Healthcare Scientists	12	0	0	0	0	0	0	0	0	0	0	0	12	12
10	Estates & Ancillary	33	36	29	27	21	15	15	15	15	15	15	15	146	251
11	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	**Sub total Testing Provider Pay**	339	382	315	300	236	194	194	194	194	194	194	193	1,572	2,927
13	Primary Care Contractor (excluding drugs)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	Primary Care - Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15	Secondary Care - Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	218	292	2	108	17	59	76	76	76	76	76	66	637	1,143
17	Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18	Non Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Continuing Care and Funded Nursing Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20	Other Private & Voluntary Sector	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21	Joint Financing and Other (includes Local Authority)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
22	Other (only use with WG agreement & state SoCNE/I line ref)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
23		0	0	0	0	0	0	0	0	0	0	0	0	0	0
24		0	0	0	0	0	0	0	0	0	0	0	0	0	0
25		0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	**Sub total Testing Non Pay**	218	292	2	108	17	59	76	76	76	76	76	66	637	1,143
27	**TOTAL TESTING EXPENDITURE**	557	674	317	408	253	253	270	270	270	270	270	259	2,209	4,070
28	**PLANNED TESTING EXPENDITURE (In Opening Plan)**	557	541	541	541	541	541	541	541	541	541	541	540	2,722	6,508
29	**MOVEMENT FROM OPENING PLANNED TESTING EXPENDITURE**	0	(133)	224	133	288	288	271	271	271	271	271	281	513	2,438
A2	***Tracing (Additional costs due to C19) enter as positive values - actual/forecast***														
30	**Provider Pay (Establishment, Temp & Agency)**														
31	Administrative, Clerical & Board Members	534	510	481	205	126	155	159	166	166	166	166	81	1,856	2,916
32	Medical & Dental	2	2	2	35	12	12	12	12	12	12	12	10	52	133
33	Nursing & Midwifery Registered	37	32	31	19	19	24	24	24	24	24	24	0	139	285
34	Prof Scientific & Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0
35	Additional Clinical Services	402	396	354	245	104	114	114	114	114	114	114	154	1,502	2,342
36	Allied Health Professionals	27	29	24	29	18	23	23	23	23	23	23	23	127	290
37	Healthcare Scientists	0	0	0	0	0	0	0	0	0	0	0	0	0	0
38	Estates & Ancillary	0	0	0	0	0	0	0	0	0	0	0	0	0	0
39	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
40	**Sub total Tracing Provider Pay**	1,002	969	892	532	280	329	333	340	340	340	340	268	3,676	5,966
41	Primary Care Contractor (excluding drugs)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
42	Primary Care - Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
43	Secondary Care - Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
44	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	0	0	3	31	0	0	0	0	0	0	0	0	34	34
45	Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
46	Non Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
47	Continuing Care and Funded Nursing Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
48	Other Private & Voluntary Sector	0	0	0	0	0	0	0	0	0	0	0	0	0	0
49	Joint Financing and Other (includes Local Authority)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
50	Other (only use with WG agreement & state SoCNE/I line ref)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
51		0	0	0	0	0	0	0	0	0	0	0	0	0	0
52		0	0	0	0	0	0	0	0	0	0	0	0	0	0
53		0	0	0	0	0	0	0	0	0	0	0	0	0	0
54	**Sub total Tracing Non Pay**	0	0	3	31	0	0	0	0	0	0	0	0	34	34
55	**TOTAL TRACING EXPENDITURE**	1,002	969	895	563	280	329	333	340	340	340	340	268	3,710	6,000
56	**PLANNED TRACING EXPENDITURE (In Opening Plan)**	1,002	890	891	354	355	355	355	355	355	355	355	375	3,492	6,000
57	**MOVEMENT FROM OPENING PLANNED TRACING EXPENDITURE**	(0)	(79)	(4)	(209)	75	27	23	15	15	15	15	108	(218)	(0)

A3	*Mass COVID-19 Vaccination (Additional costs due to C19) enter as positive values - actual/forecast*														
58	**Provider Pay (Establishment, Temp & Agency)**														
59	Administrative, Clerical & Board Members	225	216	215	218	190	240	240	240	240	225	222	215	1,064	2,686
60	Medical & Dental	2	3	1	1	4	6	6	6	5	3	3	3	11	43
61	Nursing & Midwifery Registered	153	146	113	103	69	161	175	177	154	120	120	120	583	1,610
62	Prof Scientific & Technical	2	2	2	3	(1)	2	2	2	2	2	2	2	8	20
63	Additional Clinical Services	55	46	54	49	36	78	94	95	80	48	48	48	240	731
64	Allied Health Professionals	13	2	3	2	1	20	25	25	25	18	15	25	21	174
65	Healthcare Scientists	0	(0)	(0)	(0)	0	0	0	0	0	0	0	0	(0)	(0)
66	Estates & Ancillary	2	2	2	2	2	5	8	8	5	3	3	3	10	47
67	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
68	**Sub total Mass COVID-19 Vaccination Provider Pay**	452	416	391	377	301	512	550	553	511	419	413	416	1,937	5,311
69	Primary Care Contractor (excluding drugs)	0	0	0	0	0	500	730	630	511	0	0	0	0	2,371
70	Primary Care - Drugs	0	0	185	0	0	0	0	0	0	0	0	0	185	185
71	Secondary Care - Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
72	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	44	27	0	87	95	126	126	126	126	126	126	126	254	1,134
73	Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
74	Non Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75	Continuing Care and Funded Nursing Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
76	Other Private & Voluntary Sector	0	0	0	0	0	0	0	0	0	0	0	0	0	0
77	Joint Financing and Other (includes Local Authority)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
78	Other (only use with WG agreement & state SoCNE/I line ref)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
79		0	0	0	0	0	0	0	0	0	0	0	0	0	0
80		0	0	0	0	0	0	0	0	0	0	0	0	0	0
81		0	0	0	0	0	0	0	0	0	0	0	0	0	0
82	**Sub total Mass COVID-19 Vaccination Non Pay**	44	27	185	87	95	626	856	756	636	126	126	126	438	3,690
83	**TOTAL MASS COVID-19 VACC EXPENDITURE**	496	444	576	464	396	1,138	1,406	1,309	1,147	545	538	542	2,376	9,000
84	**PLANNED MASS COVID-19 VACC EXPENDITURE (In Opening Plan)**	496	600	600	600	600	950	950	950	950	770	770	764	2,896	9,000
85	**MOVEMENT FROM OPENING PLANNED MASS COVID-19 VACC EXPENDITURE**	0	156	24	136	204	(188)	(456)	(359)	(197)	225	232	222	520	(0)
A4	*Extended Flu Vaccination (Additional costs due to C19) enter as positive values - actual/forecast*														
86	**Provider Pay (Establishment, Temp & Agency)**														
87	Administrative, Clerical & Board Members	0	0	0	0	0	0	0	0	0	0	0	0	0	0
88	Medical & Dental	0	0	0	0	0	0	0	0	0	0	0	0	0	0
89	Nursing & Midwifery Registered	0	0	0	0	0	0	0	0	0	0	0	0	0	0
90	Prof Scientific & Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0
91	Additional Clinical Services	0	0	3	1	0	5	201	401	107	0	0	0	4	718
92	Allied Health Professionals	0	0	0	0	0	0	0	0	0	0	0	0	0	0
93	Healthcare Scientists	0	0	0	0	0	0	0	0	0	0	0	0	0	0
94	Estates & Ancillary	0	0	0	0	0	0	0	0	0	0	0	0	0	0
95	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0
96	**Sub total Extended Flu Vaccination Provider Pay**	0	0	3	1	0	5	201	401	107	0	0	0	4	718
97	Primary Care Contractor (excluding drugs)	0	0	0	0	0	0	73	73	73	73	73	73	0	440
98	Primary Care - Drugs	0	0	0	0	0	59	150	86	43	21	0	0	0	359
99	Secondary Care - Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
100	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
101	Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
102	Non Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
103	Continuing Care and Funded Nursing Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
104	Other Private & Voluntary Sector	0	0	0	0	0	0	0	0	0	0	0	0	0	0
105	Joint Financing and Other (includes Local Authority)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
106	Other (only use with WG agreement & state SoCNE/I line ref)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
107		0	0	0	0	0	0	0	0	0	0	0	0	0	0
108		0	0	0	0	0	0	0	0	0	0	0	0	0	0
109		0	0	0	0	0	0	0	0	0	0	0	0	0	0
110	**Sub total Extended Flu Vaccination Non Pay**	0	0	0	0	0	59	223	159	116	94	73	73	0	799
111	**TOTAL EXTENDED FLU VACC EXPENDITURE**	0	0	3	1	0	64	424	560	223	94	73	73	4	1,517
112	**PLANNED EXTENDED FLU VACC EXPENDITURE (In Opening Plan)**	0	0	0	0	0	0	0	0	0	0	0	0	0	0
113	**MOVEMENT FROM OPENING PLANNED EXTENDED FLU VACC EXPENDITURE**	0	0	(3)	(1)	0	(64)	(424)	(560)	(223)	(94)	(73)	(73)	(4)	(1,517)

A5	**Cleaning Standards (Additional costs due to C19) enter as positive values - actual/forecast**															
114	**Provider Pay (Establishment, Temp & Agency)**															
115	Administrative, Clerical & Board Members	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
116	Medical & Dental	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
117	Nursing & Midwifery Registered	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
118	Prof Scientific & Technical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
119	Additional Clinical Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
120	Allied Health Professionals	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
121	Healthcare Scientists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
122	Estates & Ancillary	309	263	187	221	189	153	164	175	164	164	164	164	1,170	2,319	
123	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
124	**Sub total Cleaning Standards Provider Pay**	309	263	187	221	189	153	164	175	164	164	164	164	1,170	2,319	
125	Primary Care Contractor (excluding drugs)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
126	Primary Care - Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
127	Secondary Care - Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
128	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see A6**	11	12	15	1	2	19	19	19	19	19	19	18	40	171	
129	Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
130	Non Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
131	Continuing Care and Funded Nursing Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
132	Other Private & Voluntary Sector	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
133	Joint Financing and Other (includes Local Authority)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
134	Other (only use with WG agreement & state SoCNE/I line ref)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
135		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
136			0	0	0	0	0	0	0	0	0	0	0	0	0	
137			0	0	0	0	0	0	0	0	0	0	0	0	0	
138	**Sub total Cleaning Standards Non Pay**	11	12	15	1	2	19	19	19	19	19	19	18	40	171	
139	**TOTAL CLEANING STANDARDS EXPENDITURE**	320	275	202	222	191	172	183	194	183	183	183	183	1,210	2,491	
140	**PLANNED CLEANING STANDARDS EXPENDITURE (In Opening Plan)**	320	312	319	319	325	326	327	328	329	329	334	334	1,595	3,900	
141	**MOVEMENT FROM OPENING PLANNED CLEANING STANDARDS EXPENDITURE**	0	37	117	97	134	154	144	134	145	145	150	151	385	1,409	
A6	**PPE, Long Covid & Other (Additional costs due to C19) *enter as positive value - actual/forecast***															
142	**Provider Pay (Establishment, Temp & Agency)**															
143	Administrative, Clerical & Board Members	48	43	35	33	43	44	42	42	42	42	42	57	203	514	
144	Medical & Dental	1,028	649	640	485	504	464	460	433	494	392	382	366	3,306	6,298	
145	Nursing & Midwifery Registered	1,280	876	867	860	1,018	735	744	746	755	755	767	763	4,901	10,166	
146	Prof Scientific & Technical	28	21	27	26	25	26	26	26	26	26	26	26	126	307	
147	Additional Clinical Services	1,330	1,119	1,112	863	863	616	625	628	628	605	613	562	5,288	9,567	
148	Allied Health Professionals	111	112	123	101	130	131	132	135	135	137	137	136	577	1,520	
149	Healthcare Scientists	3	0	0	0	0	0	0	0	0	0	0	0	3	3	
150	Estates & Ancillary	253	395	393	351	319	286	296	296	288	286	315	359	1,711	3,837	
151	Students	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
152	Movement of Annual Leave Accrual	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
153	Other (only use with WG Agreement & state SoCNE/I line ref)		0	0	0	0	0	0	0	0	0	0	0	0	0	
154				0	0	0	0	0	0	0	0	0	0	0	0	
155				0	0	0	0	0	0	0	0	0	0	0	0	
156	**Sub total Other C-19 Provider Pay**	4,081	3,216	3,196	2,720	2,903	2,303	2,326	2,306	2,368	2,243	2,282	2,269	16,115	32,212	
157	Primary Care Contractor (excluding drugs)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
158	Primary Care Contractor (excluding drugs) - Costs as a result of lost GDS Income	0	516	61	192	192	192	192	192	192	192	192	192	962	2,308	
159	Primary Care - Drugs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
160	Secondary Care - Drugs	34	34	34	34	34	34	34	34	34	34	34	34	172	412	
161	Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) **Exclude PPE - see separate line**	477	542	540	267	330	265	252	272	133	196	150	113	2,157	3,539	
162	Provider - Non Pay - PPE	305	230	160	201	153	323	322	323	327	328	327	328	1,049	3,325	
163	Healthcare Services Provided by Other NHS Bodies	0	1	32	(1)	30	30	30	30	30	29	28	28	61	262	
164	Non Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
165	Continuing Care and Funded Nursing Care	852	737	0	596	626	581	491	428	413	414	373	417	2,811	5,928	
166	Other Private & Voluntary Sector	181	181	734	181	80	80	80	80	80	80	80	142	1,356	1,977	
167	Joint Financing and Other (includes Local Authority)	2	2	(4)	0	0	0	0	0	0	0	0	0	0	0	
168	Other (only use with WG Agreement & state SoCNE/I line ref)													0	0	
169														0	0	
170														0	0	
171														0	0	
172														0	0	
173														0	0	
174														0	0	
175														0	0	
176	**Sub total Other C-19 Non Pay**	1,851	2,244	1,557	1,471	1,445	1,505	1,401	1,359	1,209	1,273	1,184	1,254	8,567	17,751	
177	**TOTAL OTHER C-19 EXPENDITURE**	5,933	5,459	4,753	4,190	4,348	3,808	3,727	3,665	3,577	3,515	3,465	3,522	24,683	49,963	
178	**PLANNED OTHER C-19 EXPENDITURE (In Opening Plan)**	5,933	6,131	6,165	3,390	3,390	3,390	3,390	3,390	3,389	3,352	3,289	3,359	25,010	48,570	
179	**MOVEMENT FROM OPENING PLANNED OTHER C-19 EXPENDITURE**	0	672	1,413	(800)	(957)	(417)	(336)	(275)	(188)	(164)	(176)	(164)	327	(1,393)	

180	TOTAL ADDITIONAL EXPENDITURE DUE TO COVID	8,308	7,821	6,745	5,848	5,468	5,763	6,343	6,339	5,740	4,948	4,870	4,846	34,191	73,041
181	PLANNED ADDITIONAL EXPENDITURE DUE TO COVID (In Opening Plan)	8,308	8,474	8,516	5,204	5,212	5,563	5,564	5,565	5,564	5,347	5,289	5,371	35,715	73,978
182	MOVEMENT FROM OPENING PLANNED ADDITIONAL COVID EXPENDITURE	(0)	653	1,771	(644)	(256)	(201)	(779)	(774)	(176)	399	419	525	1,524	938

B - Additional Welsh Government Funding for C19

		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
	Enter as Positive values	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
183	PLANNED WG FUNDING FOR COVID-19	8,308	8,474	8,516	5,204	5,212	5,563	5,564	5,565	5,564	5,347	5,289	5,371	35,715	73,978
184	MOVEMENTS FROM OPENING PLANNED WG FUNDING FOR COVID-19	0	(653)	(1,771)	644	256	201	779	774	176	(399)	(419)	(525)	(1,524)	(938)
185	TOTAL ACTUAL / FORECAST WG FUNDING FOR COVID-19	8,308	7,821	6,745	5,848	5,468	5,763	6,343	6,339	5,740	4,948	4,870	4,846	34,191	73,041
186	ACTUAL / FORECAST NET IMPACT ON OVERALL FINANCIAL POSITION DUE TO COVID-19	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Aneurin Bevan ULHB

Period : Aug 22

Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	CHC and Funded Nursing Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Commissioned Services	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	284	241	214	233	252	261	267	275	277	276	287	294	1,224	3,162	38.72%	3,162	0	0	3,162	3,332
9		Variance	284	241	214	233	252	261	267	275	277	276	287	294	1,224	3,162		3,162	0			
10	Non Pay	Budget/Plan	0	0	0	1,174	1,174	1,174	1,834	1,834	1,834	1,834	1,834	1,834	2,348	14,524		232	14,292			
11		Actual/F'cast	0	0	0	26	26	26	42	42	1,468	3,873	3,873	3,878	52	13,255	0.39%	232	13,023	8,187	5,068	5,068
12		Variance	0	0	0	(1,148)	(1,148)	(1,148)	(1,791)	(1,791)	(365)	2,040	2,040	2,044	(2,297)	(1,269)	*(97.81%)*	0	(1,269)			
13	Pay	Budget/Plan	247	374	374	1,191	1,191	1,191	1,191	1,191	1,191	1,191	1,191	1,191	3,377	11,714		2,924	8,790			
14		Actual/F'cast	187	193	199	238	219	273	945	945	947	1,907	1,892	1,876	1,036	9,821	10.55%	2,976	6,846	329	9,492	9,702
15		Variance	(60)	(181)	(175)	(953)	(972)	(918)	(246)	(246)	(244)	716	701	685	(2,341)	(1,893)	*(69.32%)*	52	(1,945)			
16	Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	247	374	374	2,365	2,365	2,365	3,025	3,025	3,025	3,025	3,025	3,025	5,725	26,238		3,156	23,082			
20		Actual/F'cast	471	434	413	497	498	560	1,255	1,262	2,693	6,057	6,052	6,048	2,312	26,238	8.81%	6,370	19,869	8,516	17,722	18,102
21		Variance	224	59	39	(1,869)	(1,867)	(1,805)	(1,770)	(1,762)	(332)	3,033	3,028	3,023	(3,413)	0	*(59.62%)*	3,214	(3,214)			
22		Variance in month	90.78%	15.90%	10.44%	(79.00%)	(78.96%)	(76.33%)	(58.52%)	(58.27%)	(10.98%)	100.26%	100.10%	99.95%	(59.62%)							
23		In month achievement against FY forecast	1.79%	1.65%	1.57%	1.89%	1.90%	2.13%	4.78%	4.81%	10.26%	23.09%	23.07%	23.05%								

Table D - Income/Expenditure Assumptions

Annual Forecast

	LHB/Trust	Contracted Income	Non Contracted Income	Total Income	Contracted Expenditure	Non Contracted Expenditure	Total Expenditure
		£'000	£'000	£'000	£'000	£'000	£'000
1	Swansea Bay University	201	694	**895**	1,270	2,593	**3,863**
2	Aneurin Bevan University	0	0	**0**	0	0	**0**
3	Betsi Cadwaladr University	0	87	**87**	0	945	**945**
4	Cardiff & Vale University	1,179	770	**1,949**	32,668	3,692	**36,360**
5	Cwm Taf Morgannwg University	1,373	311	**1,684**	23,118	793	**23,911**
6	Hywel Dda University	290	26	**316**	394	599	**993**
7	Powys	13,727	3,104	**16,831**	185	321	**506**
8	Public Health Wales	0	4,705	**4,705**	0	1,624	**1,624**
9	Velindre	0	7,599	**7,599**	25,402	38,381	**63,783**
10	NWSSP	0	0	**0**	0	0	**0**
11	DHCW	0	781	**781**	0	4,317	**4,317**
12	Wales Ambulance Services	0	324	**324**	0	12,695	**12,695**
13	WHSSC	9,851	621	**10,472**	144,839	(2,422)	**142,417**
14	EASC	0	0	**0**	43,470	2	**43,472**
15	HEIW	0	11,669	**11,669**	0	39	**39**
16	NHS Wales Executive	0	0	**0**	0	0	**0**
17	**Total**	**26,621**	**30,691**	**57,312**	**271,346**	**63,579**	**334,925**

Aneurin Bevan ULHB

This Table is currently showing 0 errors

Period : Aug 22

Table E - Resource Limits 1. BASE ALLOCATION		STATUS OF ISSUED RESOURCE LIMIT ITEMS HCHS £'000	Pharmacy £'000	Dental £'000	GMS £'000	Total Revenue Resource Limit £'000	Recurring (R) or Non Recurring (NR)	Total Revenue Drawing Limit £'000	Total Capital Resource Limit £'000	Total Capital Drawing Limit £'000	WG Contact and Date Item First Entered Into Table
1	LATEST ALLOCATION LETTER/SCHEDULE REF:	50	1	2	5						
2	Total Confirmed Funding	1,293,992	32,831	33,249	105,091	1,465,163		1,420,018	48,630	48,630	

3. TOTAL RESOURCES & BUDGET RECONCILIATION

59	Confirmed Resources Per 1. above	1,293,992	32,831	33,249	105,091	1,465,163		1,420,018	48,630	48,630	
60	Anticipated Resources Per 2. above	104,231	0	0	1,603	105,834		119,064	0	0	
61	Total Resources	1,398,222	32,831	33,249	106,694	1,570,997		1,539,082	48,630	48,630	

Aneurin Bevan ULHB **Period : Aug 22**

This table needs completing monthly from Month: 3

This Table is currently showing 0 errors

	Table F - Statement of Financial Position For Monthly Period	Opening Balance Beginning of Apr 22	Closing Balance End of Aug 22	Forecast Closing Balance End of Mar 23
	Non-Current Assets	£'000	£'000	£'000
1	Property, plant and equipment	810,479	818,554	852,232
2	Intangible assets	5,211	4,045	3,273
3	Trade and other receivables	125,697	123,409	125,697
4	Other financial assets	521	521	521
5	Non-Current Assets sub total	**941,908**	**946,529**	**981,723**
	Current Assets			
6	Inventories	8,726	8,871	8,726
7	Trade and other receivables	133,774	120,677	133,774
8	Other financial assets	33	33	33
9	Cash and cash equivalents	1,720	4,119	1,720
10	Non-current assets classified as held for sale	0	0	0
11	Current Assets sub total	**144,253**	**133,700**	**144,253**
12	**TOTAL ASSETS**	**1,086,161**	**1,080,229**	**1,125,976**
	Current Liabilities			
13	Trade and other payables	223,290	213,960	223,053
14	Borrowings (Trust Only)	0	0	0
15	Other financial liabilities	0	0	0
16	Provisions	63,283	60,025	63,283
17	Current Liabilities sub total	**286,573**	**273,985**	**286,336**
18	**NET ASSETS LESS CURRENT LIABILITIES**	**799,588**	**806,244**	**839,640**
	Non-Current Liabilities			
19	Trade and other payables	3,709	19,850	19,850
20	Borrowings (Trust Only)	0	0	0
21	Other financial liabilities	0	0	0
22	Provisions	132,424	129,952	132,424
23	Non-Current Liabilities sub total	**136,133**	**149,802**	**152,274**
24	**TOTAL ASSETS EMPLOYED**	**663,455**	**656,442**	**687,366**

	FINANCED BY: Taxpayers' Equity			
25	General Fund	530,429	523,423	532,366
26	Revaluation Reserve	133,026	133,019	155,000
27	PDC (Trust only)			
28	Retained earnings (Trust Only)			
29	Other reserve			
30	Total Taxpayers' Equity	**663,455**	**656,442**	**687,366**

	EXPLANATION OF ALL PROVISIONS	Opening Balance Beginning of Apr 22	Closing Balance End of Aug 22	Closing Balance End of Mar 23
31	Clinical Negligence	183,724	178,731	183,724
32	Personal Injury	3,991	3,801	3,991
33	Early Retirement	3,706	3,619	3,706
34	Continuing Healthcare	495	503	495
35	Other	3,791	3,323	3,791
36				
37				
38				
39				
40	Total Provisions	**195,707**	**189,977**	**195,707**

	ANALYSIS OF WELSH NHS RECEIVABLES (current month)	£'000
41	Welsh NHS Receivables Aged 0 - 10 weeks	1,486
42	Welsh NHS Receivables Aged 11 - 16 weeks	9
43	Welsh NHS Receivables Aged 17 weeks and over	0

	ANALYSIS OF TRADE & OTHER PAYABLES (opening, current & closing)	£'000	£'000	£'000
44	Capital	10,838	2,435	10,601
45	Revenue	216,161	231,375	232,302

	ANALYSIS OF CASH (opening, current & closing)	£'000	£'000	£'000
46	Capital	275	2,257	400
47	Revenue	1,445	1,862	1,320

Aneurin Bevan ULHB

Period : Aug 22

This Table is currently showing 0 errors

This table needs completing monthly from Month: 2

Table G - Monthly Cashflow Forecast

		April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £,000	Total £,000
	RECEIPTS													
1	WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA only	127,500	125,088	119,738	126,765	134,963	153,907	127,158	126,494	136,274	114,338	120,936	125,923	1,539,082
2	WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only	0	0	0	0	0	0	0	0	0	0	0	(495)	(495)
3	WG Revenue Funding - Other (e.g. invoices)	1,031	1,834	4,840	369	661	250	275	475	250	300	450	500	11,235
4	WG Capital Funding - Cash Limit - LHB & SHA only	7,500	2,500	3,700	3,700	1,000	2,000	2,500	4,600	6,000	5,400	5,400	4,330	48,630
5	Income from other Welsh NHS Organisations	7,169	4,135	8,215	4,757	3,601	4,180	3,980	3,605	4,030	4,380	3,940	4,320	56,312
6	Short Term Loans - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
7	PDC - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Interest Receivable - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
9	Sale of Assets	0	61	5	75	207	0	0	0	0	0	0	150	498
10	Other - (Specify in narrative)	3,495	6,303	3,417	2,521	6,763	3,515	3,606	3,513	4,185	3,441	3,358	4,788	48,904
11	TOTAL RECEIPTS	**146,695**	**139,920**	**139,915**	**138,187**	**147,195**	**163,852**	**137,518**	**138,687**	**150,739**	**127,858**	**134,084**	**139,516**	**1,704,165**
	PAYMENTS													
12	Primary Care Services : General Medical Services	9,330	7,058	9,084	7,324	6,621	8,575	6,985	6,250	8,705	7,400	6,350	8,935	92,617
13	Primary Care Services : Pharmacy Services	4,861	10	3,076	2,359	2,478	4,915	8	2,585	5,175	9	2,425	2,750	30,651
14	Primary Care Services : Prescribed Drugs & Appliances	17,999	6	8,787	9,362	8,529	17,950	10	9,650	16,850	15	9,945	9,875	108,978
15	Primary Care Services : General Dental Services	2,688	2,749	2,651	2,642	2,746	2,700	2,700	2,700	2,700	2,700	2,700	2,700	32,376
16	Non Cash Limited Payments	(530)	521	(133)	6	(109)	(783)	951	6	(656)	476	(94)	(150)	(495)
17	Salaries and Wages	45,171	53,477	53,237	53,822	52,826	64,370	61,120	54,080	53,970	54,190	53,520	54,570	654,353
18	Non Pay Expenditure	59,104	72,709	60,011	60,017	72,225	62,262	63,764	58,480	57,695	57,769	55,237	57,378	736,650
19	Short Term Loan Repayment - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
20	PDC Repayment - Trust only	0	0	0	0	0	0	0	0	0	0	0	0	0
21	Capital Payment	7,345	2,988	2,369	1,745	2,277	4,257	2,500	4,600	6,000	5,400	5,400	4,057	48,938
22	Other items (Specify in narrative)	0	0	41	0	34	0	0	0	0	0	0	23	98
23	TOTAL PAYMENTS	**145,968**	**139,518**	**139,123**	**137,277**	**147,627**	**164,246**	**138,038**	**138,351**	**150,439**	**127,959**	**135,483**	**140,138**	**1,704,166**
24	Net cash inflow/outflow	727	402	792	910	(432)	(394)	(520)	336	300	(101)	(1,399)	(622)	
25	Balance b/f	1,720	2,447	2,849	3,641	4,551	4,119	3,725	3,205	3,541	3,841	3,741	2,342	
26	Balance c/f	2,447	2,849	3,641	4,551	4,119	3,725	3,205	3,541	3,841	3,741	2,342	1,720	

Aneurin Bevan ULHB

Period : Aug 22

Table I - 2022-23 Capital Resource / Expenditure Limit Management

£'000	48,630
Approved CRL / CEL issued at :	7/9/22

Ref:	Performance against CRL / CEL	Year To Date Plan £'000	Year To Date Actual £'000	Year To Date Variance £'000	Forecast Plan £'000	Forecast F'cast £'000	Forecast Variance £'000
	Gross expenditure						
	All Wales Capital Programme:						
	Schemes:						
1	Primary Care - Fees - Tredegar - Main scheme	2,645	1,334	(1,312)	9,934	9,934	0
2	Radiotherapy Satellite - FBC fees	257	109	(149)	257	257	0
3	Covid Recovery Funding	1,619	1,620	1	1,620	1,636	16
4	National Programme - Imaging P2	263	312	49	4,195	4,195	0
5	Grange University Hospital - remaining works	1,183	968	(215)	(394)	(394)	(0)
6	Breast centralisation YYF	282	214	(68)	8,978	8,978	0
7	ICF Neville Hall Children's Centre	0	0	0	43	43	0
8	ICF Assessment Unit MV and CCH	17	3	(14)	32	32	0
9	Newport East FBC Fees	58	58	0	58	58	0
10	Specialist inpatient services Unit - Development Fees	161	104	(56)	263	263	0
11	Eye Care e-referral system	33	43	10	66	66	0
12	National Programmes – Infrastructure	11	15	4	12	15	3
13	RadiotherapySatellite Centre at Nevill Hall Hospital – Enabling Works	403	414	11	403	403	0
14	SDEC	57	52	(4)	79	79	0
15	ICF - Trethomas Feasibility	0	(7)	(7)	34	34	0
16	ICF - Pontllanfraith Feasibility	0	0	0	44	44	0
17	Newport East Health & Wellbeing Centre FBC scheme	1,308	1,308	0	9,229	9,229	0
18	Redevelopment and Expansion of Endoscopy Services at RGH – BJC.	200	(0)	(200)	7,395	7,188	(207)
19	DPIF - Digital Medicines Transformation Portfolio	0	0	0	14	14	0
42	**Sub Total**	**8,497**	**6,546**	**(1,951)**	**42,262**	**42,073**	**(189)**
	Discretionary:						
43	I.T.	715	728	14	2,883	2,883	0
44	Equipment	166	166	(0)	604	604	0
45	Statutory Compliance	196	221	26	935	935	0
46	Estates	715	621	(95)	1,946	2,167	221
47	Other			0			0
48	**Sub Total**	**1,792**	**1,736**	**(56)**	**6,368**	**6,589**	**221**
	Other (Including IFRS 16 Leases) Schemes:						
49	Charitable Funds Donated Assets	0	0	0		118	118
68				0			0
69	**Sub Total**	**0**	**0**	**0**	**0**	**118**	**118**
70	**Total Expenditure**	**10,289**	**8,282**	**(2,006)**	**48,630**	**48,780**	**150**

	Less:						
	Capital grants:						
71	Charitable Funds	0	0	0		118	118
75				0			0
76	**Sub Total**	**0**	**0**	**0**	**0**	**118**	**118**
	Donations:						
77	Sparkle and R&D Income contributions	0	20	20	0	32	32
78	**Sub Total**	**0**	**20**	**20**	**0**	**32**	**32**
	Asset Disposals:						
90	**Sub Total**	**0**	**0**	**0**	**0**	**0**	**0**
91	***Technical Adjustments***			**0**			**0**
92	**CHARGE AGAINST CRL / CEL**	**10,289**	**8,262**	**(2,026)**	**48,630**	**48,630**	**0**
93	**PERFORMANCE AGAINST CRL / CEL (Under)/Over**		**(40,368)**			**0**	

Aneurin Bevan ULHB

Table M - Debtors Schedule

Period: **Aug 22**

11 weeks before end of Aug 22 = 15 June 2022

17 weeks before end of Aug 22 = 04 May 2022

Debtor	Inv #	Inv Date	Orig Inv £	Outstand. Inv £	Valid Entry	>11 weeks but <17 weeks	Over 17 weeks	Arbitration Due Date	Comments
CARDIFF & VALE UNIVERSITY LHB	219236	30 May 2022	4158.00	4,158.00	Yes, valid entry for period	4,158.00		26 September 2022	To be paid on next payment run
HEALTH EDUCATION & IMPROVEMENT WALES	219173	25 May 2022	2320.86	2,320.86	Yes, valid entry for period	2,320.86		21 September 2022	To be paid on next payment run
HEALTH EDUCATION & IMPROVEMENT WALES	219174	25 May 2022	2449.44	2,449.44	Yes, valid entry for period	2,449.44		21 September 2022	Further information requested and provided - awaiting notification of payment date

Aneurin Bevan University Health Board

Revenue Financial Forecast 2022/23

Executive Summary

This report provides the committee with an update of the forecast revenue resource position for the financial year 2022/23, based on August 2022 (month 5) financial reporting. There is an extreme risk of not achieving financial balance if spend levels continue at current rates.

The paper outlines a range of possible forecast positions and the actions proposed to mitigate the financial risks.

This paper should be read in conjunction with the Board's Month 5 Financial Performance Report and the Board 'in committee' financial forecast report of the 28th September 2022.

The IMTP identified how the £1.6bn allocation would be applied as part of the financial plan for 2022/23. The IMTP assumed WG Covid-19 funding for national and local schemes is received and exceptional cost pressures are WG funded, in line with guidance from the NHS Wales Director General. Thus, this report focusses on the 'core' revenue financial position.

2022/23 Forecast

The possible deficit could be as much as £49m based on current service assumptions if no further action is taken, however a range of between £30m to £40m is considered more likely, on the basis that potential opportunities to reduce expenditure are identified and progressed.

The significant issues driving this deficit are linked to significant income reductions previously received for Covid related expenditure but without the corresponding reductions in expenditure with some areas continuing to increase including:

- Variable Pay - driven predominantly by service pressures & delayed discharges and vacancies
- Prescribing Growth – unaffordable volume & prices
- CHC growth (complex and mental health)
- Premium rate elective delivery plans above core levels
- Limited savings achievement through transformation

The preferred approach to financial sustainability identified in the IMTP is through transformation, however the pace of delivery is insufficient to meet the current financial pressures.

Recognising this delayed delivery and increased demand on services, alternative approaches are required. In parallel with transformation, the Executive Team have implemented an internal financial recovery 'turnaround' approach and have identified service and workforce areas to focus on as key income and cost mitigation opportunities. The implications of these opportunities including service, workforce, patient and financial implications will be identified for Board consideration.

The Board is required to provide a final financial forecast for month 6 (mid year review) reporting to WG and provide clarity for how costs and savings are likely to achieve that forecast. The Board will be held to this forecast by WG.

Governance approach:

The Board agreed at its meeting on 28th September 2022 to request the Finance & Performance Committee to receive and review the current forecast and consider options for mitigating, fully or in part, the deficit risk.

The Finance & Performance committee is asked to consider and agree the approach to establish the revised Board forecast financial value to report to WG as part of month 6 reporting.

The Finance & Performance committee is recommended to:

1. Receive this report for assurance, noting the significant risk of achieving financial balance if no pro-active action is taken and the likely deficit,
2. Discuss and provide views on the proposed mitigating action to establish a revised forecast value for 2022/23, and
3. Confirm the approach to establish the revised Board forecast financial value to report to WG as part of month 6 reporting.

The Committee is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	√
Receive the Report for Assurance/Compliance	√
Note the Report for Decision	
Executive Sponsor: Rob Holcombe, Interim Director of Finance, Procurement & Value	
Report Author: Suzanne Jones, Interim Assistant Director of Finance	
Report Received consideration and supported by :	
Executive Team √ **Committee of the Board**	
Date of the Report: 28th September 2022	
Supplementary Papers Attached: Attachment – supporting slide pack detailing cost drivers	

Purpose of the Report

This report provides the committee with an update of the forecast revenue resource position for the financial year 2022/23, based on August 2022 (month 5) financial reporting. There is an extreme risk of not achieving financial balance if spend levels continue at current rates.

The paper outlines a range of possible forecast positions and the actions proposed to mitigate the financial risks.

The committee is asked to confirm the approach to establish the revised Board forecast financial value to report to WG as part of month 6 reporting.

Background and Context

Financial Governance

The Health Board allocation is c. £1.6bn (including £32m for sustainability & recovery) and has been applied to set delegated budgets in accordance with the aims and objectives of the Integrated Medium Term Plan for 2022/23.

Budgets have been set and delegated within available funds. The 2022/23 IMTP financial plan identified £26m savings and £19m cost mitigation and avoidance to enable a budget break-even position.

IMTP Financial Plan

The Financial plan for 22/23 financial year comprises three component parts:

1. **Core plan,** based on service & workforce baselines that reflect Covid de-escalation, cost and savings assumptions and aligned to core funding,
2. **Exceptional cost pressures** and anticipated funding (assumed neutral impact to ABUHB), and
3. **Covid-19** national and local response costs and anticipated funding (assumed neutral impact to ABUHB)

This report assumes funding (at risk) for exceptional and Covid-19 costs will be received in line with guidance from the Director General, NHS Wales. Thus this forecast review focusses on the core health board position.

2022/23 Forecast overview

It should be noted that during 2021/22 the Health Board received allocation funding of £1,599m, which included non-recurrent funding to the value of £255m. The health board spend for 21/22 was £1,599m.

The funding received and anticipated for 2022/23 has reduced by £53m to £1,546m, including £109m non recurrent funding. However current spend estimates are continuing at 21/22 levels with a spend reduction of £4m and are thus contributing to the adverse forecast position.

At month 5 the actual YTD deficit is reported as £17.4m.
If this monthly run rate continues it would indicate a potential forecast deficit of £42m (£17.4m/5*12).
Divisional forecasts, based on operational plans indicate a potential deficit of c. £49m.
These forecast estimates are based on no further savings and cost avoidance action being taken.

A forecast range of between £25m to £40m deficit is considered more likely, on the basis that potential opportunities to reduce expenditure are identified and progressed.

Mitigating actions are presented below and will be subject to consideration by the committee to support the month 6 forecast for ABUHB to report to WG.

Savings opportunities of £26m were identified in the IMTP, YTD savings plans indicate a forecast delivery of £7m. therefore there remains significant scope to improve, ***but only if positive action is promptly taken.***

Cost Driver Estimates Impacting the Financial Forecast

Medicine Division surge bed plans – 45 beds, **£4.8m**.

Community Division surge bed plans – 43 beds, **£2.4m.**

Urgent Care cost pressures- Variable pay, 10% increased demand **£8m.**

Enhanced Care - nursing costs **£2.7m.**

Delayed discharges – 301 beds (c.50% due to LA social care reasons), costing £16.6m (basic variable rate of £150 per bed day). Compared with 21/22, 208 beds (97 due to LA social care reasons), costing £11.4m. An adverse movement of £5.2m over 21/22.

Variable pay – Premium costs if usage continues in line with current run rates, compared with 21/22 identifies a potential overspend in excess of £20m.
Agency - £7.4m
Medical Locum £0.6m
Additional Duty Hours £2.2m
Waiting list initiatives £1.4m
Bank £8.1m

Prescribing – Current forecast cost level not recurrently mitigated **£7m**.

Complex Continuing Health Care – Fee uplift in excess of IMTP of **£3.3m**.

Mental Health CHC placements – Fee uplift in excess of IMTP of **£2.7m**.

Step closer to home - (July to March) 12 beds, at a cost of **£0.9m**

Testing Service Costs above WG £4m allocation **£1.6m**.

Elective Surgical activity delivery plans:

Outpatient activity currently planned to be delivered includes Backfill and WLI costs of **£0.7m**.
Treatment activity currently planned to be delivered includes Backfill and WLI costs of **£7.5m**.

Medicine Service delivery plans:
Cardiology – WLI forecast costs **£0.4m**
Gastro – WLI & Backfill costs of **£1m**

The attachment provides further detail supporting these estimates.

Approach to Achieving a Sustainable Financial and Service plan

The ABUHB 'Approach to Sustainability' has been reported to the Finance Performance Committee in July & is summarised in the Board finance reports for the 28th September 2022 meeting.

Four key elements of the sustainability approach are identified and a summary of how the approach is being operationalised and implemented is included.

The 4 key elements include:

- People Focussed
- Support to drive transformational change
- Autonomy & Accountability
- Monitoring & reporting & holding to account

These are operationalised through an organisation and system wide set of actions, including:

- System & Financial Planning
- Governance compliance
- Financial Sustainability focus
- Programme Approach to Transformation
- Identification & delivery of Efficiency Opportunities

Opportunities to Recover the Financial Forecast

The table below presents the savings position at month 5. The green schemes are reported as deliverable, the amber schemes represent the opportunities identified in the IMTP to be progressed and are at an extreme level of risk of achievement.

		Forecast		
Category	Category	Green	Amber	Total
Medicines Management	Prescribing	2,148		2,148
	Scheduled Care rationalisation	70		70
	Scheduled Care Lenaliomide	944		944
Pay	Variable pay - sickness / overseas & medical agency	2,716	-	2,716
	CHC - agency mitigation	-	250	250
	MSK	83	-	83
	All others	177	6,595	6,772
Non-pay	Corporate / CHC review		3,657	3,657
	NR opps		2,047	2,047
	Facilities related	232	368	600
	Theatres		4,368	4,368
	Other non-pay / schemes		2,583	2,583
				0
Total		6,370	19,868	26,238

The above opportunities identified as part of the IMTP can be expanded to consider the updated compendium work (previously reported to Finance & Performance Committee).

The IMTP intention is to improve efficiency and financial sustainability and cost reduction through the 10 IMTP priority and transformation programmes. However current service pressures are impacting on progress and there is no financial benefit directly reported at the end of month 5 or forecast for delivery in 2022/23 albeit they will be inherent within the opportunity themes described below.

Additional Action for Financial Recovery & Turnaround

An internal financial recovery 'turnaround' status has been agreed by the Executive team to improve short term delivery and acceleration of savings to support break even for 2022/23.

The Executive Team have held a number of workshop sessions to identify specific areas for further focus with a 'Task & Finish' group approach to be developed to make immediate progress with the following areas;

Executive lead	Supported by	Focus area	sub elements
SS	JW	**Variable pay**	Medical agency and locum Enhanced Care Recruitment HCSW Agency
COC	JC/LW LW	**Bed reductions**	DTOC / RPB plans - surge beds Urgent Care system Cohorting and overall bed reductions
COC	JC	**Medicines Management**	off patents/good practice Formulary review
COC	JW	**CHC**	Mental Health Complex Care Other
RH		**Procurement**	Procurement - overall Divisional specific
All	SS	**Current savings review**	Agile working transformation schemes All schemes not within other sections
All		**Investment opportunities slippage**	Executive decisions 2022/23 WG and other funding slippage
All		**Choices (minimise / avoid new spend)**	Executive decisions 2022/23 hold budget underspends
RH	all all	**Corporate opportunities / commissioning**	Corporate opportunities / slippage Corporate vacancy review External contracts WHSSC/EASC
All	all	**Executive Director options / opportunities**	Review of current list
RH	all	**Income and allocations**	Any potential additional allcoations

Consideration is being given to establishing a dedicated financial recovery turnaround group to monitor progress.

In terms of future financial management and monitoring delivery, the setting of expenditure control totals for budget areas may be an area for consideration.

Forecast Risk Range

At month 5 the Board has reported a forecast position of break even, however there are significant risks to this estimate which rely on actions to be progressed to achieve this forecast, the 'core' risk value is estimated to be circa £49m.

The current range of deficit mitigation opportunities identifies net cost reduction of between £9m to £19m, these will be outlined in further detail and considered as part of the discussion at the meeting.

The Finance & Performance committee is asked to consider the above range and discuss and confirm the approach to establish the revised Board forecast financial value to report to WG as part of month 6 reporting.

Risks (2022/23) - reported in the month 5 Finance Board Report

There are serious, immediate and significant risks to managing the 2022/23 financial position, which have been reported within the Board financial reports of the 28th September 2022. Delivery of cost reductions and maximising income opportunities remain the most relevant to achieving a reduced level of forecast risk. The underlying position will also need to be re-assessed to determine how these risks affect the recurrent position of the board.

The table below presents the risks reported to Welsh Government for month 5:

Risk narrative	Likelihood	£'000
Under delivery of Amber Schemes included in Outturn via Tracker	High	19,869
Operational pressures requiring mitigation actions	High	19,000
Additional Covid costs q2 -q4 not assumed in covid response	High	8,000
Funding for exceptional cost pressures	High	40,705
Funding for local Covid response	High	45,180
Funding for National Covid response	Low	16,656
Testing forecast above anticipated funding level	High	1,560
Total		**150,970**

Managing the financial risk is dependent on developing service and workforce plans that are sustainable during 2022/23 and in the future. The operational assumptions will be reviewed to inform revised forecasts for 2022/23.

Key implications of forecasting a financial deficit plan

Potential breach of statutory duty to break even over 3 years.
Risk of IMTP approval being withdrawn along with the associated flexibilities.
NHS escalation framework enacted.
WG and FDU intervention & increased reporting and management burden to respond to queries and actions.

Plus reputational implications, adverse publicity and patient anxiety.

Conclusion

This report has outlined the current financial forecast for ABUHB following a month 5 review. The financial estimates have been formed from operational business intelligence and forecast operational plans and assumptions of demand and delivery.

Forecast savings achievement and opportunities are included along with ideas for further development. Board governance has been described and the financial recovery turnaround approach and proposed actions are presented for clarity.

In order to improve the Boards financial forecast position, several actions are being quickly progressed, including a 'Task & Finish' approach with specific service and operational areas.

Welsh Government are expecting ABUHB to provide a definitive full year forecast as part of the month 6 reporting process, the Finance & Performance Committee is requested to confirm the approach to establishing the revised forecast.

The proposed governance approach:

The Board agreed at its meeting on 28th September 2022 to request the Finance & Performance Committee to receive and review the current forecast and consider options for mitigating, fully or in part, the deficit risk.

The Finance & Performance committee is asked to consider and agree the approach to establish the revised Board forecast financial value to report to WG as part of month 6 reporting.

Recommendation
The Finance & Performance committee is recommended to: 1. Receive this report for assurance, noting the significant risk of achieving financial balance if no pro-active action is taken and the likely deficit, 2. Discuss and provide views on the proposed mitigating action to establish a revised forecast value for 2022/23, and 3. Confirm the approach to establish the revised Board forecast financial value to report to WG as part of month 6 reporting.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The risks to achievement of the Health Board's statutory financial duties are identified in this paper, of particular risks are the level of recurrent savings required to manage within allocated resources & the impact of Covid.
Financial Assessment, including Value for Money	This paper provides details of the month 5 forecast review for 2022/23 financial year, based on service plans and forecast cost drivers.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	The delegation of budgets is based on the IMTP priorities agreed by the Board. On the basis that relevant impact assessments have been undertaken in agreeing these priorities, then further assessments have not been considered necessary. Further impact assessments may be required where savings plans impact patient services.
Health and Care Standards	This paper links to Standard for Health Services One – Governance & Assurance

Link to Integrated Medium Term Plan/Corporate Objectives	This paper provides an update of the delivery of the Health Board's IMTP financial plan for 2022/23.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** refresh of the IMTP 3 year plan and future longer term strategy including foundational economy principles. **Integration** – investment plan recognises Clinical Futures and wider Partnership arrangements and internal & external pathway system integration. **Involvement** – Board and Executive team have considered wider priorities. **Collaboration** – Board approved IMTP includes reference to partners and wider stakeholder initiatives and joint working initiatives. **Prevention** – Prevention initiatives are part of budget plans as a priority.
Glossary of New Terms	Provided
Public Interest	Written for the Finance & Performance Committee

Glossary

IMTP	Integrated Medium Term Plan
SFI's	Standing Financial Instructions
EASC	Emergency Ambulance Services Committee
WHSSC	Welsh Health Specialised Services Committee
GMS	General Medical Services
FYE	Full Year Effect
FDU	Finance Delivery Unit
GDS	General Dental Services
GUH	Grange University Hospital
CF	Clinical Futures
LD	Learning Disabilities
LTA	Long Term Agreement (contracts between NHS bodies)
ICF	Intermediate Care Fund
RAG	Red / Amber / Green Savings Rating
WG	Welsh Government
PIP	Health Board's Pre Investment Panel
CHC	Continuing Health Care
FNC	Funded Nursing Care
RTT	Referral to Treatment
WCCIS	Welsh Community Care Information System
NICE	National Institute for Clinical Excellence
AWMSG	All Wales Medicines Strategy Group
RPB	Regional Partnership Board
SLC	Speech, Language Communication
CAMHS	Children & Adolescent Mental Health Services
NCN	Neighbourhood Care Network
AOF	Annual Operating Framework
RGH	Royal Gwent Hospital
YYF	Ysbyty Ystrad Fawr
DOSA	Day Of Surgery Admission
COTE	Care of the Elderly
NWSSP	NHS Wales Shared Services Partnership

F&PC Attachment 2022/10/05
Month 5 Reported Position

Performance against key financial targets 2022/23
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Trend	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	3,105	17,441	↑	0
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the curent month and YTD expenditure levels along with the % this is of total forecast spend.*	£'000 £49,107	2,517 5.1%	7,219 14.7%	↔	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)	%	96.6%	94.5%	↔	>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

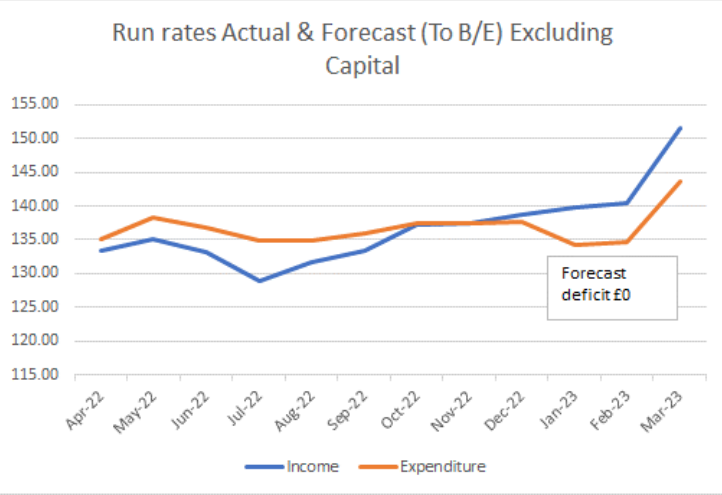
Summary Reported position - August 2022 (M05)	Full Year Budget £000s	YTD Reported Variance £000s	Prior month reported variance £000s	Movement from prior month £000s
Operational Divisions:-				
Primary Care and Community	271,231	(944)	(1,334)	390
Prescribing	99,190	3,101	2,050	1,051
Community CHC & FNC	71,296	(1,844)	(1,170)	(675)
Mental Health	104,853	3,960	2,562	1,398
Director of Primary Community and Mental Health	311	(63)	22	(85)
Total Primary Care, Community and Mental Health	**546,881**	**4,210**	**2,131**	**2,079**
Scheduled Care	226,287	10,097	7,470	2,627
Medicine	106,819	9,250	7,996	1,254
Urgent Care	41,204	2,676	2,358	319
Family & Therapies	119,405	(346)	13	(358)
Estates and Facilities	104,043	588	(37)	625
Director of Operations	7,634	392	311	81
Total Director of Operations	**605,392**	**22,659**	**18,112**	**4,547**
Total Operational Divisions	**1,152,273**	**26,869**	**20,242**	**6,626**
Corporate Divisions	111,486	(6,406)	(4,513)	(1,893)
Specialist Services	172,248	(957)	(499)	(458)
External Contracts	83,965	605	732	(126)
Capital Charges	34,734	(159)	(67)	(92)
Total Delegated Position	**1,554,706**	**19,952**	**15,895**	**4,057**
Total Reserves	28,595	(2,511)	(1,559)	(952)
Total Allocations	(1,571,270)	0	0	0
Other Corporate Income	(12,031)	0	0	0
Total Reported Position	**0**	**17,441**	**14,336**	**3,105**

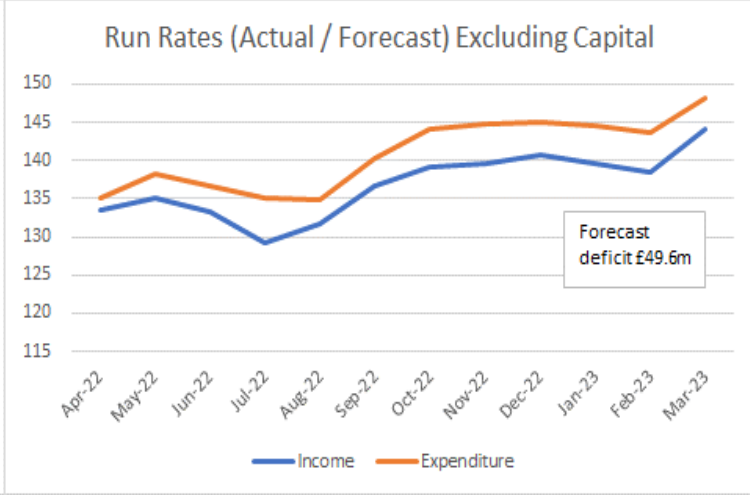
Divisional Forecast

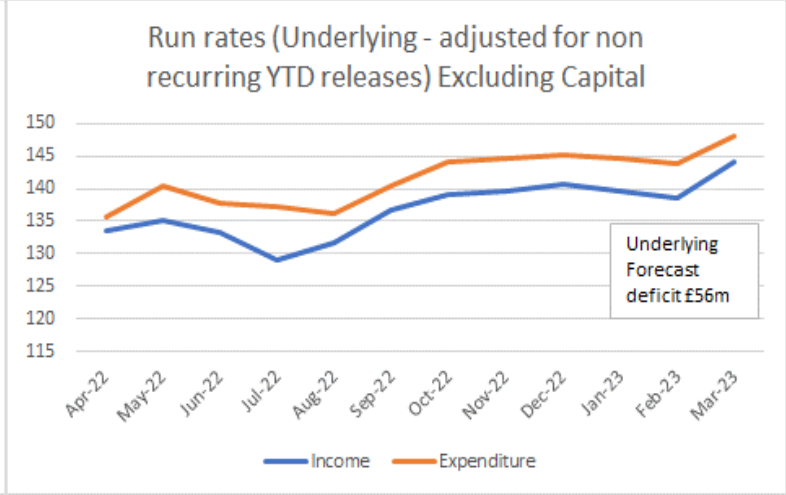
	Annual budget £000s	Full-year Forecast at M05 £000s
Operational Divisions:-		
Primary Care and Community	271,231	(2,909)
Prescribing	99,190	7,672
Community CHC & FNC	71,296	(3,481)
Mental Health	104,853	13,939
Director of Primary Community and Mental Health	311	(141)
Total Primary Care, Community and Mental Health	**546,881**	**15,079**
Scheduled Care	226,287	26,956
Clinical Support Services	0	0
Medicine	106,819	19,895
Urgent Care	41,204	5,741
Family & Therapies	119,405	(300)
Estates and Facilities	104,043	17,828
Director of Operations	7,634	646
Total Director of Operations	**605,392**	**70,766**
Corporate / Exec budgets:-		
Finance & Performance	3,653	(587)
Annual leave provision	*0*	*(16,663)*
Workforce & OD	6,847	236
Nurse Director	5,116	189
Chief Executive and non officer members	37,149	(124)
ABCi	713	(130)
Planning & Digital/ICT	30,177	3,012
Therapies Director	3,997	1,603
Board Secretary	901	13
Public Health Director	18,429	(280)
Unallocated Corporate	0	(0)
Medical Director	3,746	(196)
Litigation	759	1,532
Total Corporate Divisions	**111,486**	**(11,396)**

	Annual budget £000s	Full-year Forecast at M05 £000s
Specialist Services		
WHSSC	136,069	(2,602)
EASC	36,179	304
Total Specialist Services	**172,248**	**(2,297)**
External Contracts		
External Commissioning - LTAs'	83,305	2,245
External Commissioning - Access Plans'	660	398
Total External Contracts	**83,965**	**2,643**
Capital Charges	34,734	(287)
Total Capital Charges	**34,734**	**(287)**
Total Delegated Position	**1,554,706**	**74,508**
Centrally held Reserves:-		
Commitments	1,696	(1,244)
Contingency	0	0
Allocations - Exceptional (NI)	4,606	(4,606)
Allocations - Covid response (Local)	0	0
Allocations - Covid National Priorities (Test+PPE)	0	0
Allocations - Other	22,293	(17,704)
Total Reserves	**28,595**	**(23,554)**
RINC Total Income	(1,583,301)	**0**
Total Income	**(1,583,301)**	**0**
Total Reported Position	**0**	**50,954**
Potential nurse agency accruals releases		(1,000)
Final Pay Controls Appeals		(292)
		49,662

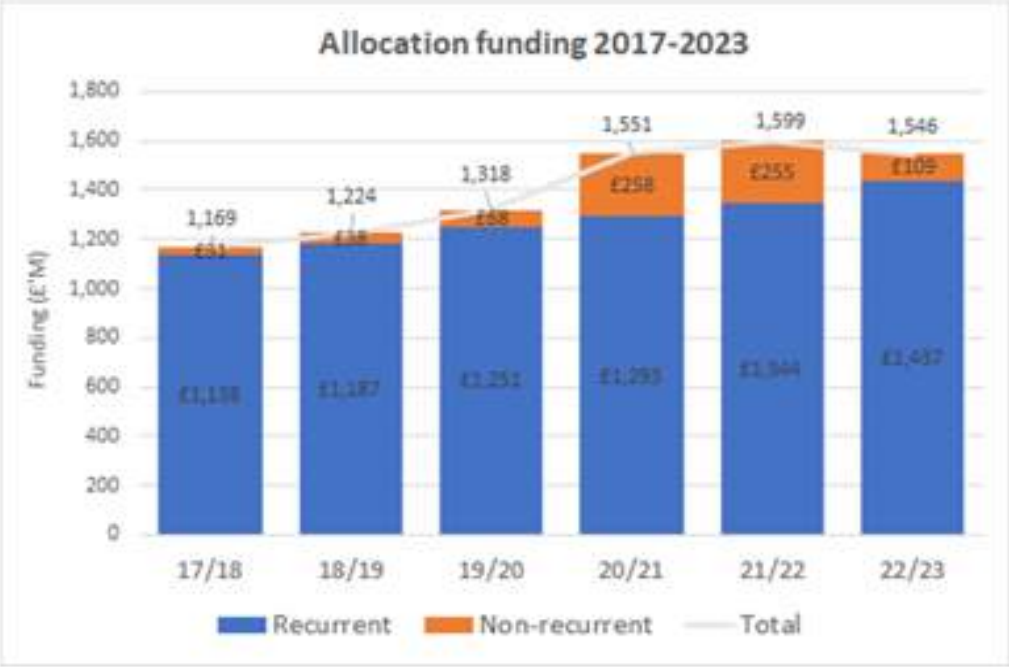
Income & Expenditure Run Rates (Actual & Forecast) 2022/23





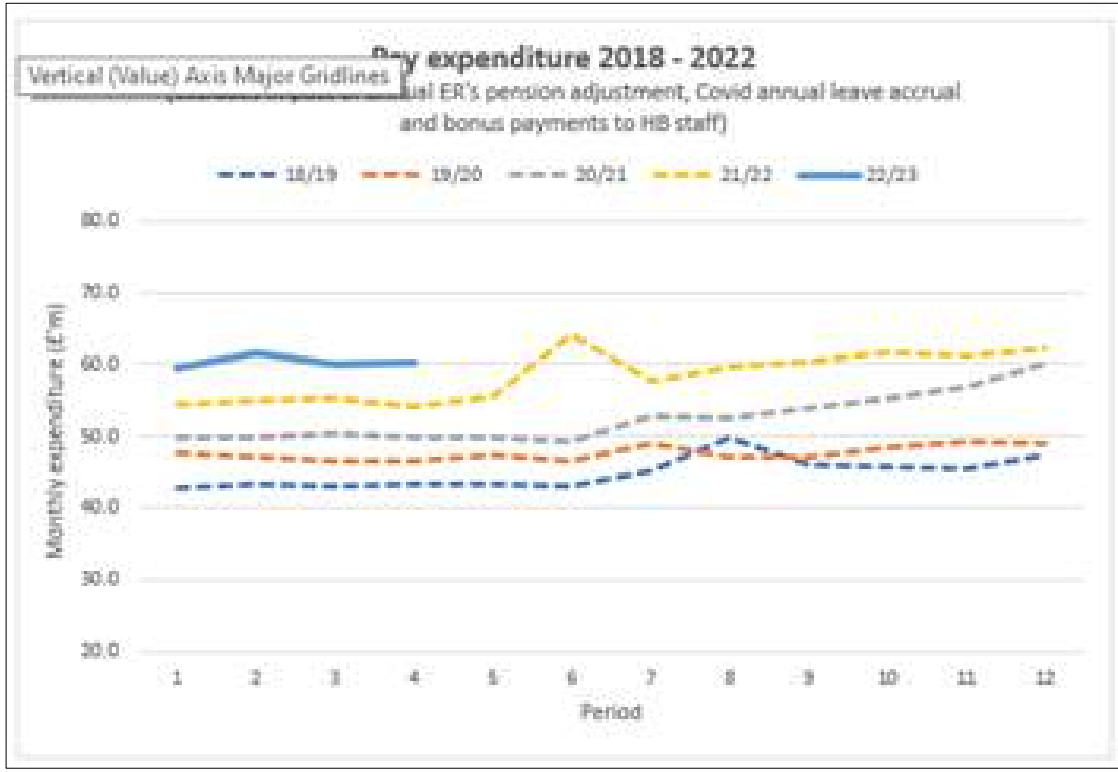


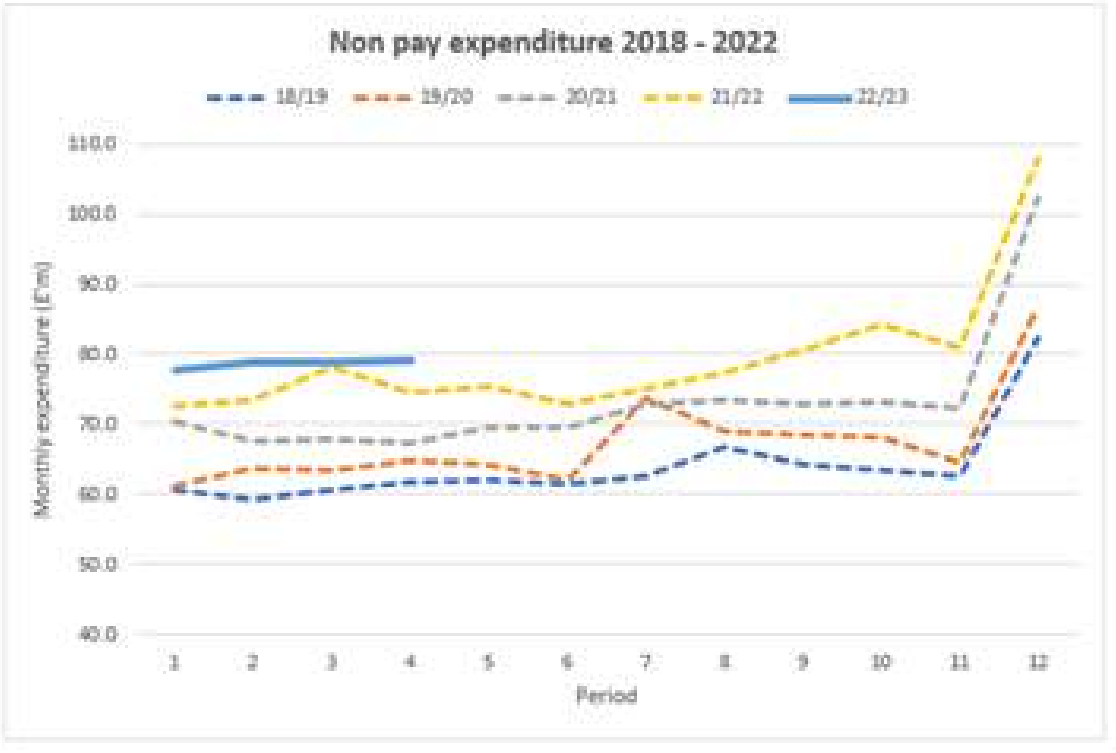
Allocations: Recurrent v Non Recurrent



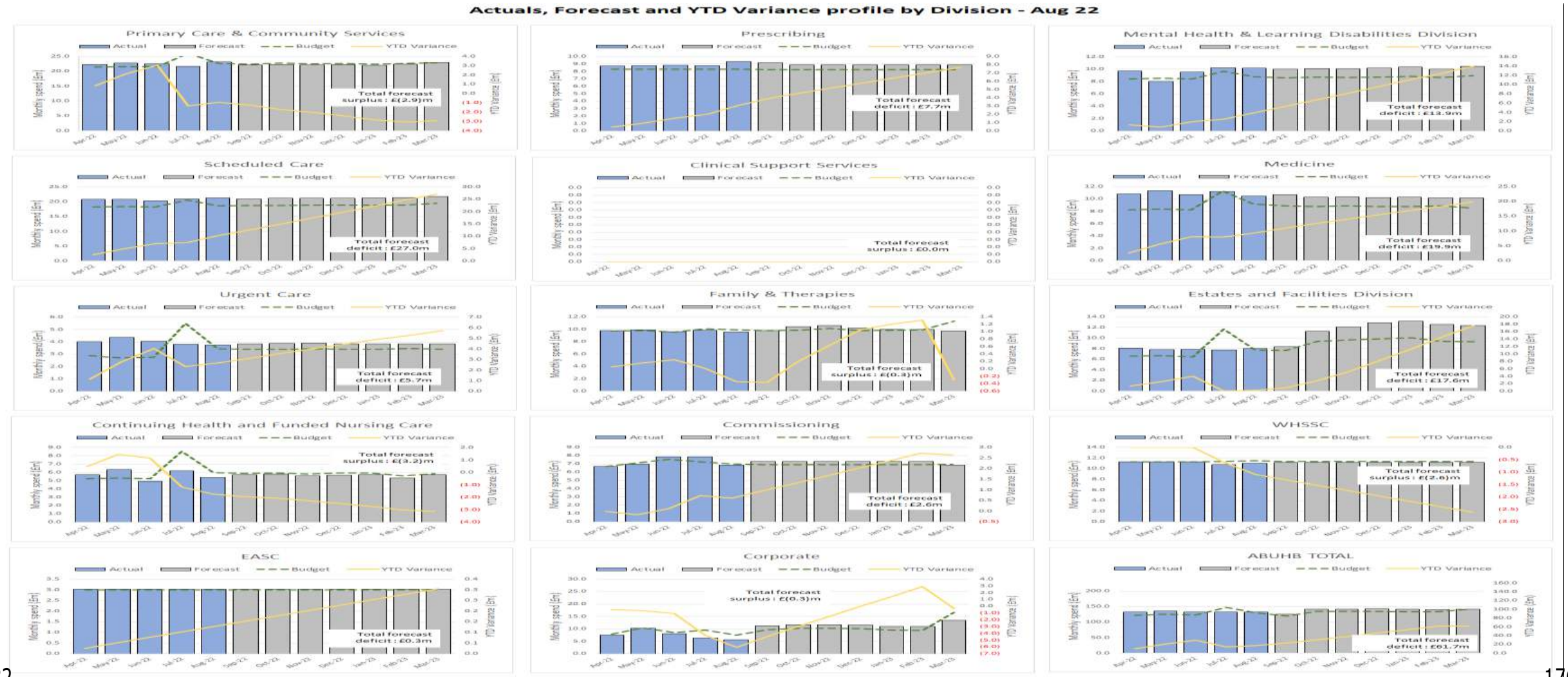
- The non recurring funding increased significantly during covid-19, the spend is demonstrated above. It can be seen that the spend, although classes as non recurrent for covid, appears to be recurrent as it has not dropped since being in covid stable.

Expenditure Run rates





Divisional Run Rates @ M05



Costs driving the current Forecast position (M05)

Bed Blocked Days Per Month

- **In 21/22 there were 75,960 bed blocked days , approximate avoidable cost of £11.4m.**
- **In 22/23 46,136 bed blocked days so far, if this continues it will be approx. 110,726 for the year.**
- **This is 34,766 greater than 21/22 at an avoidable cost of £5.2m**
- Bed blocked days per month are taken from the complex care list, by reason
- These reasons have been allotted to grouped categories,
- These are not official groupings and are subject to confirmation as it has not been possible to confirm them.
- Reasons allotted to groups are:
  - Patient / Family: selecting a placement, home of choice, family issues
  - Covid: ‘ covid related delay’ including a swab
  - Care / Nursing Home: awaiting care home manager assessment or availability / vacancy
  - Local Authority: social worker assessment, packages of (new, restart and increases), housing related issues
  - NHS: assessments (OT, Physio, OT, capacity, psychology), awaiting MDT, CHC process, definite discharge date identified (DDD).

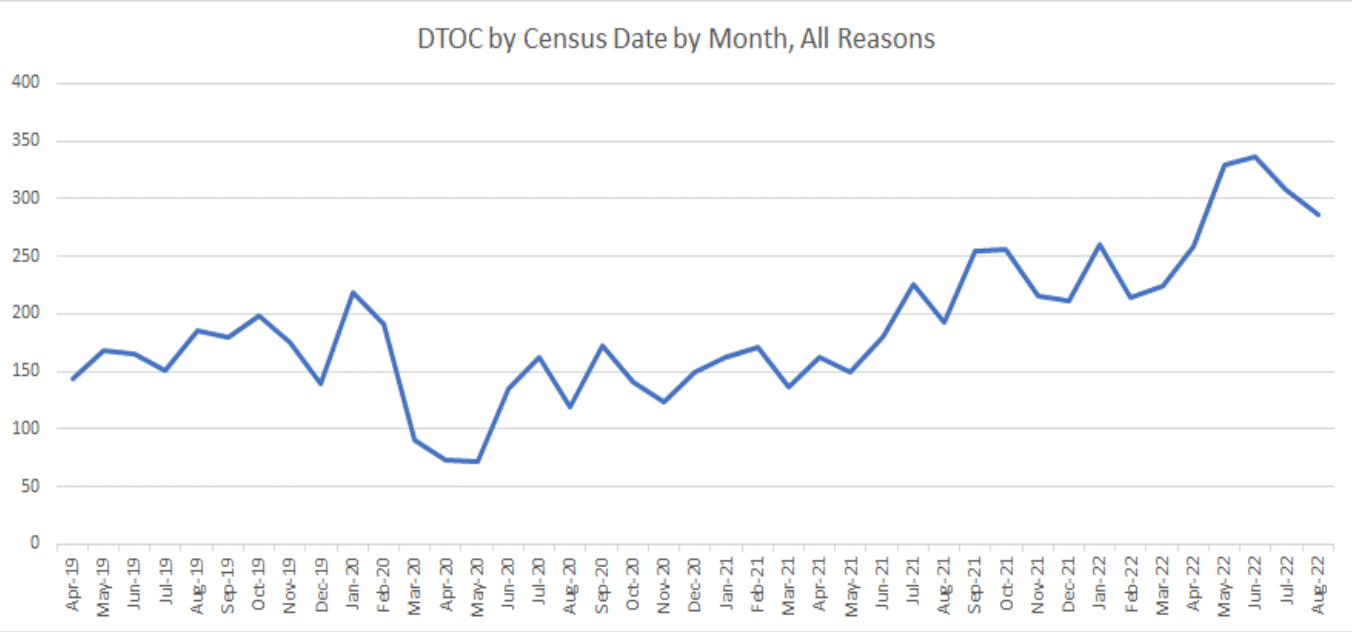
	Bed blocked 'Days' per Month			Variable Cost £150 p day		Cost Avoidance - reduce 'days' by 50% - from Sept - March (@ Variable Cost £150 p day)
M05 Categorise	Sum of Total 21/22	Sum of April-August 22/23	Extrapolated 'Days'	Extrapolated Cost for 22/23		Extrapolated Cost for 22/23
CARE / NURSING HOME	7,301	3,962	9,509	1,426,320	9%	356,580
COVID	8,830	1,270	3,048	457,200	3%	114,300
LA	35,544	22,859	54,862	8,229,240	50%	2,057,310
NHS	15,251	13,448	32,275	4,841,280	29%	1,210,320
OTHER	1,011	1,113	2,671	400,680	2%	100,170
PATIENT / FAMILY	8,023	3,484	8,362	1,254,240	8%	313,560
Grand Total	**75,960**	**46,136**	**110,726**	**16,608,960**	**1.00**	**4,152,240**

Bed Blocked Days Per Month – Attributed to NHS

- Categories have been allocated to 'NHS', this is not an official categorisation, areas covered are shown in the table.
- Of the top 10 reasons the definite discharge date is the largest reason – further work is needed to understand this category
- The remaining top 10 are related to awaiting MDT's, waiting for assessments for OT, Physio, ward referrals, chc process, rehab and a number of blanks (again this a will need further review).
- If we attribute the variable cost to the delays in the top 2-10 covers 72% of the total and could have avoided £3.1m of costs ytd.

	Reason on List	Total 21/22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Total YTD 22/23	Total 21/22 and YTD 22/23
1	Definite discharge date (DDD) identified	2,902	290	647	1001	994	926	3,858	6,760
2	Awaiting MDT	2,894	253	537	617	570	523	2,500	5,394
3	Assessment - Occupational Therapy	2,173	130	609	673	734	1012	3,158	5,331
4	Assessment - Capacity	1,656	173	212	147	180	119	831	2,487
5	Assessment - Physiotherapy	741	88	199	251	321	302	1,161	1,902
6	Ward to refer	1,588	92	17				109	1,697
7	CHC Process	1,419	79	9				88	1,507
8	Blank	57	0	138	162	304	305	909	966
9	No rehabilitation vacancy	868	37	17				54	922
10	Active rehab	452	20	8				28	480
11	Awaiting transfer to intermediate care bed	0			3	111	236	350	350
12	Medical intervention	291	15	2				17	308
13	Assessment - Psychology	177	26	0				26	203
14	Fast Track Assessment	0			9	36	41	86	86
15	Mental Capacity Related Issues	0		6	6	34	34	80	80
16	Awaiting completion of CHC Process	0		3	17	31	16	67	67
17	Bed Booked / Awaiting Transfer	0		3	8	23	21	55	55
18	Awaiting LD Arrangements	0		25	22	0		47	47
19	SALT required	33	0	0				0	33
20	Awaiting Mental Health Arrangements	0		5		13	5	23	23
21	LD Assessment	0					2	2	2
22	Awaiting Service Start Date	0			1	0		1	1
	Grand Total	**15,251**	**1,203**	**2,437**	**2,917**	**3,351**	**3,542**	**13,450**	**28,701**

DTOC by Census Date, by Month. All Reasons.



DToC @ Census Date	Average DToC @ Census Date	*Minimum*	*Maximum*
19/20	167	*90*	*218*
20/21	135	*72*	*173*
21/22	212	*149*	*261*
22/23	304	*259*	*336*

Community Beds

47 surge beds open in community at a cost of £2.4m

COMMUNITY HOSPITAL BEDS — Actual | Forecast

				Avg Surge Beds Open											
Hospital	**Core Funded Beds**	**Maximum Surge Beds**	**Total Beds Available**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**
YAB															
- Tyleri	16	15	31	11	15	15	15	15	15	15	15	15	15	15	15
- Ebbw	32		32												
- Sirhowy	32		32												
RIHSCC	12		12												
Chepstow	32		32												
Monnow Vale	19		19												
St Woolos															
- Ruperra	0	24	24	24	24	24	24	24	24	24	24	24	24	24	24
- Gwanwyn	26		26												
- Penhow	24		24												
- Holly (SCTH)	0	10	10	10	10	10	10	10							
Parklands	0	8	8					8	8	8	8	8	8	8	8
County			0												
- Oak	29		29												
- Rowan	18		18												
TOTAL	**240**	**57**	**297**	**45**	**49**	**49**	**49**	**57**	**47**	**47**	**47**	**47**	**47**	**47**	**47**
No charge for Parklands Beds								-8	-8	-8	-8	-8	-8	-8	-8
Surge Beds Open At Cost To PC&CS Division				**45**	**49**	**49**	**49**	**49**	**39**	**39**	**39**	**39**	**39**	**39**	**39**

		Actual / Forecast Cost Of Surge Beds												
Hospital	**Surge Beds Forecast**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**TOTAL**
YAB (Tyleri)	15	£20,766	£60,272	£71,238	£78,007	£68,747	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	£50,000	**£649,030**
St Woolos (Ruperra)	24	£108,851	£134,659	£124,955	£125,669	£126,347	£121,756	£121,756	£121,756	£121,756	£121,756	£121,756	£121,756	**£1,472,773**
St Woolos (Holly - SC2H		£61,742	£67,600	£61,413	£59,446	£49,236								**£299,437**
Parklands (External)	8													**£0**
TOTAL	**47**	**£191,359**	**£262,531**	**£257,606**	**£263,122**	**£244,330**	**£171,756**	**£171,756**	**£171,756**	**£171,756**	**£171,756**	**£171,756**	**£171,756**	**£2,421,240**

Medicine – Surge Beds

2022/23

Additional Capacity - No of beds	April Mth 01	May Mth 02	June Mth 03	July Mth 04	August Mth 05	September Mth 06	October Mth 07	November Mth 08	December Mth 09	January Mth 10	February Mth 11	March Mth 12
Fox Pod	8	8	8	8	8							
GUH A1	8	8	8	8	8	8	8	8	8	8	8	8
RGH AMU D1W	18	18	18	6								
RGH AMU 8 beds for Streaming (10 trolleys in total)	10	10	10	10	10	10	10	10	10	10	10	10
NHH AMU 8 Trollies Streaming	8	8	8	8	8	8	8	8	8	8	8	8
NHH AMU Surge				6	0							
GUH AMU Chairs overnight & Trolley breaches @ 7am				4	5							
RGH C6E			28	28	28	28	28	28	28	28	28	28
GUH A4			1	1	1	1	1	1	1	1	1	1
NHH all wards			18	18	18	18	18	18	18	18	18	18
	52	52	99	97	86	73	73	73	73	73	73	73

Additional Capacity - Cost included in actual/forecast	April Mth 01 £'000	May Mth 02 £'000	June Mth 03 £'000	July Mth 04 £'000	August Mth 05 £'000	September Mth 06 £'000	October Mth 07 £'000	November Mth 08 £'000	December Mth 09 £'000	January Mth 10 £'000	February Mth 11 £'000	March Mth 12 £'000
Fox Pod RN	54	61	53	55	39		0	0	0	0	0	0
Fox Pod HCSW	23	25	23	19	12		0	0	0	0	0	0
A1 RN x 5	190	209	181	179	163	165	165	165	165	165	165	165
a1 HCSW x 4	57	26	25	55	57	57	57	57	57	57	57	57
RGH D1W Beds RN	72	80	47		0	0	0	0	0	0	0	0
RGH D1W Beds HCSW	36	26	14	55	0	0	0	0	0	0	0	0
RGH AMU 8 covid beds RN	104	104	104	119	104	104	104	104	104	104	104	104
RGH AMU 8 covid beds HCSW	12	12	12	12	12	12	12	12	12	12	12	12
GUH AMU Chairs Overnight				8	10							
NHH AMU RN				70	0							
NHH AMU HCSW				11	0							
RGH C6E Ward			156	157	160	156	156	160	156	156	161	156
C6E Medical			95	68	68							
B3 medical delay recruiyment			50	50	50	50						
NHH AMU	91	90	86	94	94	91	94	91	94	94	85	94
GUH A4			0	0	0	0	0	0	0	0	0	0
NHH all wards			0	0	0	0	0	0	0	0	0	0
	639	633	847	952	769	635	588	589	588	588	584	588

- Core Divisional beds of 595 across RGH, NHH, GUH and YYF.
- 73 additional beds assumed open for the rest of 22-23 across multiple sites (Unsch Care Divisions only).
- Majority of staffing sourced via additional variable pay
- £8m full year effect of additional beds being open
- An average of £594k per month additional costs forecasted, £4.16m for the full year (September 22 – March 23 inclusive)

Medicine – Variable Activity

	2022/23												
	Mth 01	Mth 02	Mth 03	Mth 04	Mth 05	Mth 06	Mth 07	Mth 08	Mth 09	Mth 10	Mth 11	Mth 12	FYF22-23
WLI (Patients):													
Cardio - WLI - Invasive	36	21	15	39	39	39	39	39	39	39	39	39	423
Cardio - WLI - Non-Invasive	74	318	246	303	477	320	320	320	320	320	320	320	3,658
Neuro	0	0	0	0	0	0	0	0	0	0	0	0	0
Diabetes	0	0	88	16	39	39	39	39	39	39	39	39	416
WLI Spend £'000													
Cardio - Total	29	36	26	40	34	34	34	34	34	34	34	30	399
Neuro	0	0	0	1	0	0	0	0	0	0	0	0	1
Diabetes	0	1	9	2	3	3	3	3	3	3	3	3	37
	29	37	35	43	37	37	37	37	37	37	37	33	437

	2022/23												
	Mth 01	Mth 02	Mth 03	Mth 04	Mth 05	Mth 06	Mth 07	Mth 08	Mth 09	Mth 10	Mth 11	Mth 12	FYF 22-23
Additional Activity - Volume													
Patient Numbers													
Gastro - Endo Back Fill	305	263	308	357	295	58	58	58	58	58	58	58	1,936
Gastro - Endo WLIs	171	162	202	174	177	138	138	138	138	138	138	138	1,851
Gastro - Outpatient Backfill				125									
Additional Activity - Cost included in actual/forecast £'000													
Gastro - Back Fill	41	58	40	56	41	4	4	4	4	4	4	4	264
Gastro - WLIs	68	78	60	90	86	59	59	59	59	59	59	59	797
Gastro - Outpatient Backfill				5									
	109	136	100	150	127	63	63	63	63	63	63	63	1,061

- Additional plans on top of core for Cardiology, Neuro, Diabetes and Gastro.
- Core monthly volumes as follows – Cardio 628, Gastro 1,263.
- Potential cost saving to ABUHB demonstrated in the table, the implications on performance and patient risk need to be worked through.
- Patient impact and cost in Blue shaded areas are actuals YTD. Forecast opportunity overall of £699k in the year to go forecast.

Scheduled Care – Variable Activity

Elective Care M05 Summary

			Activity							
			Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
Total	OP's	WLI	716	726	736	526	764	764	764	4,996
		Backfill	168	168	168	48	168	168	168	1,056
		Core	486	496	506	414	464	461	453	3,280
	Treatments	WLI	171	171	201	145	211	211	211	1,321
		Backfill	225	249	247	241	249	249	249	1,709
		Core	54	55	56	45	51	52	50	363
			1,820	1,865	1,914	1,419	1,907	1,905	1,895	12,725

			£'000							
			Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
Total	OP's	WLI	57	58	59	44	62	62	62	404
		Backfill	59	59	59	34	59	59	59	389
		Core	63	70	70	69	69	70	136	547
	Treatments	WLI	175	212	307	279	311	312	312	1,908
		Backfill	194	207	276	273	277	276	276	1,778
		Core	0	0	0	0	0	0	0	0
			548	606	771	699	778	779	845	5,026

- £5.026m in current financial forecast (September 22 to March 23 inclusive).
- 9,332 O/P Appointments and 3,393 Treatments, across a range of specialties.
- Revised plans finalised and reflected in the figures opposite.
- **Performance impact and risk to patient harm of stopping variable activity needs to be worked through, although we know that there are efficiency opportunities in maximising core capacity (Compendium, GIRFT etc).**
- Real Time data being worked up to go through with Division to identify such opportunities.

Medicine – Insourcing

	2022/23												
	Mth 01	Mth 02	Mth 03	Mth 04	Mth 05	Mth 06	Mth 07	Mth 08	Mth 09	Mth 10	Mth 11	Mth 12	FYF22-23
Additional Activity - Volume													
Cardio - Insourcing Echoes (CH)	188	215	156	139	107	213	213	213	213	213	213	213	**2,294**
Cardio - Insourcing Echoes (IMC)	693	833	734	924	873	802	802	802	802	802	802	802	**9,671**
Additional Activity - Cost included in actual/forecast (£'000)													
Cardio - Insourcing Echoes (CH)	12	14	10	9	14	14	14	14	14	14	14	13	**156**
Cardio - Insourcing Echoes (IMC)	45	54	48	60	52	52	52	52	52	52	52	53	**624**
Cardio - Insourcing Support Staff (various)	7	8	8	7	8	9	10	9	10	9	10	10	**105**
	64	76	66	76	74	75	76	75	76	75	76	76	**885**

	2022/23												
	Mth 01	Mth 02	Mth 03	Mth 04	Mth 05	Mth 06	Mth 07	Mth 08	Mth 09	Mth 10	Mth 11	Mth 12	Total
Additional Activity - Volume													
Gastro - Endo Insourcing in Points	*542*	*673*	*595*	*460*	*575*	*600*	*620*	*600*	*580*	*600*	*560*	*620*	***7,025***
Patient Numbers													
Gastro - Endo Insourcing	500	664	537	281	370	401	415	401	388	401	375	415	**5,147**
Additional Activity - Cost included in actual/forecast £'000													
Gastro - Endo Insourcing	173	173	173	345	216	216	216	216	216	216	216	216	**2,587**

- Forecasted patient activity and cost of Cardiology and Gastro Insourcing contracts.
- Core activity – Cardiology 628, Gastro 1,263.
- Contractual implications of stopping these contracts being worked through.
- Potential cost saving is transparent, risk to patient harm and performance needs to be quantified.

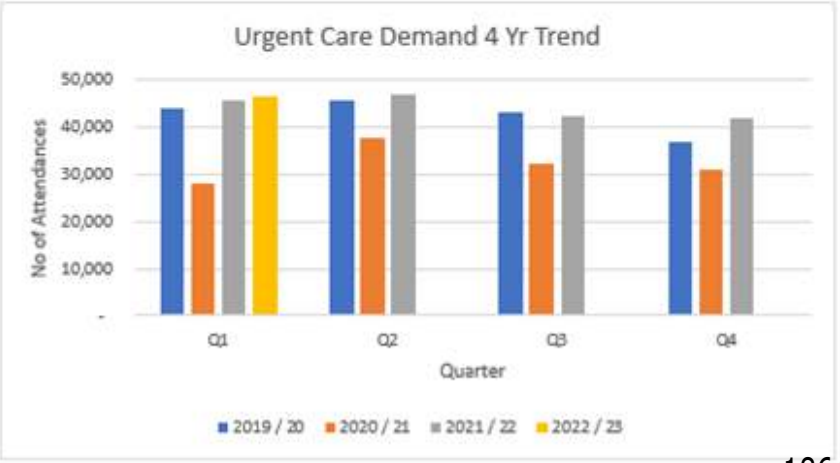
Urgent Care – Demand

Care Group	Hospital	Financial Year 2019/20	2020/21	2021/22	2022/23 Extrapolated
Majors	Grange University Hospital		18,811	62,108	62,923
	Nevill Hall Hospital	24,156	14,510	767	514
	Royal Gwent Hospital	38,854	23,309	292	442
	Ysbyty Ystrad Fawr		1		0
Majors Total		63,010	56,631	63,167	63,878
Minors	Grange University Hospital		182	417	53
	Nevill Hall Hospital	14,563	11,083	16,870	19,214
	Royal Gwent Hospital	22,835	16,160	33,467	37,978
	Ysbyty Aneurin Bevan	10,298	5,979	8,895	9,562
	Ysbyty Ystrad Fawr	21,683	13,793	24,101	27,199
Minors Total		69,379	47,197	83,750	94,006
Paeds	Grange University Hospital		5,614	26,883	26,933
	Nevill Hall Hospital	6,769	2,624		0
	Royal Gwent Hospital	19,576	7,255		0
	Ysbyty Ystrad Fawr	7,741	2,475		0
Paeds Total		34,086	17,968	26,883	26,933
Resus	Grange University Hospital		1,204	3,764	2,700
	Nevill Hall Hospital	832	313		0
	Royal Gwent Hospital	2,644	5,827		0
Resus Total		3,476	7,344	3,764	2,700
Not Defined	Nevill Hall Hospital	1	3		0
	Royal Gwent Hospital	2	3		0
	Ysbyty Aneurin Bevan	15	10		0
	Ysbyty Ystrad Fawr	12	4		0
Not Defined Total		30	20		0
Grand Total		169,981	129,160	177,564	187,517

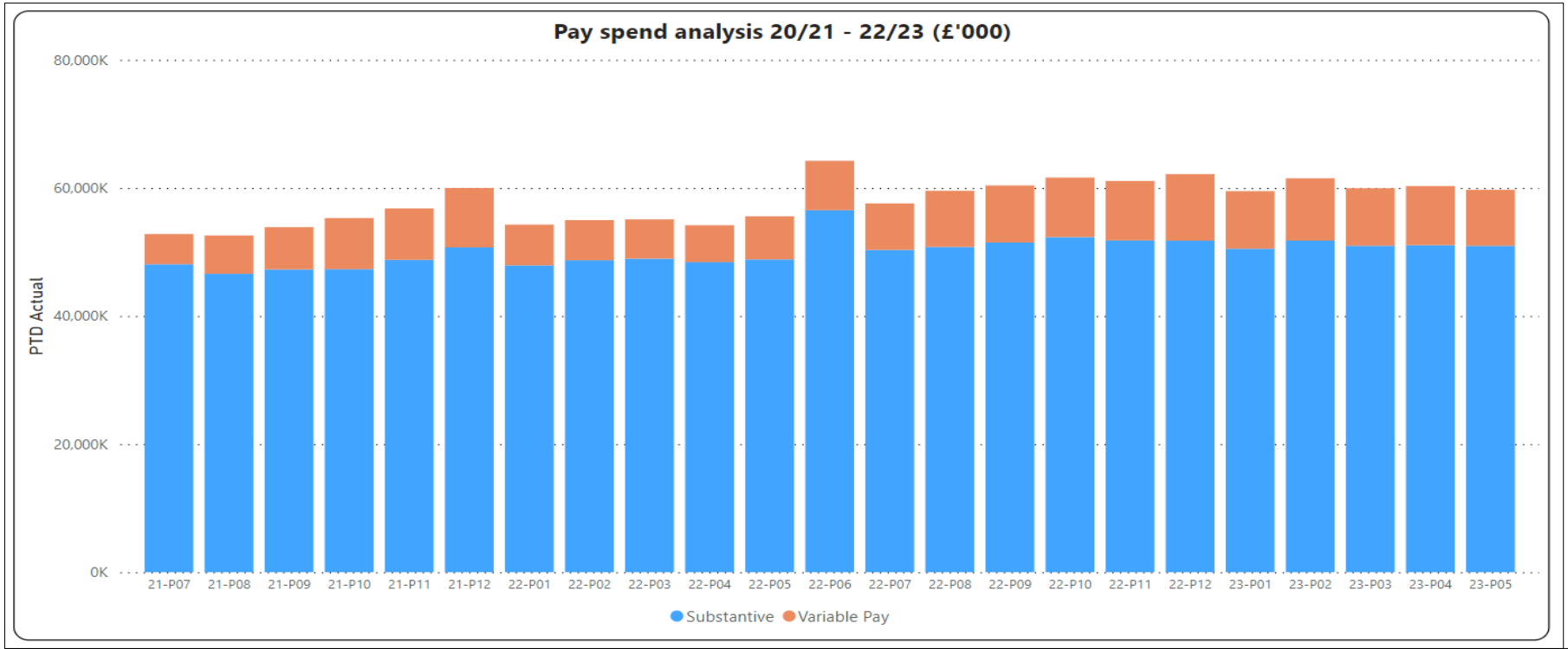
Urgent Care has spent £3.6m (77% on RN agency) on agency year to and including month 5, **this could cost £8.64m** by the end of the year if it continues at the same rate of spend.

- Attendances at MIUs driving overall increases in attendances for 22 / 23.
- Minor Injury group demonstrating a 35.4% increase on 19 / 20 levels, based on current run rate of 22 / 23 attendances.

Year	Q1	Q2	Q3	Q4	Total
2019 / 20	44,127	45,764	43,221	36,839	169,951
2020 / 21	27,971	37,737	32,267	31,165	129,140
2021 / 22	45,888	47,065	42,538	42,073	177,564
2022 / 23	46,377				46,377

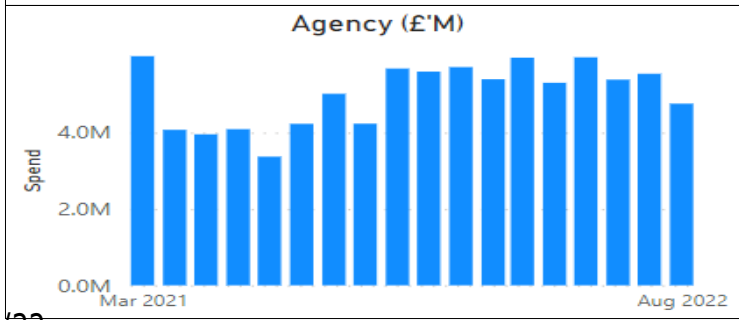


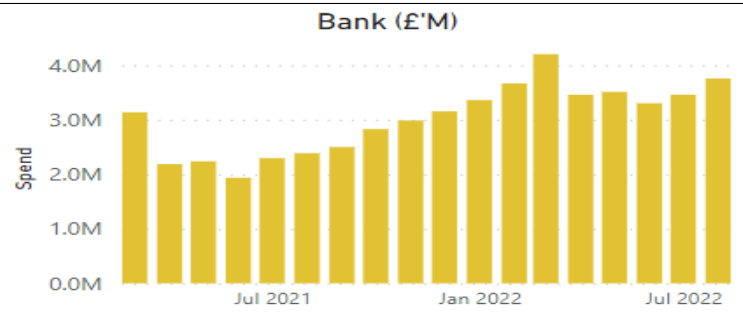
Pay & Variable Pay

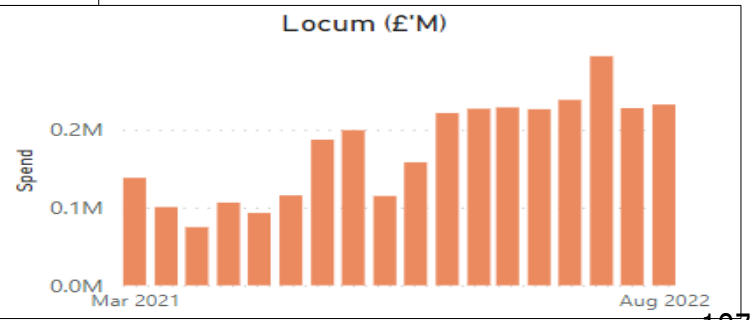


If Spend continues at the current averages:

- Agency could cost £64.7m (£57.3m in 21/22),
- Medical Locum could cost £2.6m in 22/23 (£2m in 21/22),
- ADH's could cost £11.5m in 22/23 (£9.3m in 21/22) and
- WLI's could cost £4.4m in 22/23 (£3m in 21/22) .
- Bank could cost £41.9m in 22/23 (£33.8m in 21/22) and
- Substantive could cost £612m in 22/23 at current rates (£608m in 21/22).
- Annual leave and pension adjustments are excluding from the cost comparisons.







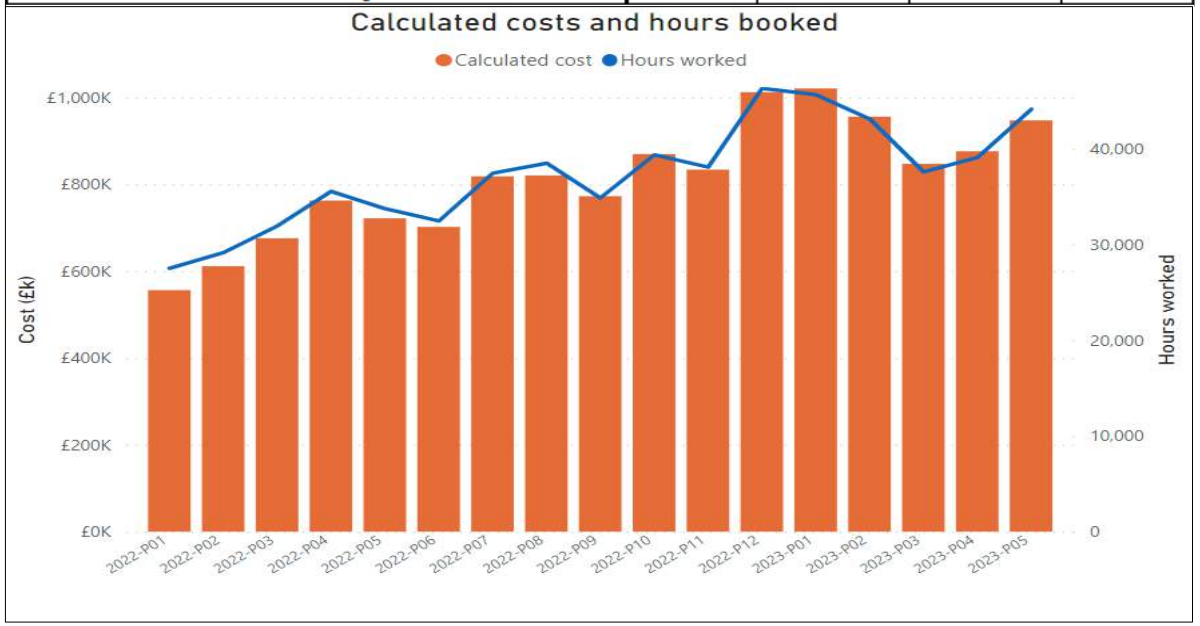
Enhanced Care (Acuity)

Medicine

Enhanced Care (acuity EC4 & EC5) by Hospital Site as a percentage of total bed capacity	Month 4	Month 5
YYF		
Total no of Medicine beds	148	148
Monthl's average bed numbers occupied by EC4 & EC5 pts	46	35
%age of beds in receipt of Enh Care (EC4 & EC5)	**31%**	**24%**
RGH		
Total no of Medicine beds	192	192
July monthly average enh care patients	30	45
%age of beds in receipt of enh care	**16%**	**23%**
NHH		
Total no of Medicine beds	164	164
July monthly average enh care patients	39	35
%age of beds in receipt of enh care	**24%**	**21%**
GUH		
Total no of Medicine beds	91	91
July monthly average enh care patients	18	32
%age of beds in receipt of enh care	**20%**	**35%**

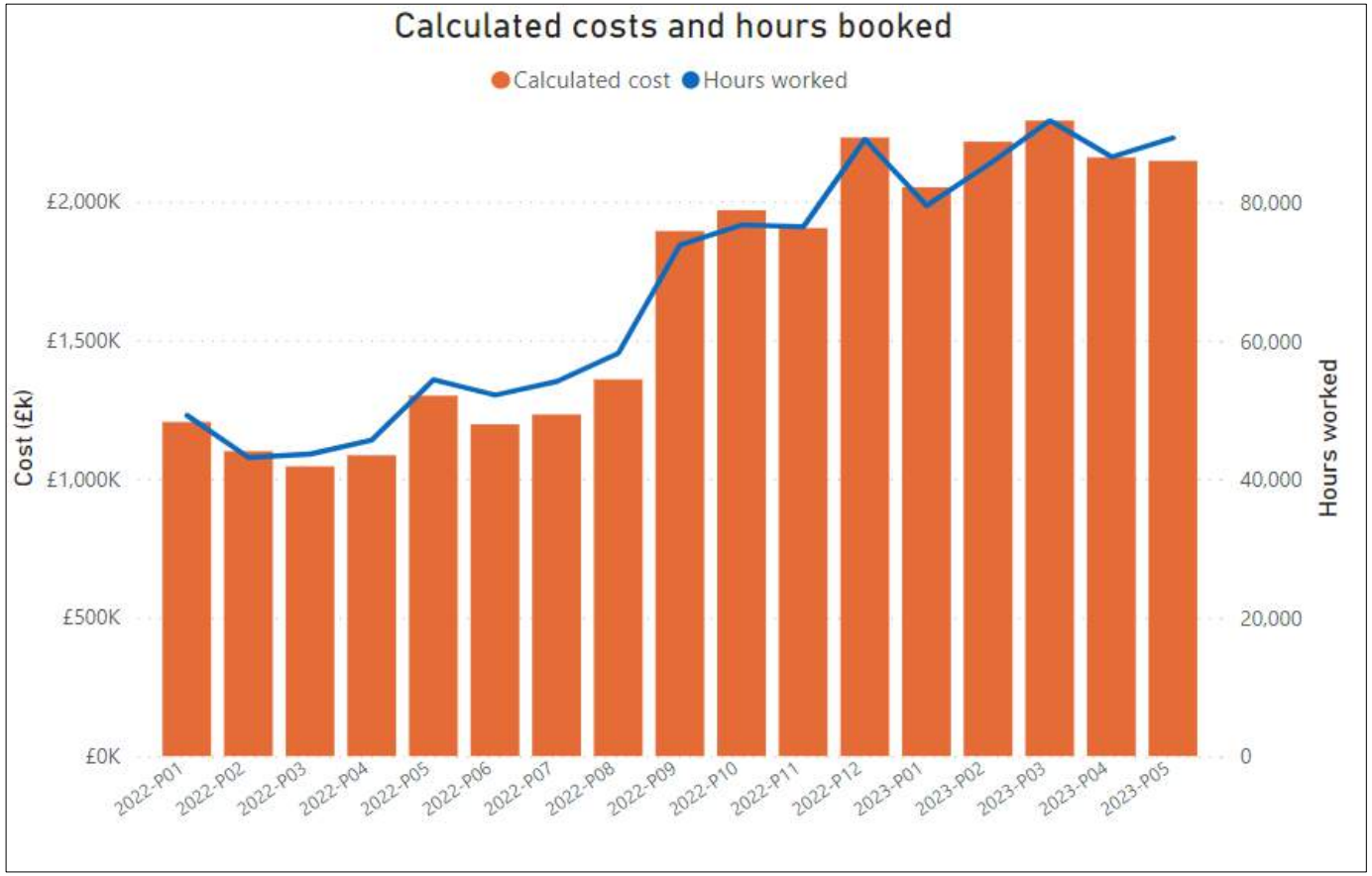
ABUHB

	2020/21	2021/22	2022/23	2022/23 increase
Average number of hours used per month	15,305	35,446	41,916	17%
Average monthly notional expenditure (£m)	0.24	0.70	0.93	
Increase in average notional cost per month compared to prior year				£0.2m
Estimated increase in the calculated annual cost based on average hours				£2.7m



Vacancies

Bank and Agency usage as a result of vacancies



Medicine Divisions Nursing & RN Vacancies (WTE)

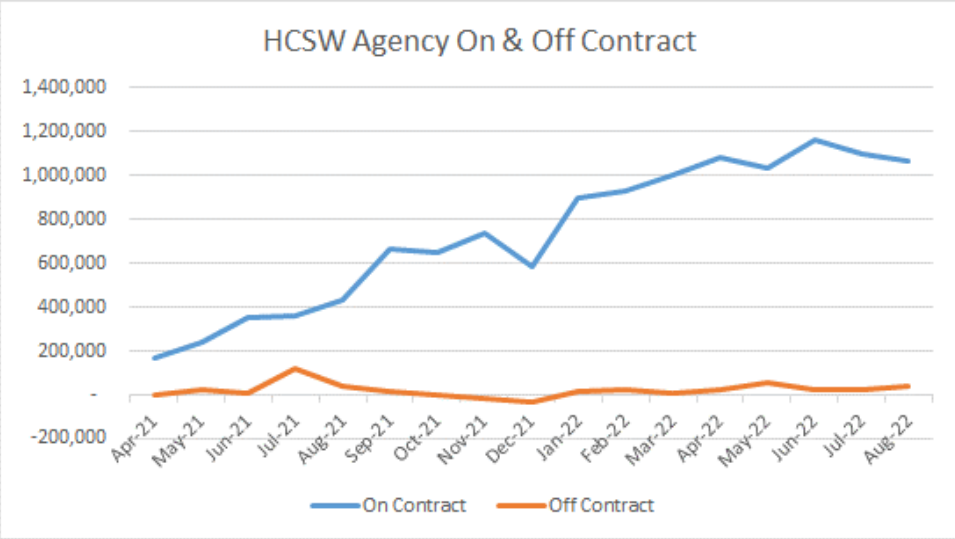
- RN – 139.97
- HCSW – 67.25

Scheduled Care Division Nursing & RN Vacancies (WTE)

- RN – 68.8
- HCSW – 103.43

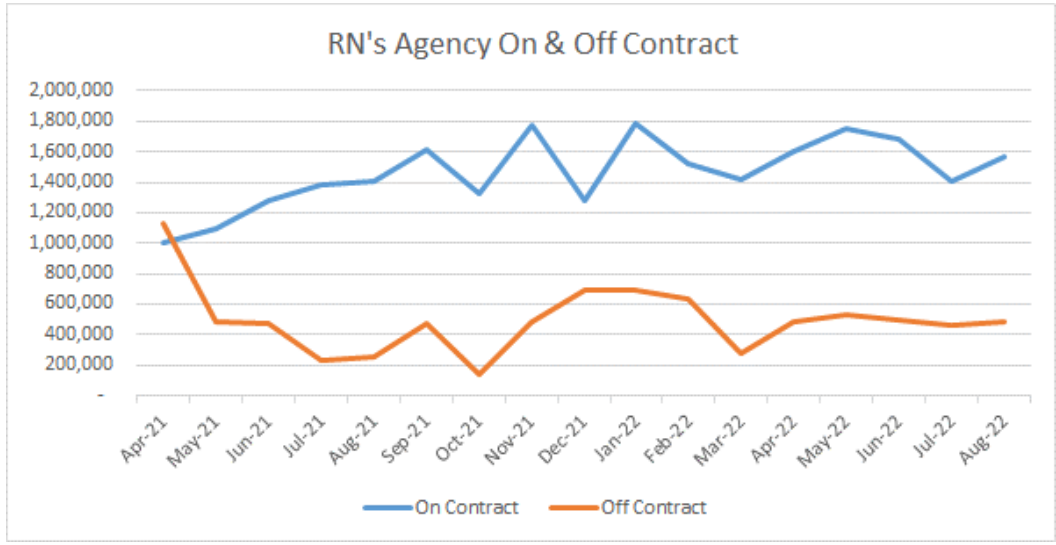
Average prices	HCSW	RN
Substantive	17.07	27.5
Agency (On-Con)	25.66	32.4
Agency (Off-Con)	40	50
Increase on Substantive Price	**HCSW**	**RN**
Substantive	17.07	27.5
Agency (On-Con)	50%	18%
Agency (Off-Con)	134%	82%

Nursing Agency On & Off Contract



- Need to ensure all are aware of the premium costs for off contract agency and re-iterate booking procedures

Nursing Off contract agency is subject to an Internal audit review , brief agreed August 2022



Scheduled Care – Nursing Vacancy, Covid and Acuity Cover

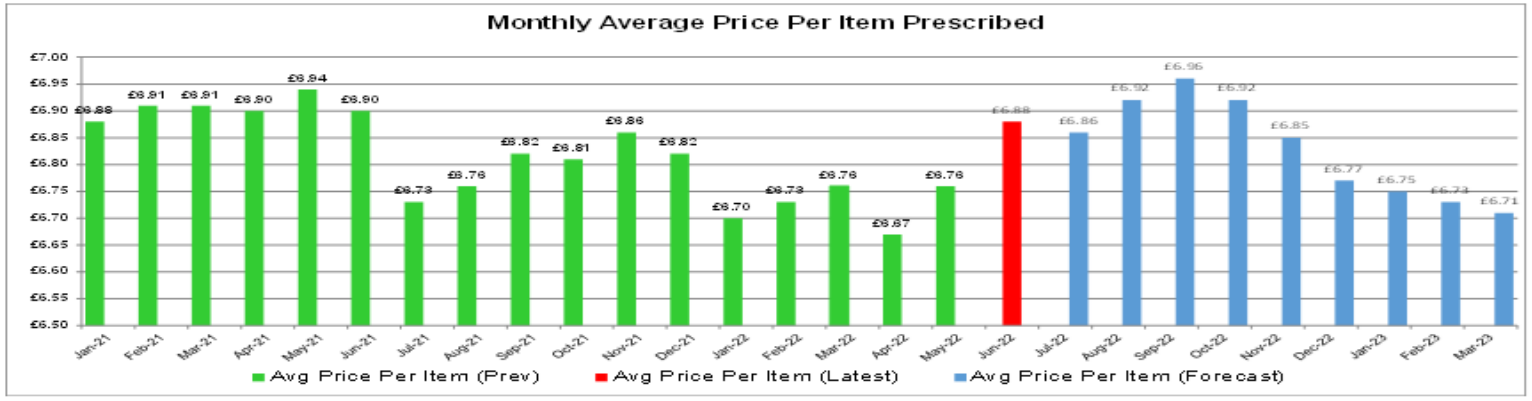
Nursing Vacancy & Excess Absence Cover

	Hours	Rate	£
Enhanced Care	5,000	43.64	218,200
Covid	750	43.64	32,730
Vacancy Cover	27,987	40.03	1,120,292
			1,371,222
Vacancies	27,987	24.13	675,335
Net Monthly Cost Pressure			695,887

- Requirement for 5,000 hours of monthly Enhanced Care
- Sickness absence running at 6.23% and rising over the last few months.
- 172.23 Nursing vacancies, backfilled with premium cost additional staff at an increased rate of 65.9%
- Divisional finance Team currently working with Nursing team on rota efficiency. Opportunities yet to be quantified.

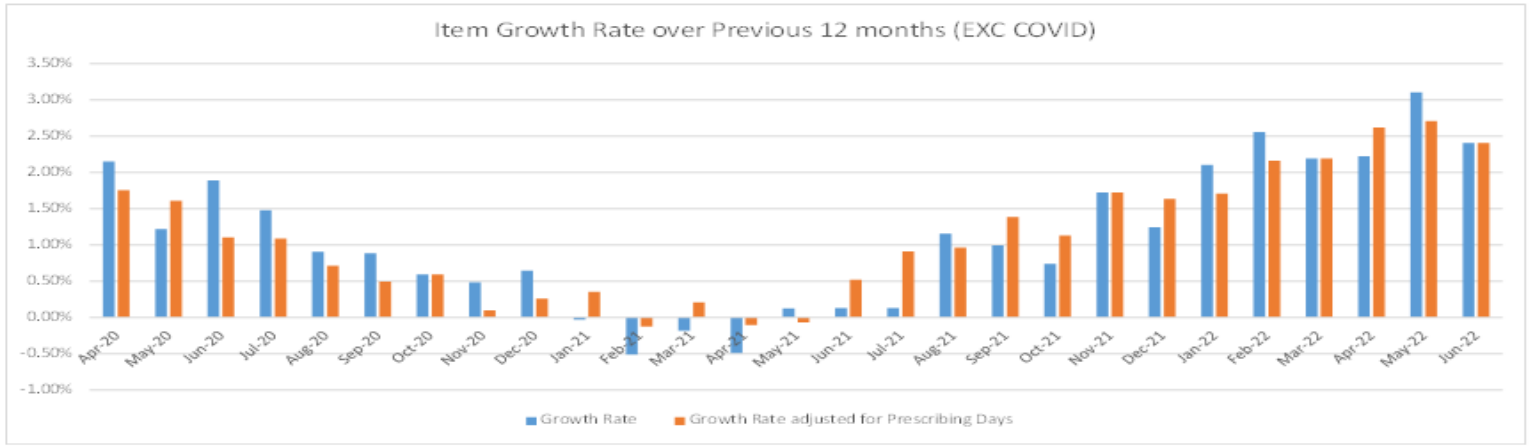
Prescribing

Cost pressures are a result of the cumulative impact of price and volume growth - £7.5m increase over 20/21



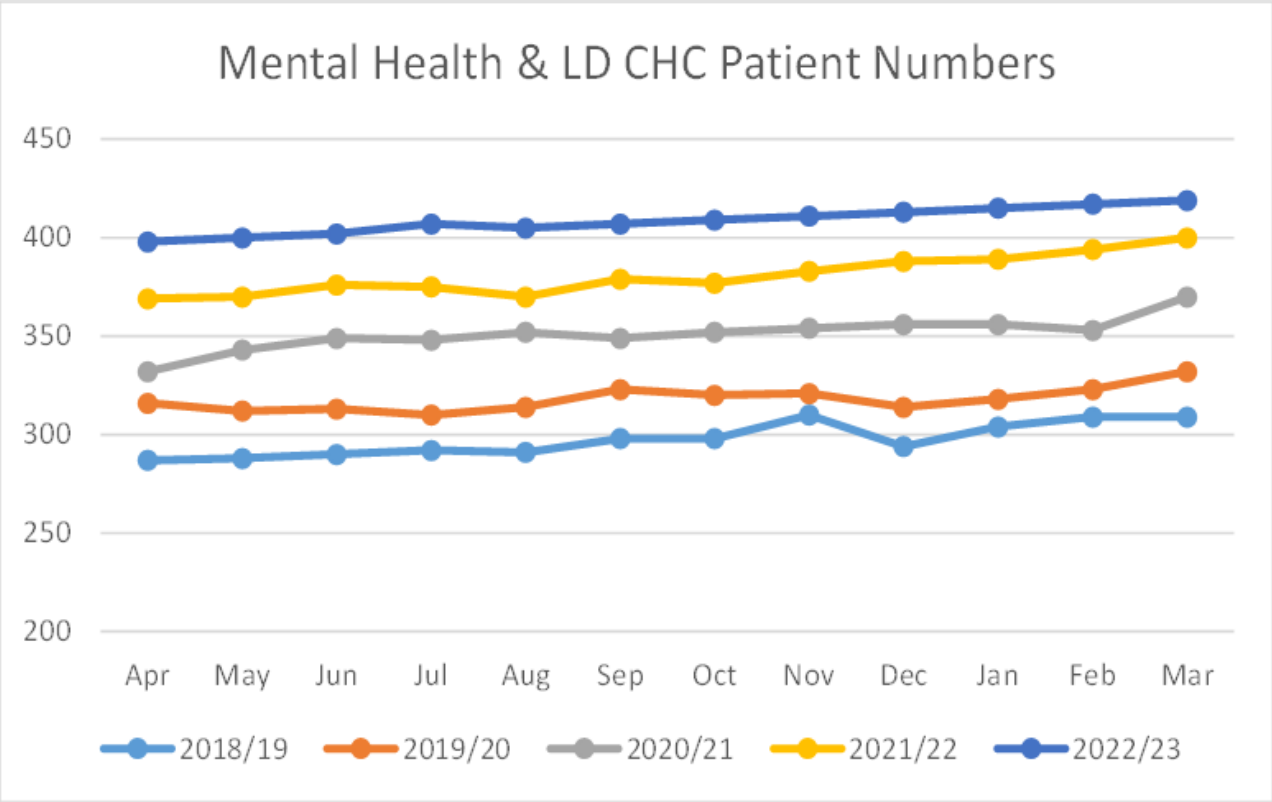
Financial Year	Average Price Per Item	Annual Change
2017/18	£6.37	
2018/19	£6.33	-0.63%
2019/20	£6.16	-2.69%
2020/21	£6.36	3.25%
2021/22	£6.81	7.08%
2022/23	£6.82	0.15%

Non-recurrent funding totallin g £7.3m received in 2021/22



Financial Year	Unadjusted Item Nos	Annual Change
2017/18	15,700,240	
2018/19	15,742,521	0.27%
2019/20	16,227,365	3.08%
2020/21	16,026,833	-1.24%
2021/22	16,378,768	2.20%
2022/23	16,510,030	0.80%

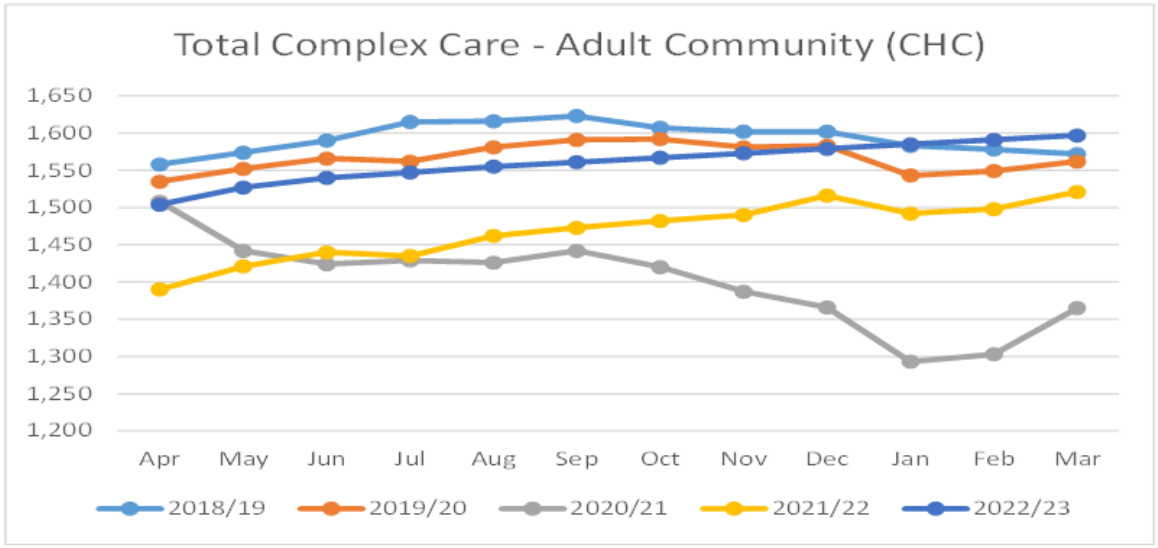
Mental Health CHC – Patient Numbers



Year	Average Patient Numbers	Annual % age Change
2018/19	298	
2019/20	318	7%
2020/21	351	10%
2021/22	381	8%
2022/23	409	7%

Year	All CHC Spend £m	Change £m	Annual % Change
2018/19	£31.0		
2019/20	£32.0	£1.1	3.5%
2020/21	£36.7	£4.6	14.5%
2021/22	£39.7	£3.0	8.3%
2022/23	£43.8	£4.1	10.3%

Complex Care – Patient Numbers



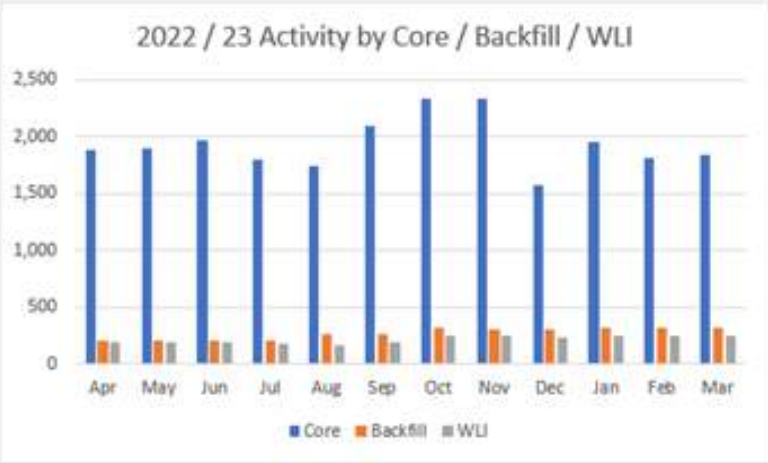
Year	Average Patient Numbers	Annual % age Change
2018/19	1,593	
2019/20	1,566	-2%
2020/21	1,400	-11%
2021/22	1,468	5%
2022/23	1,561	6%

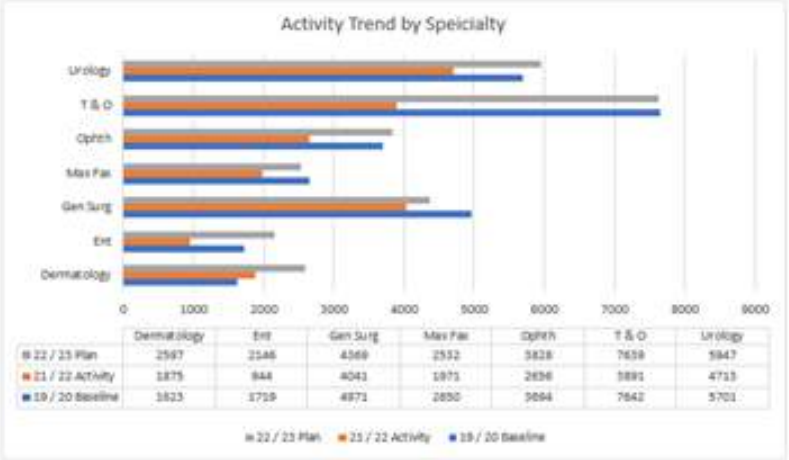
This includes: CHC, FNC, Palliative Care, D2A, CAHT, SCTH, External packages and FNC conversions

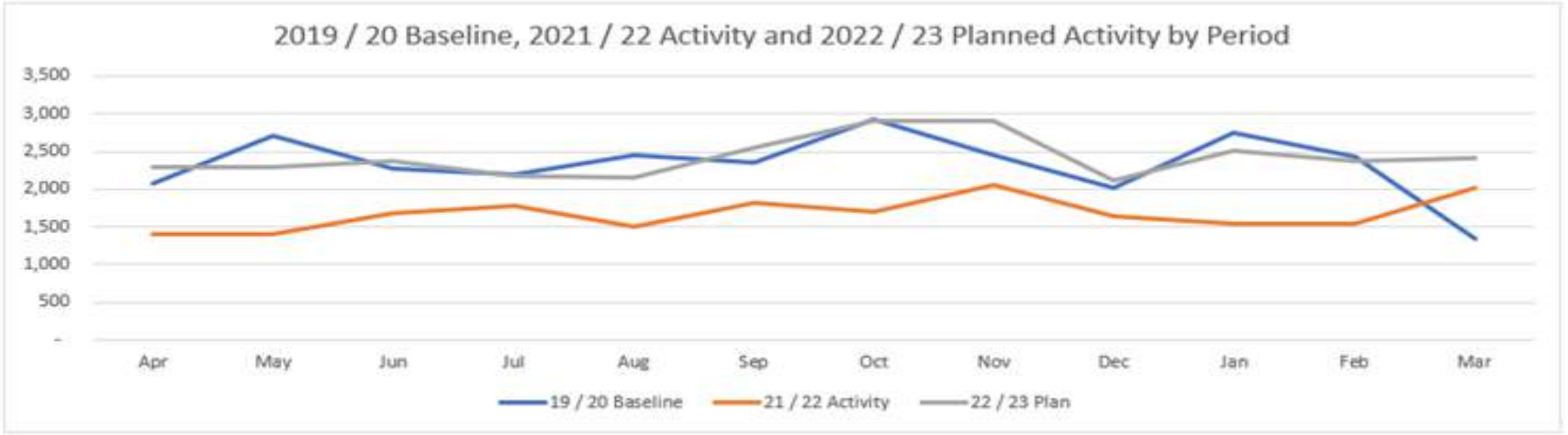
Activity	May 2022	June 2022	July 2022	August 2022	Movement
D2A	65	70	62	57	-5
Step Closer To Home	47	45	35	47	12
All Other CHC	1,428	1,432	1,458	1,457	-1
Total	**1,540**	**1,547**	**1,555**	**1,561**	**6**

Type	Weekly Cost 2020/21	Weekly Cost 2021/22	Weekly Cost 2022/23	% change 2022/23 - 2020/21
CHC	£1,384	£1,539	£1,661	20%
FNC	£179	£184	£194	8%
Palliative	£743	£752	£864	16%
D2A	£0	£1,461	£1,751	
CAHT	£3,378	£3,499	£3,602	7%
SCTH	£0	£727	£851	
External	£1,124	£1,460	£1,559	39%

Elective Treatment Performance Trends







Elective Treatment 2022 / 23

Planned Treatments YTD					
Treatment	Core	Backfill	WLI	Other	Total
Derm	821	0	125	56	1,002
ENT	696	0	190	0	886
GS	1,430	410	20	0	1,860
Max Fax	802	48	96	0	946
Ophth	1,445	120	30	0	1,595
Rheum	0	0	0	0	0
T&O	1,662	365	448	0	2,475
Urology	2,451	90	0	0	2,541
	9,307	1,033	909	56	11,305

Actual Treatments YTD					
Treatment	Core	Backfill	WLI	Other	Total
Derm	759	22	88	0	869
ENT	455	22	14	0	491
GS	1,192	430	15	0	1,637
Max Fax	954	0	0	0	954
Ophth	1,169	68	20	0	1,257
Rheum	0	0	0	0	0
T&O	1,736	318	104	0	2,158
Urology	1,834	121	53	0	2,008
	8,099	981	294	0	9,374

Treatment Variance YTD					
Treatment	Core	Backfill	WLI	Other	Total
Derm	-62	22	-37	-56	-133
ENT	-241	22	-176	0	-395
GS	-238	20	-5	0	-223
Max Fax	152	-48	-96	0	8
Ophth	-276	-52	-10	0	-338
Rheum	0	0	0	0	0
T&O	74	-47	-344	0	-317
Urology	-617	31	53	0	-533
	-1,208	-52	-615	-56	-1,931

Key Divisional Issues – Hospital Divisions

Scheduled Care

- Variable activity – £6.3m full year pressure (£1.3m YTD and £5.0m in forecast from M06).
- Nursing Workforce pressures driven by vacancies and additional acuity pressures required Enhanced Care - £5m
- Medical staffing - £10m
- Increase in Drug spend - £3.5m

Unscheduled Care (Medicine & Urgent Care)

- Variable activity – £4.9m. WLI, Backfill and Insourcing contracts across Cardiology, Diabetes and Gastro.
- Operational pressures - £7m. Back door or discharge blockages and workforce challenges driving incremental cost pressure. 73 surge beds in forecast.
- Increase in RN / HCSW Vacancies - £5m.
- MIU attendances up 35% on 19/20 levels - £1m.

Estates & Facilities

- Unfunded HSDU Decontamination GUH - £0.4m
- Backlog Maintenance - £0.3m
- Unfunded Water Risk Management case - £0.2m

Key Issues: Out Of Hospitals (1)

Primary Care & Community Services (inc Prescribing) (£4.763m forecast overspend)

- Prescribing (£7.672m forecast overspend)
  - Increase overspend compared to 21/22 due to non-recurrent budget received in 21/22
- Managed Practices (£2.36m forecast overspend)
- Community Hospitals (£1m forecast overspend)
- Pharmacy Staffing (£1m forecast overspend)
  - Poly Pharmacy £280k, Clinical Futures £221k, Antimicrobial £194k
- Eyecare (£960k forecast overspend)
  - EHEW, Wet AMD, ODTC
- Out Of Hours (£525k forecast overspend)

- GMS Contract (£3.9m forecast underspend)
- Pharmacy Contract (£958k forecast underspend)

Key Issues: Out Of Hospitals (2)

Complex Care (£5.7m forecast underspend)

- Increased Patient Numbers
  - 1,400 (20/21), 1468 (21/22), 1561 (22/23)
- Increased Weekly Costs
  - 20% average increase in CHC costs from 20/21
  - 8 % increase in FNC costs from 20/21

Mental Health & Learning Disabilities (£13.9m forecast overspend)

- CHC £13.9m forecast overspend
- 37% increase in patient numbers since 2018/19

Corporate

- Planning Director: Digital developments - unfunded: MS Office (£1.6m), Careflow (£0.6m),O365 (£0.2m), MS Office team costs (£0.2m), telephony / telecoms (£0.2m) and ICT accommodation (£0.2m).

- Litigation: Welsh Risk Pool provision share, unfunded (£1.5m).

- Dir of Ops: Reduction in expected RTA income (£0.5m).

Key Issues – External Commissioning

External Commissioning

- Specialist Services:
  - EASC deficit of £304k, decision by AWCEO's to fund £1.8m of pressures after the IMTP.
- WHSSC
  - Release of WHSSC held ‘reserves’ reflected in forecast

- Contracts:
  - Non-recurrent NICE New Treatment Funding & reduced income from Powys HB following the GUH opening and reconfigured service delivery £0.9m.
  - Managing risks and opportunities for C&V and Cwm Taf respectively
  - Risk increased Velindre NICE spend
  - SJH contract £0.8m

Savings by Division Green and at Risk

		Forecast Savings												
Category	IMTP & Green/Amber (as at Month 3)	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Complex Care	IMTP													0
	Green													0
	Amber	-	-	-	-	-	-	-	-	-	83	83	84	250
Medicine	IMTP	42	42	42	251	251	251	251	251	251	251	251	251	2,388
	Green	8	12	18	15	13	12	12	12	14	14	14	14	158
	Amber	-	-	-	-	-	-	-	-	-	276	276	281	833
Urgent Care	IMTP	-	-	-	102	102	102	102	102	102	102	102	102	915
	Green	6	8	10	24	24	24	24	24	24	24	8	5	202
	Amber	-	-	-	-	-	-	129	129	129	129	129	129	774
Scheduled Care	IMTP	48	175	175	1,305	1,305	1,305	1,305	1,305	1,305	1,305	1,305	1,305	12,144
	Green	166	192	122	131	131	131	132	132	132	132	132	132	1,662
	Amber	-	-	- 0	-	-	-	543	543	543	3,158	3,158	3,143	11,088
Primary Care and Community	IMTP	54	54	54	54	54	54	54	54	54	54	54	54	646
	Green	219	150	192	202	233	242	247	255	257	256	266	274	2,795
	Amber													0
Mental Health and Learning Disabilities	IMTP	32	32	32	32	32	32	32	32	32	32	32	32	378
	Green	-	-				54	54	54	54	54	54	54	378
	Amber													0
Family & Therapies	IMTP	25	25	25	125	125	125	125	125	125	125	125	125	1,202
	Green	25	25	25	53	25	25	25	25	25	44	44	43	383
	Amber	-	-	-	-	-	-	-	-	-	217	217	218	652
Estates and Facilities	IMTP	29	29	29	84	84	84	101	101	101	101	101	101	947
	Green	29	29	29	55	55	55	55	55	55	55	55	55	579
	Amber	-	-	-	-	-	-	17	17	17	106	106	107	368
Corporate	IMTP	18	18	18	245	245	245	888	888	888	888	888	888	6,118
	Green	18	18	18	18	18	18	18	18	18	18	18	18	214
	Amber	-	-	-	-	-	-	-	-	1,426	1,493	1,493	1,491	5,903
Commissioning	IMTP				167	167	167	167	167	167	167	167	167	1,500
	Green													0
	Amber													0
Total	IMTP	247	374	374	2,365	2,365	2,365	3,025	3,025	3,025	3,025	3,025	3,025	26,238
	Green	471	434	414	497	498	560	566	573	578	595	590	594	6,370
	Amber	-	-	- 0	-	-	-	689	689	2,115	5,462	5,462	5,453	19,868

Aneurin Bevan University Health Board

Finance & Performance Committee

Budgetary Control Finance Control Procedure

Executive Summary

This briefing paper identifies the key governance documents, guidance and controls which are established to ensure financial expenditure is managed within available resources.

The documents are available on the ABUHB intranet and share point sites for all staff and are copied (via electronic links) into the budget delegation letters issued to budget holders.

Key documents include:

- Standing Orders
- Standing Financial Instructions
- Budgetary Control Financial Control Procedure
- Scheme of Delegation

A summary is provided below of the most relevant paragraphs for reference.

The Committee is requested to note the report.

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

Executive Sponsor: Rob Holcombe, Director of Finance, Procurement & Value			
Report Author: Heulwen Griffiths, Head of Business Systems and Governance			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 23/9/22			
Supplementary Papers Attached:			

Purpose of the Report

This briefing paper identifies the key governance documents, guidance and controls which are established to ensure financial expenditure is managed within available resources.

Background and Context

ABUHB is facing significant service and workforce pressures which are driving financial challenge and significant risk to delivering financial balance for 2022/23.

This paper describes the key financial controls and governance 'rules' and behaviours which the organisation has established to ensure expenditure is managed within available resources.

These key documents are aligned with Welsh government requirements and best practice financial control procedures.

Assessment and Conclusion

The following excerpts reflect the key sections identified in terms of financial control and operating within available resources. Electronic links to the full documents are included for reference and key points are highlighted.

Summary

1. Standing Orders
   - 1.1 Reservation and delegation of LHB Functions (Page 19 Section 2)
2. Standing Financial Instructions
   - 2.1 Financial provisions and obligations of LHBs (Page 8 Section 1.3)
   - 2.2 Financial Duties (Page 18 Section 4)
   - 2.3 Non Pay Expenditure – Duties of Budget Holders and Managers (Page 36 Section 10.3)
   - 2.4 Pay Expenditure – Staff Appointments (Page 60 Section 14.3)
3. Budgetary Control FCP
   - 3.1 Roles and Responsibilities (Page 4 Section 6)
   - 3.2 Delegation and Accountability (Page 9 Section 7.4)
4. Scheme of Delegation

Main Document

1. Standing Orders

1.1 Reservation and delegation of LHB Functions (Page 19 Section 2)

2.0.1 *Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the LHB may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.*

2.0.2 *The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:*

i) *Schedule of matters reserved to the Board;*
ii) *Scheme of delegation to committees and others; and*
iii) *Scheme of delegation to officers.*

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 *Subject to Standing Order 4, the LHB retains full responsibility for any functions delegated to others to carry out on its behalf.*

2. Standard Financial Instructions

2.1 Financial provisions and obligations of LHBs (Page 8 Section 1.3)

1.3.1.1 The financial provisions and obligations for LHBs are set out under Sections 174 to 177 of, and Schedule 8 to, the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the LHB meets its statutory obligation to perform its functions within the available financial resources.

2.2 Financial Duties (Page 18 Section 4)

4.1.1 The Health Board has two statutory financial duties, the basis for which is section 175 of the National Health Service (Wales) Act 2006, as amended by the National Health Service Finance (Wales) Act 2014. Those duties are then set out and retained in the Welsh Health Circular "WHC/2016/054 - Statutory Financial Duties of Local Health Boards and NHS Trusts." They are as follows:

- *First Duty - A duty to secure that its expenditure, which is attributable to the performance by it of its functions, does not exceed the aggregate of the funding allotted to it over a period of 3 financial years.*
- *Second Duty - A duty to prepare a plan to secure compliance with the first duty while improving the health of the people for whom it is responsible, and the provision of health care to such people, and for that plan to be submitted to and approved by the Welsh Ministers.*

2.3 Non Pay Expenditure – Duties of Budget Holders and Managers (Page 36 Section 10.3)

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or LHB officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the LHB to a future uncompetitive purchase;

2.4 Pay Expenditure – Staff Appointments (Page 60 Section 14.3)

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or LHB official may engage, re-engage, or re-grade employees, either on a permanent

or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

3. Budgetary Control FCP

3.1 Roles and Responsibilities (Page 4 Section 6)

6.6 Budget Holders

A budget holder is defined as a person to whom a budget is delegated. At the lowest level the budget holder is defined as the person responsible for managing resources at the lowest cost centre level and is able to approve expenditure goods and services and pay related costs against a cost centre budget within financial approval limits set by their line manager. The line manager is likely to be managing a number of budget areas delegated to others within their management area but is nevertheless also a budget holder with responsibility for a number of budgets delegated to others.

Accountability for budgetary control is exercised through line management relationships and this principle applies through all tiers of management where budgetary control is applicable.

Specific responsibilities of budget holders are:

- *Budget holders are responsible for providing services within their respective budget*
- *Budget holders are responsible for monitoring monthly budgets, actuals and variance utilising the Finance Business Intelligence Tool (FBI) and liaising with the Business Partner Finance Teams as necessary.*
- *Budget holders must not exceed the budgetary total or virement limits set by the Board*
- *Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive*
- *Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance, Procurement and Value*
- *All budget holders must provide information as required by the Director of Finance, Procurement and Value to enable budgets to be compiled and managed appropriately.*
- *To not incur any overspend or reduction of income without the prior consent of the Chief Executive subject to the Board's scheme of delegation*
- *No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board*
- *Develop recovery plans to address adverse budget variances*
- *Budget holders should keep a record of any recovery plan meetings with line managers and/or Division as appropriate.*

3.2 Delegation and Accountability (Page 9 Section 7.4)

Managers must deliver a balanced budget within each and every financial year.

The key principle of delegation is that accountability for budgetary control is exercised through the line management hierarchy. Budgets are therefore formally delegated through the management hierarchy. Budget holders must not overspend against their budget. The requirement to deliver within the allocated budget must therefore form part of all budget holder's annual objectives and be reviewed as part of the annual review process. The principles of delegation mean that accountability for budget management is to the line manager. Review of performance against budget should therefore take place as part of the line management PADR process in the context of the wider performance review of quality, safety and other targets.

3.3 Performance Management (page 12 section 7.8)

Aneurin Bevan Health Board has a statutory duty to deliver its services within its allocated budget. The Board via the Chief Executive and tiers of line management formally delegates this responsibility to individual budget holders across the organisation. Budget holders are held to account for budgetary performance through formal line management arrangements and are expected to manage within delegated resources on both a monthly and annual basis. This requirement links to the Health Board's statutory requirement to manage within its Revenue Resource Limit.

Where budget variances arise the following actions must be undertaken by the budget holder and line manager in a formal process of escalation:

- *If a budget is overspent in any one month the budget holder where practicable will recover the position by the next reported period.*
- *If a deficit will take longer than one month to correct and recover then the budget holder and line manager will:*

  Either

  - *agree recovery actions over a defined period*

  Or

  - *agree virements from another area of budgetary responsibility*

A record of actions agreed must be made. A suggested format for recording actions is shown in Appendix 2.

- *If a deficit cannot be recovered within a period of 3 months, or virements agreed with the budget holder, the line manager will be required to agree remedial actions with the Divisional Director.*
- *If remedial actions to recover the deficit, or agree virements still cannot be agreed with the Divisional Director, the line management team will agree remedial actions or virements with the responsible Executive Director.*
- *If remedial actions to recover the deficit, or agree virements, still cannot be agreed with the Executive Director, the Chief Executive will agree remedial actions or virements.*
- *If there is continued failure to agree a recovery plan or virements, the Executive Director and Chief Executive will agree remedial actions with the Audit Committee and Board.*
- *A record of the meeting to discuss and agree recovery actions must made. A suggested proforma is attached in Appendix 2 to record agreed actions.*

Budgetary control must form a key objective each year for all management staff with budget responsibilities. Managers will be held to account for not meeting budgetary targets and subject to formal review as part of their wider performance management review with their line manager.

Recommendation
The committee is requested to note the content of the report for information and reference.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risk of achieving the Health Board's statutory financial duties. Risks of non-compliance.
Financial Assessment, including Value for Money	Compliance with Governance and control procedures should improve financial control and value for money.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
Equality and Diversity Impact Assessment (including child impact assessment)	Applicable to all ABUHB activities.

Health and Care Standards	This paper links to Standard for Health services One – Governance and Assurance.
Link to Integrated Medium Term Plan/Corporate Objectives	Governance Controls should support delivery of all aspects of the IMTP and corporate objectives.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** **Integration** – **Involvement** – **Collaboration** – **Prevention –** Financial governance is a universal control to support the best use of public resources and decision making for public benefit.
Glossary of New Terms	n/a
Public Interest	Open, public documents

Aneurin Bevan University Health Board

Performance Report

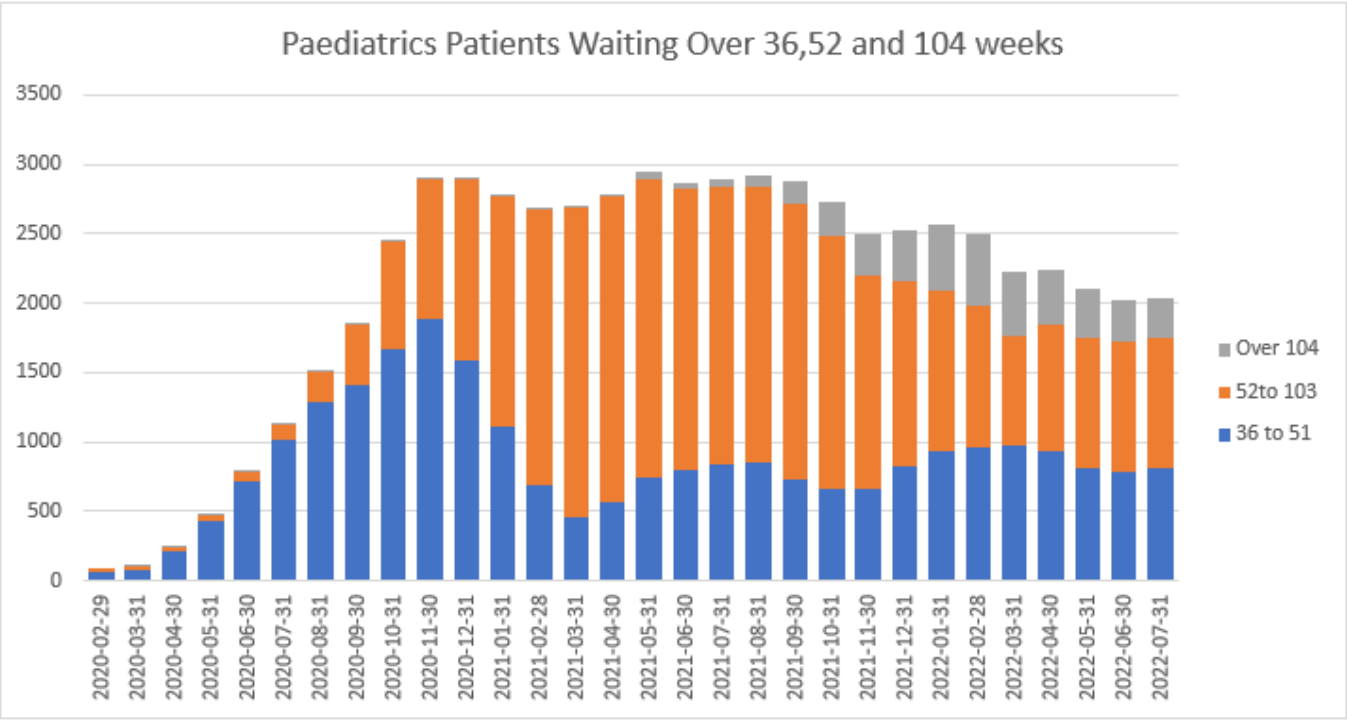
Executive Summary

The Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views	✓		
Receive the Report for Assurance/Compliance	✓		
Note the Report for Information Only			
Executive Sponsor: Christopher Dawson-Morris**,** Interim Director of Planning and Performance			
Report Author: Lloyd Bishop, Assistant Director of Performance and Information Sue Shepherd, Head of Corporate Performance and Compliance			
Report Received consideration and supported by:			
Executive Team		**Committee of the Board [Committee Name]**	**Public Board**
Date of the Report: 5th September 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 July 2022, with a focus on delivery against key national targets included in the performance dashboard. Outcomes based reporting will be provided on a Quarterly Basis in line with the IMTP cycle. This report therefore focusses on specific performance against the organisations key priorities in line with the national performance framework.
Report Narrative

Every Child has best start in life

The number of children on the Health Board's waiting lists who have been waiting over 36 weeks increased over the pandemic and peaked during the summer of 2021. Since the end of 2021, the number of children who have been experiencing longer waits has been falling. The chart below shows the number of children who have been waiting for 36, 52 and 104 weeks, it is anticipated that these numbers will continue to fall as activity increases to pre-pandemic levels in the coming months.



Getting it Right for Children and Young Adults

CAMHS

Sustained performance of the CAMHS measure of 80% is reported, with 94.4% of patients waiting less than 28 days for a first appointment at the end of July 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 has a target of children waiting less than 26 weeks to start an ADHD or ASD neurodevelopmental assessment. The service has unfortunately not seen an improvement in July 2022 with 47.2% compared with 47.5% in June 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 has grown by 103% since the relaunch in April 2021. The team have been operating additional evenings and weekend clinics, as well as 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.

Part of the changes, that are being introduced to better meet the demands, is working more closely with Local Education teams with the help of our Schools InReach, School Nurses, the Locality Community support services and School staff to help schools produce a tailored school setting support plan. 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).

The service is also reviewing all children and young people on the existing waiting list assessing their appropriateness for assessment and working with their parents/carers with signposting to alternative support or if they would benefit from support by other community services. Continuing this work will mean only those children and young people who need to be on the waiting list are progressed to ND for assessment.

With the 2022 Mental Health Service Improvement funding, the service is committed to it's ongoing investment in ND this year with a focus on further reducing the current waiting lists by providing additional capacity for the ND pathway that will enhance its assessment capability.

Adults in Gwent live Healthily and Age Well

Primary Care Mental Health

Performance against the 80% target for Primary Care Mental Health Measures for assessment improved in July 2022 to 91.6% compared with 78.3% in the previous month. However, the position for intervention remains below the target with position improving from 18.1% to 27.8% between June and July 2022.

The continued delay in recovery of the 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.

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 Primary Care Mental Health waiting list to be addressed. 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.

The service is due to migrate across to the new Welsh Community care Information System (WCCIS). WCCIS is a unique system that will allow local authorities and health service to share records and optimise services for citizens across Wales, as required by the Integrated Health and Social Care, Social Services and Well-being (Wales) Act. It is anticipated that it will provide a mobile solutions to deliver workflow for Mental Health, CAMHS, Learning Disability, Young Persons and Community Nursing staff, delivering scheduling and information, and therefore allowing transformational service change to better deliver person-focused, coordinated care that meets the needs of individuals and their families. This is a significant change to the services involved including the training of clinical and administrative staff already identified as resource light.

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, particularly with the anticipated downtime associated with the implementation of WCCIS.

Planned Care

Measure	Target	Forecast				
		Mar-22	APR	MAY	JUN	July
Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by 2024		6,514	6,029	5,813	5,778
	Planned	8,946	6,514	6,029	5,813	4,485
Number of patients waiting more than 36 weeks for treatment	Improvement trajectory towards a national target of zero by 2026		33,177	32,959	33,570	34,998
	Planned	32,720	33,177	32,959	33,570	29,640
Percentage of patients waiting less than 26 weeks for treatment	Improvement trajectory towards a national target of 95% by 2026		61.20%	61.40%	62.10%	62.1%
	Planned	58.00%	61.20%	61.40%	62.10%	58.00%
Number of patients waiting over 104 weeks for a new outpatient appointment	Improvement trajectory towards eliminating over 104 week waits by July 2022		1,462	1,362	1,354	1,443
	Planned	1,884	1,462	1,362	1,369	1,064
Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards eliminating over 52 week waits by December 2022	9,975	8,925	9,147	9,381	10,252
	Planned		8,925	9,147	9,381	9,200
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	A reduction of 30% by March 2023 against a baseline of March 2021		18,787	18,402	19,055	21,650
	Planned	17,910	18,787	18,402	19,055	16,927
Number of patients waiting over 8 weeks for a diagnostic endoscopy	Improvement trajectory towards a national target of zero by March 2026		3,528	3,515	3,247	3,212
	Planned	2,986	3,528	3,515	3,247	1,977
Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of 75%	65.00%	57.00%	53.00%	49.40%	50.40%
	Planned	53.00%	57.00%	53.00%	49.40%	50.00%

Outpatients

The number of patients waiting 52 weeks for a new outpatient appointment has deteriorated in a three month trend and the Health Board is not meeting the planned performance.

This is being driven by long waiting in mostly the high-volume specialties of Trauma and Orthopaedic, Ear, Nose and Throat (ENT) and Ophthalmology. Alongside the Divisional Plans, further action is in place to assist with reducing the number of patients waiting over 52-weeks through the Outpatient Transformation Programming including:

- Development of SoS and Pifu pathways – 5 new pathways within Scheduled Care to be implemented by December 2022. Impact review to be determined.
- Review 'Treat out of Turn' and identify any opportunities to improve efficiency
- A review of clinic space allocation is being undertaken to identify any space that is either being held for services or not allocated which can then be released/allocated as appropriate
- Specialities being reviewed in terms of Pre-covid and current activity levels to identify reasons for variance

- Activity throughput in clinics versus clinic capacity being used currently being evaluated to identify areas of opportunity
- One stop Outpatient Treatment Unit at RGH – staged opening commencing with general surgery lumps and bumps, colorectal infusions and dermatology one stop. This is planned for September 2022
- Interventions not Normally Undertaken (INNU) The INNU policy has been recirculated to Divisions, along with the current data showing 'potential' INNU procedures that have been undertaken. Each service has been asked to evaluate the information and report back by September and present the outcome of the review at the directorate outpatient meetings
- The design stage has been completed and a pre-review of potential suppliers to be undertaken for an automated booking system for allocation and reuse of Outpatient clinical space.
- Development of Individual Outpatient Transformations plans which will also assist with delivering transformation as well as linking to increased activity
- Roll out of consultant connect specialist advice system which will assist with decreasing demand onto waiting lists and emergency demand
- Use of advice process – this reduces demand onto waiting lists where consultants review the clinical letter and send advice back direct back to General Practitioners
- Patient Activation and Support project commenced to ensure support to patients whilst waiting
- A rolling programme of patient contact and validation of long waiting patients is ongoing (the patient is required to confirm whether they wish to remain on the waiting list from this exercise)
- Development of an Outpatient Treatment Unit focussing on interventions that do not require a 'main' theatre setting. Carpel Tunnel and ENT pathways are being developed

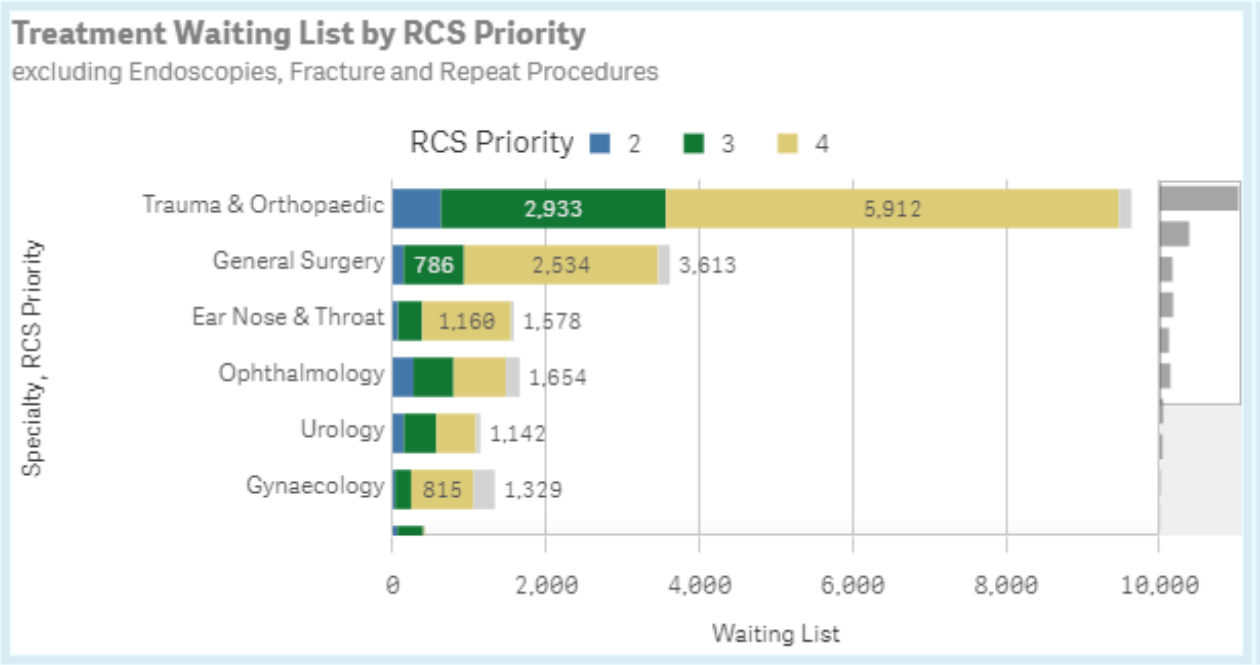
Elective Activity

Elective inpatient admissions had been increasing but remain at a lower level than pre-COVID-19. The number of elective inpatient admissions have steadily increased in July from June activity. Elective inpatient admission activity for July represented 62% of pre-pandemic levels. Daycase activity also increased in July to 90% of pre-pandemic levels. Whilst services are developing plans to improve activity further over the next few months this is in the context of sustained urgent care pressure. 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.

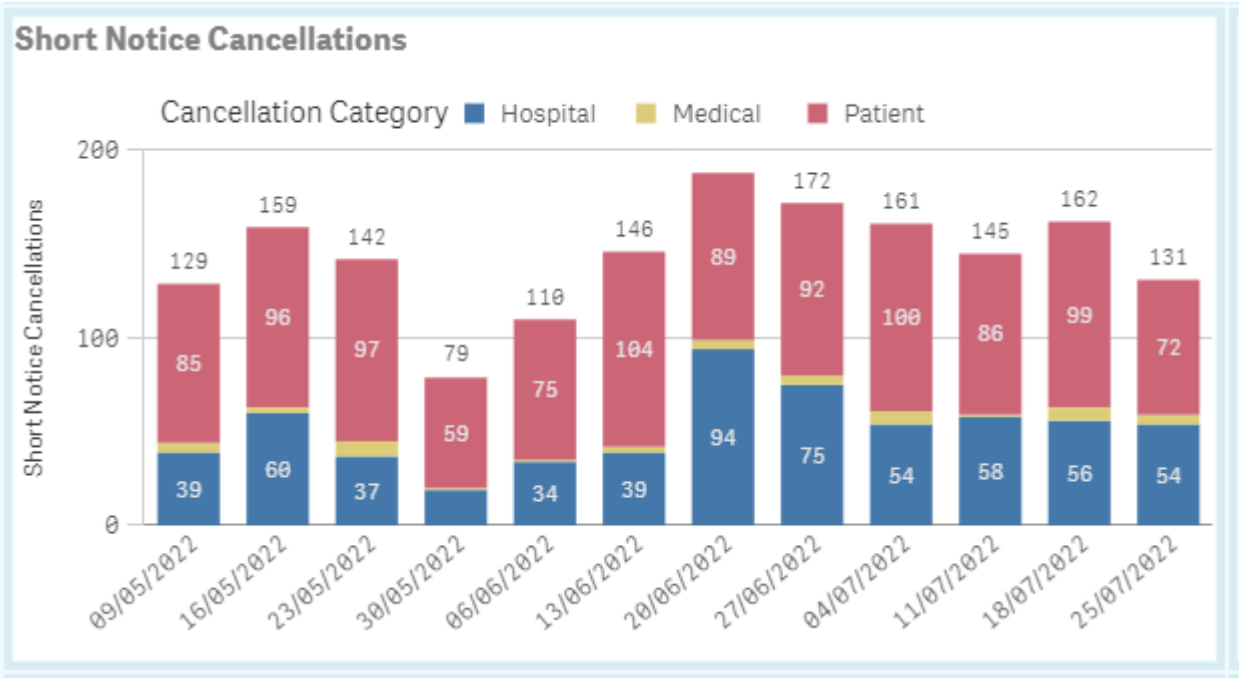
The Royal College of Surgeons (RCS) introduced guidance on how and what pathways should be prioritised. Changes to incorporate the agreed RCS risk prioritisation on the national Welsh Patient Administration System (WPAS) has enabled services to apply a risk code of P2, P3 or P4 to those patients waiting 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. However, Welsh Government via the Chief Medical Officer for Wales has now issued new guidance to Health Boards to ensure that clinical risk and long waiting patients are prioritised in the same way. This is likely to increase the volumes in the highest risk category and the available capacity.

Under the RCS prioritisation methodology, overall compliance of a risk priority applied to the inpatient and daycase waiting lists is just under 95% with 12% 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.



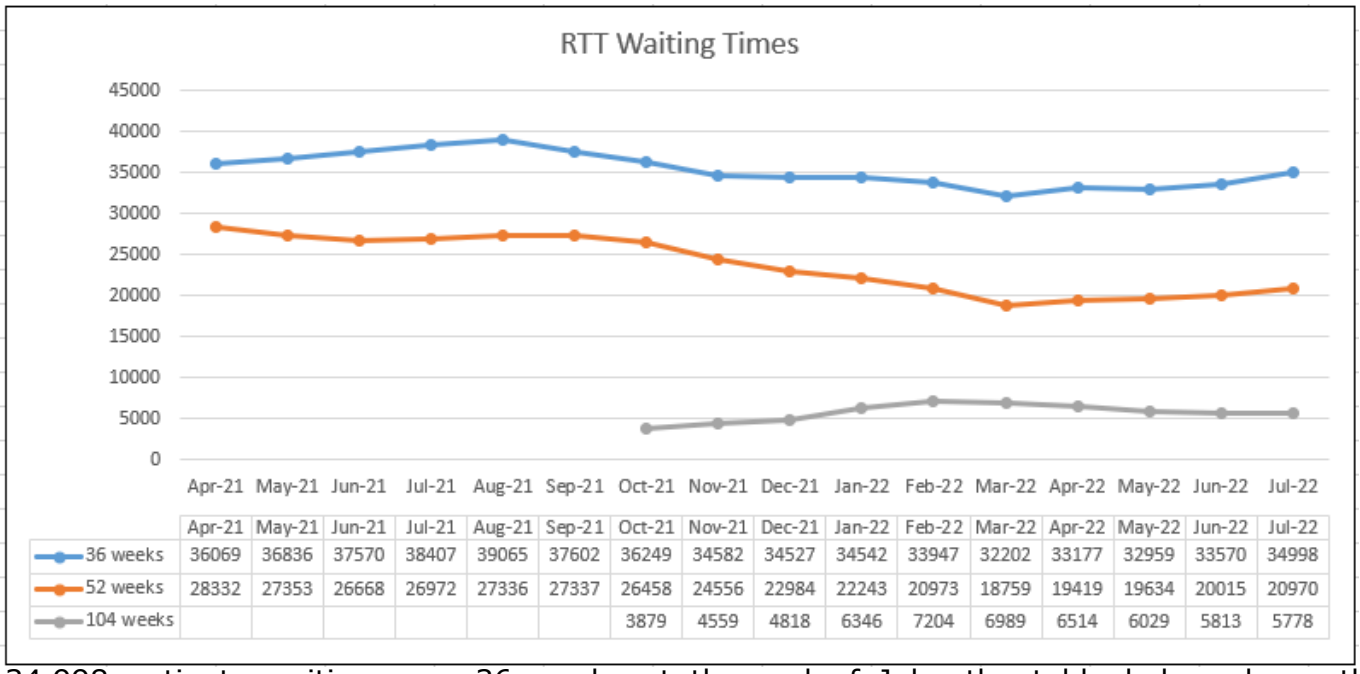
P2 patients are prioritised for admission, there are however, a number of patients who decline the offer of treatment due to the pandemic or pre-admission Covid isolation requirements and prefer to remain on the waiting list. The breakdown of cancellations is shown below with patient cancellations making up the majority of cancellations each week. The 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 increased in July 2022 with 34,998 compared with 33,570 in June 22. The chart below illustrates the trend in the 36+ week breach patients and also the focus on treating the longest waiting patients:

Of



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
36 weeks	36069	36836	37570	38407	39065	37602	36249	34582	34527	34542	33947	32202	33177	32959	33570	34998
52 weeks	28332	27353	26668	26972	27336	27337	26458	24556	22984	22243	20973	18759	19419	19634	20015	20970
104 weeks							3879	4559	4818	6346	7204	6989	6514	6029	5813	5778

the 34,998 patients waiting over 36 weeks at the end of July, the table below shows that approximately 20,253 of those are at the new outpatient waiting list stage. There are also 20,970 waiting over 52 weeks with 10,252 of those at the new outpatient waiting list stage. Of the 20,970 patients waiting over 52 weeks, 5,778 of those patients have been waiting over 104 weeks with 1,443 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	52,042	2,885	184	4,125	8,408	2,346	69,990
26 to 35	8,959	607	31	1,014	1,866	814	13,291
36 to 51	10,001	590	22	515	1,761	1,139	14,028
52 to 103	8,809	692	71	604	2,616	2,371	15,163
104 +	1,443	236	21	190	2,031	1,857	5,778
Total	**81,254**	**5,010**	**329**	**6,448**	**16,682**	**8,527**	**118,250**

Whilst the contract with care UK for ophthalmology treatments ceased at the end of June 2022, discussions are ongoing to renew and opportunities continue to be explored 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.

To address this challenge the Health Board has added additional assurance into the Planned Care programme

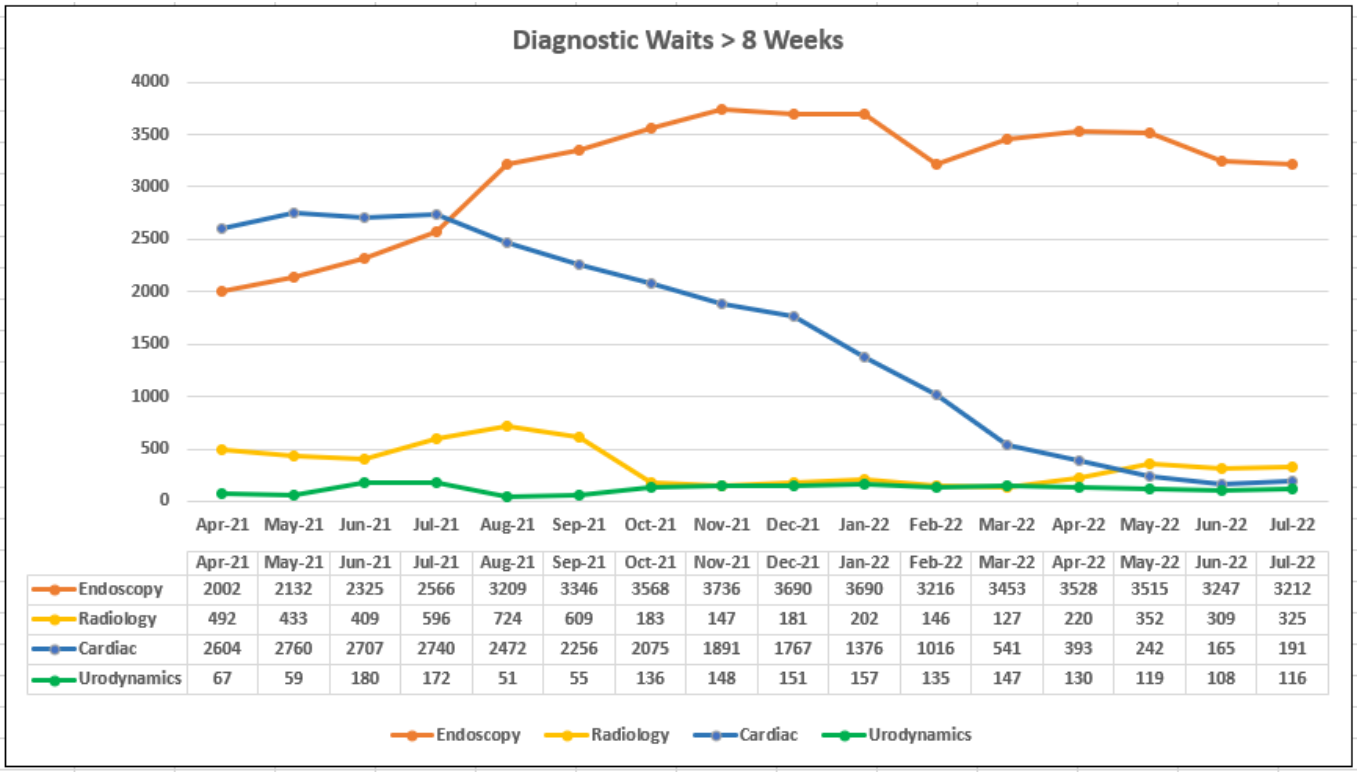
- In addition to the Planned Care Recovery Programme, a Planned Care System Leadership and Response group has been established to oversee core metrics of activity. This includes RTT (focus on 52 and 104 week waits), Treat in Turn, Activity levels and Outpatient KPIs.
- Scheduling review across theatres related to use/output and RTT focus
- Detailed review of modelling of demand and productivity of outpatient and theatre system to inform trajectories of waiting times and opportunities for improvement
- Theatre Improvement workshop planned for 17th October 2022 to develop action plan to improve utilisation of planned theatre sessions

- GIRFT reviews and action plans in orthopaedics and gynaecology that support adopting best practice in terms of performance and quality

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 July 2022 for the fourth consecutive month, with 3,212 waiting over 8 weeks compared with 3,247 in June.

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. These include sustained insourcing of additional activity at the Royal Gwent Hospital and the training of non-medical endoscopists to consolidate the workforce.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Endoscopy	2002	2132	2325	2566	3209	3346	3568	3736	3690	3690	3216	3453	3528	3515	3247	3212
Radiology	492	433	409	596	724	609	183	147	181	202	146	127	220	352	309	325
Cardiac	2604	2760	2707	2740	2472	2256	2075	1891	1767	1376	1016	541	393	242	165	191
Urodynamics	67	59	180	172	51	55	136	148	151	157	135	147	130	119	108	116

The most significant improvement has been in Cardiology diagnostics with the numbers waiting over 8 weeks is almost a third compared to the position at the end of March. With the procurement of an insourcing company to deliver additional echo capacity, this has resulted in a significant reduction in the number of 8-week breach patients, 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

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 decrease 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.

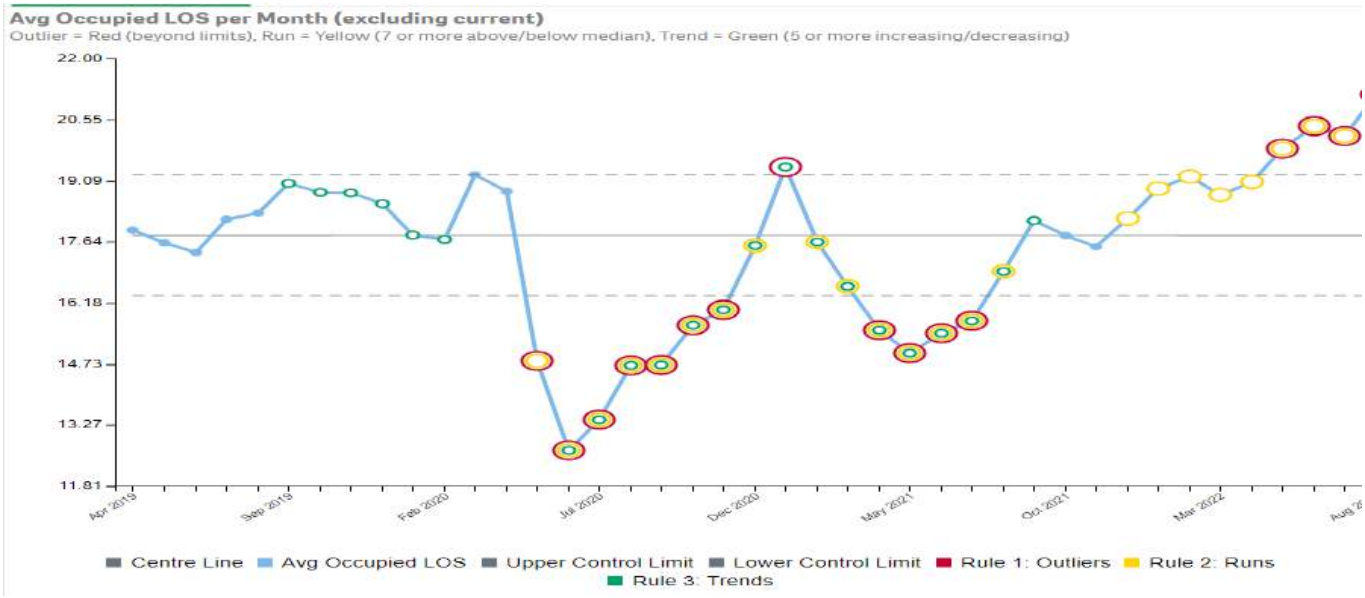
- Radiology diagnostics continue to recover well, with a few areas of exception. The main backlog is in MSK ultrasound although performance continues to higher than other parts of Wales. Some areas where there have been some longer waits are with those patients who require a general anaesthetic and a 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.

The Health Board has recently commenced its Planned Care Recovery Programme and is starting to plan and deliver service improvements at pace across the planned care pathway. Some highlights of work underway and planned include:

Urgent Care

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.

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 improved slightly in July but is still high compared to previous years. The chart below illustrates the monthly average length of stay for patients admitted as an emergency:

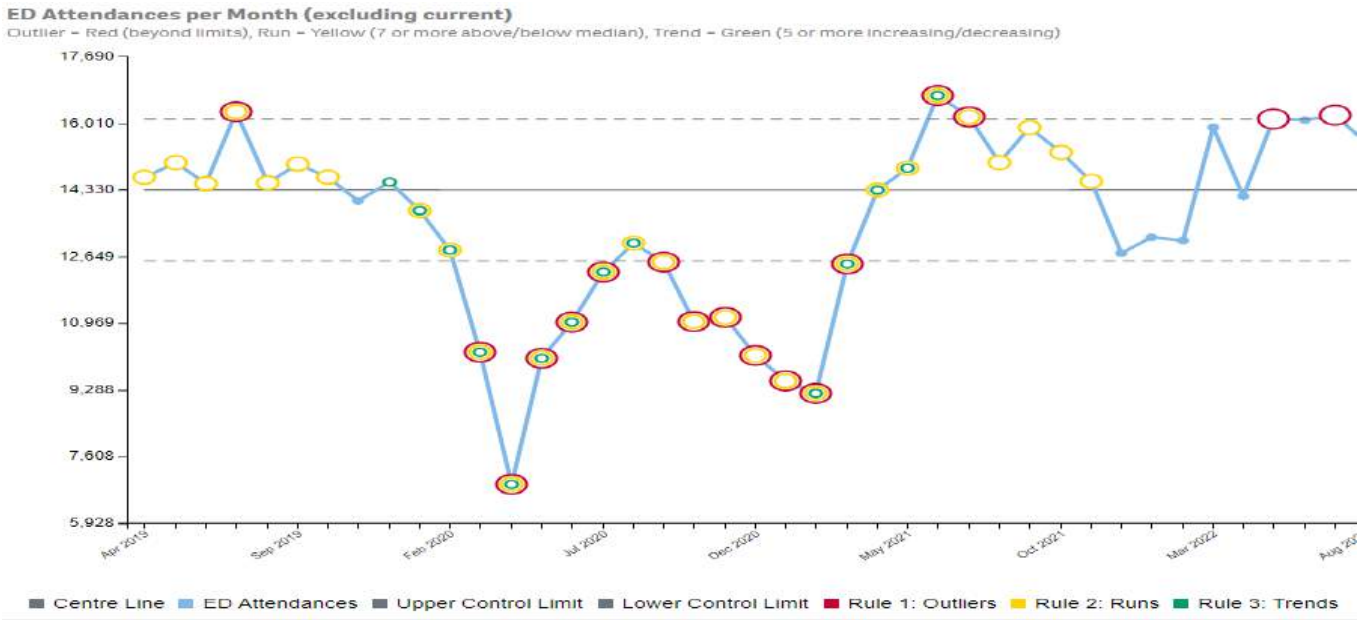


Emergency Demand

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 and with the following months trend remaining over 16k with 16,214 attendances in July 2022.

The graph below provides an overview of the overall monthly ED attendances across the Health Board since April 2019.



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 19% 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 hours.

The ambulance handovers over 60 minutes increased slightly in July compared with previous months. In July 2022, 808 patients waited over 60 minutes compared with the previous month where the June position reported 793. 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 July 22. 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 improved slightly in July 2022 with performance at 73% compared with 71.4% for June 2022. For July, 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 in July improved slightly on June's position with 1607 waiting over 12 hours in July 2022 compared with 1658 in June 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. For example, in July 6% of the attendances at the GUH were categorised as inappropriate and a quarter of these were redirected to minor injuries, Out of Hours or the patients' GP services.

Other factors that can delay patients in ED are the turnaround times for 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.

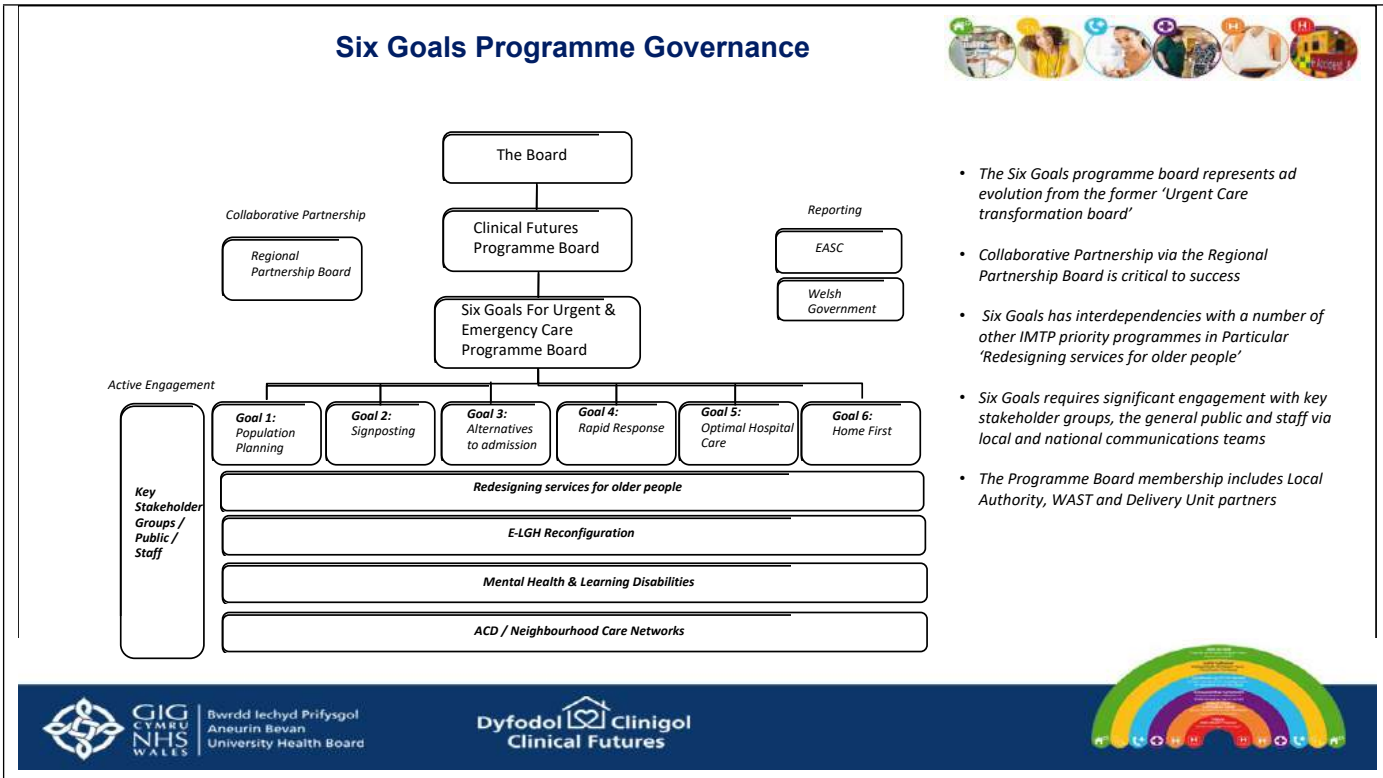
The community health and social care system is under intense pressure with a significant gap in the availability of domiciliary care provision and rehabilitation placements.

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.

Six Goals for Urgent and Emergency Care
In May 2022, Welsh Government launched 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. These include:

- Coordination, planning and support for people at greater risk of needing urgent or emergency care.
- Signposting to the right place, first time.
- Access to clinically safe alternatives to hospital admission.
- Rapid response in a physical or mental health crisis.
- Optimal hospital care following admission.
- Home-first approach and reduce risk of readmission.

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 has revised its existing Urgent Care transformation programme to align with the requirements and structure of the new national programme as follows:



Clinical and Non Clinical Leads have been identified for each goal supported by the Clinical Futures programme team. Additional resource from Welsh Government will be deployed to enhance programme clinical leadership and a dedicated Six Goals Programme Management Lead role.

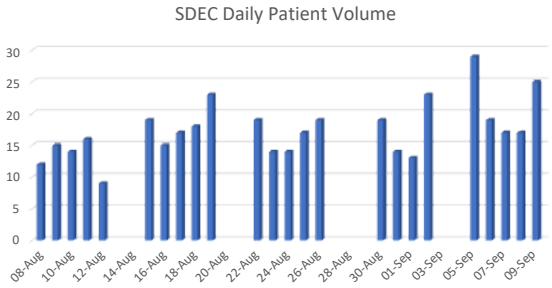
An overarching Programme plan is under development including highlighting where other improvement and transformation work will impact on 6 Goals measures

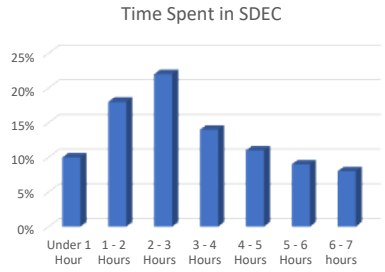
Specific areas of improvement include:

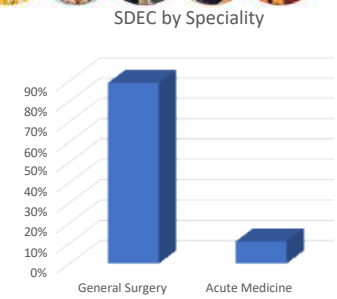
- Establishment of Same Day Emergency Care (SDEC) at GUH from August 2022 following capital and revenue investment from Welsh Government
- Development of SDEC at YYF following funding via Regional Partnership Board
- Development of eTriage pilot in collaboration with Cardiff and Vale 9supported by the National 6 Goals team) to modernise patient flow at the start of their ED department arrival and assist with signposting and data gathering
- Development of speciality same day services e.g. Respiratory, Gastro and Frailty to reduce ED attendance and Assessment Unit stays
- Review of Flow Centre clinical model and processes to ensure optimum utilisation and reduce unrequired attendances at the GUH ED
- Commencement of review of eLGH Front Door services and links to community services via RSfOP programme
- Development of patient discharge pathways from GUH to home and eLGH sites to improve system flow

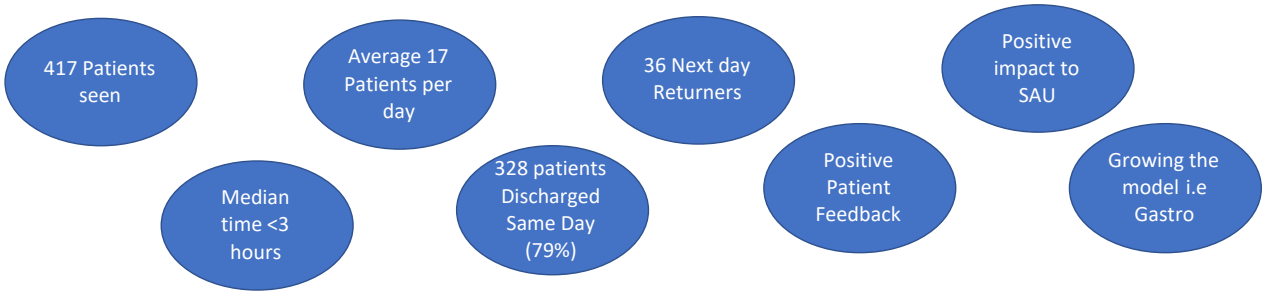
The SDEC service is a key addition to our emergency care services and is a significant opportunity in streaming of patients from Same Day to next day and acting as an incubator for speciality ambulatory service development. The below infographic illustrates the impact of SDEC at GUH in its first 4 weeks

SDEC at a Glance 8/8/22 –9/9/22





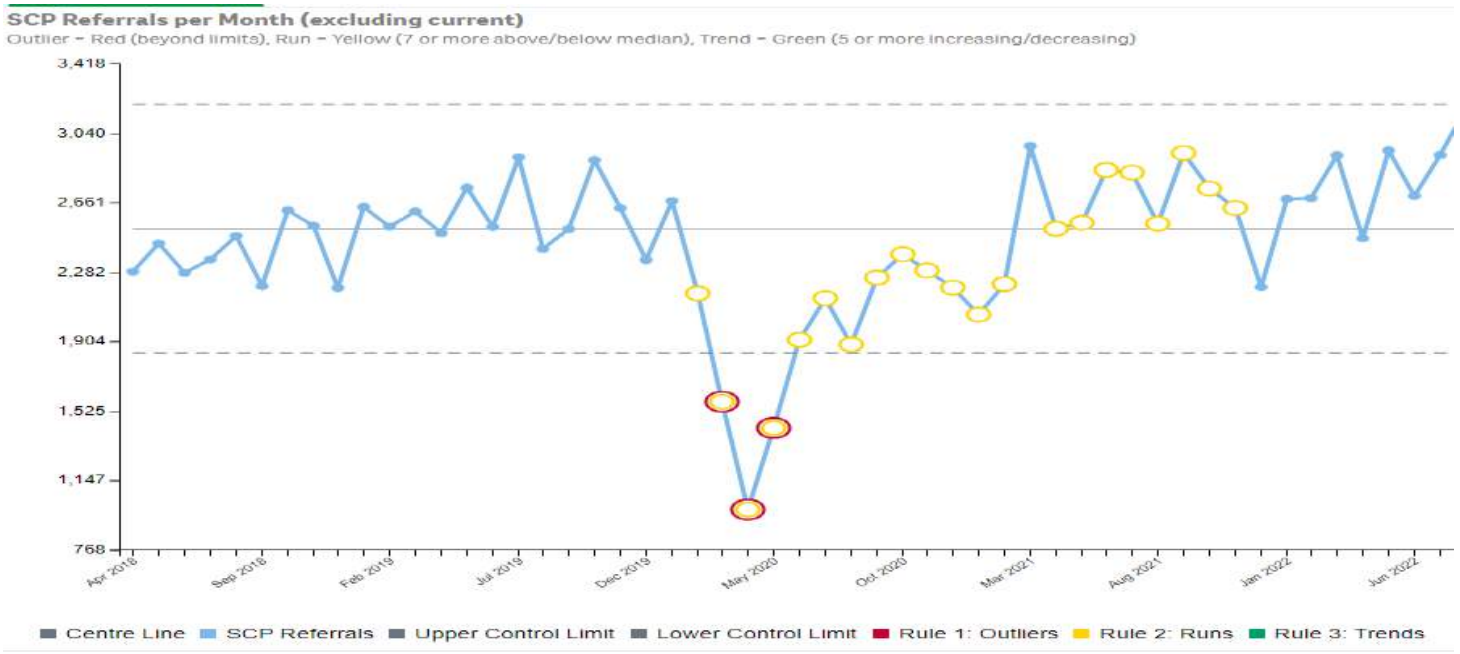




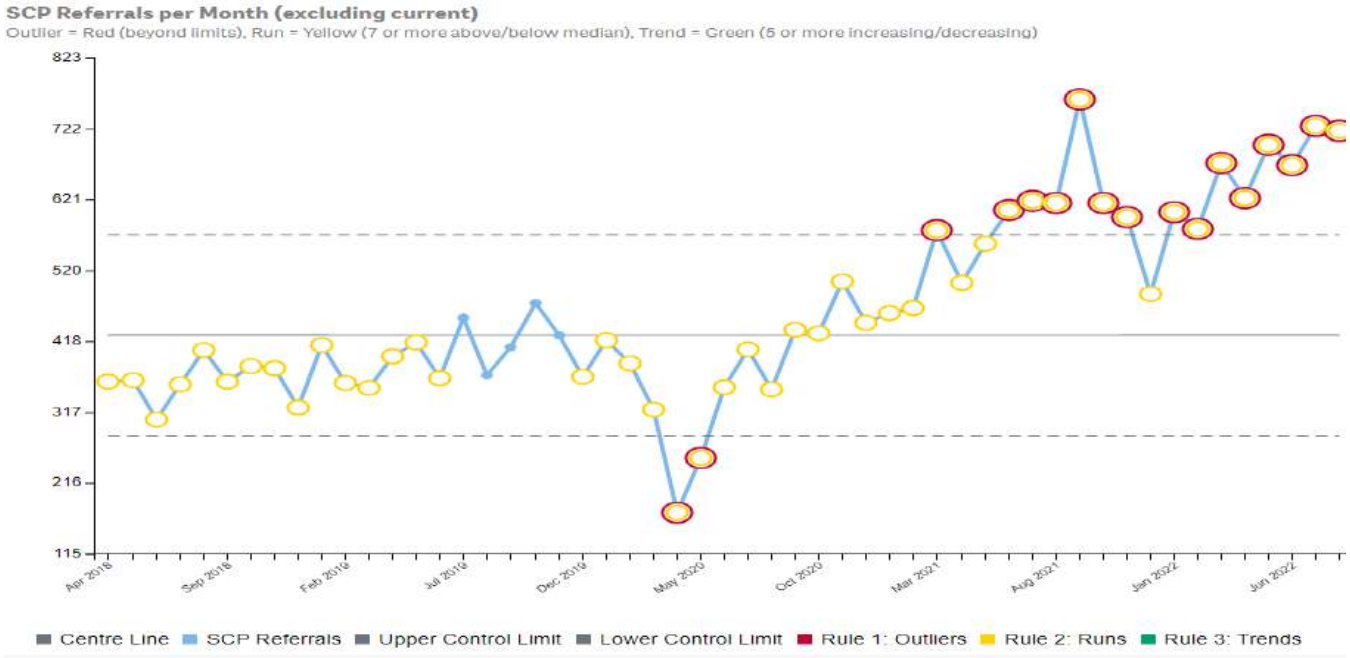
Further development of the acute medicine service linked to the broader review of the acute medicine eLGH service in ongoing. Phases 2 and 3 of SDEC roll out will increase connections to community services via the Flow Centre and direct from ED attendance (linked to eTriage opportunities) in quarter 4.

Cancer Access, including Single Cancer Pathway

Suspected cancer referrals in the first 4 months of 22/23 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 this year. However, the demand for Colorectal in particular, is challenging. The service experienced the 2nd highest referrals in July with 726 referrals. The chart below illustrates the significant increase in demand for Colorectal since March 2021 and far exceeds pre-pandemic levels.



The Health Board's 62-day compliance position during the last 4 months has been between the high 50% and low 50%. 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 July performance figure has been reported as a disappointing 50.4%, a slight improvement on June's position of 49.4%. There are a number of factors which have had an impact on overall performance, but this has been primarily driven by a considerable reduction in skin treatments whose high volumes have historically helped in increasing the performance denominator and gynaecology. This reduction has been influenced by the current pathology pressures, and reduced cancer activity to recover waiting lists.

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. The recovery of cancer performance is multifactorial, with capacity issues particularly for Head and Neck at the Grange University Hospital and delays throughout the pathway including treatment at Tertiary providers. 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

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 4 months of 2022 have seen an increase of over 30% compared to the first 4 months of the same period last year. 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.

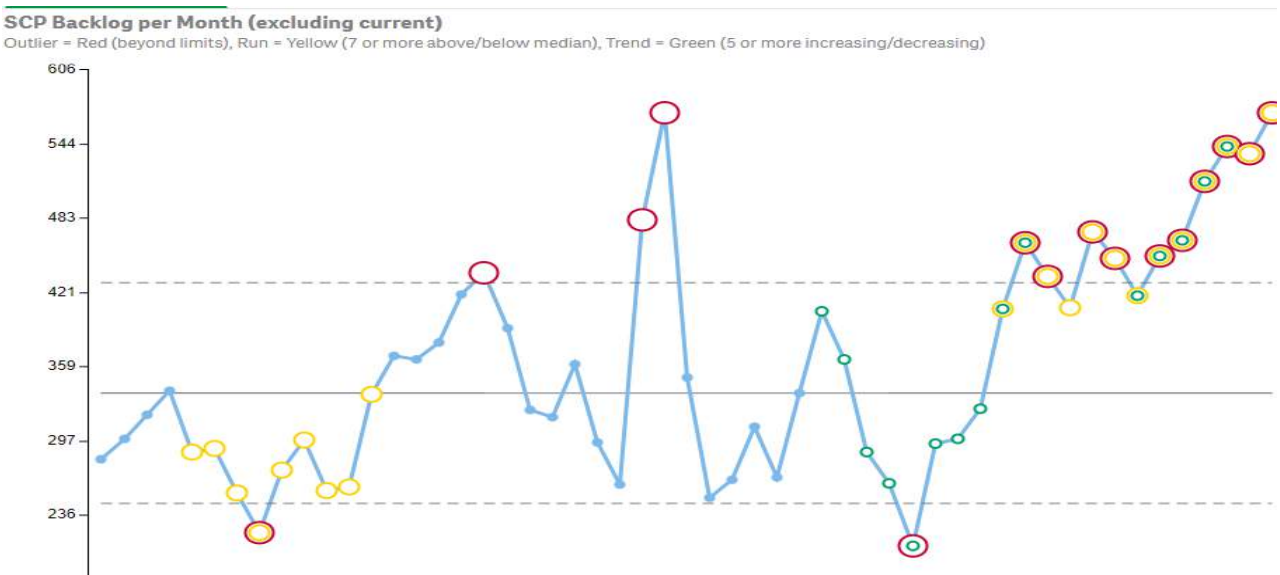
This high demand is not evenly distributed across tumour sites. Those tumour sites that have seen the biggest increases have subsequently struggled to achieve against the 62-day pathway target. Most notably, the huge Lower GI demand seen throughout the year has been sustained. Urology is also seeing very high demand which is affecting the timeliness at the start of the cancer pathway. Urology has been severely impacted by the loss of consultant sessions associated with the opening of the GUH. Sickness and annual leave over the summer months is further exacerbating these capacity challenges.

In Breast, the high demand, and ongoing workforce issues in supporting radiologists has resulted in the service is struggling to meet compliance within several parts of the pathway. Generally, there are further issues that can result 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). 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 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. Plans to improve performance are focussing on those areas that will align pathways against the optimal pathway and a number of these are expected to go live in September. A recovery action plan has now been implemented which outlines an organisational focus on reducing waits to all First Outpatients to within 14 days, reducing the volume of "Did Not attends" and "Could not attends" (DNA/CAN) and accurately mapping demand and capacity.

The chart below illustrates that the current backlog is still a concern with the forecast that the volume is likely to increase before the implementation plans take effect.



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.

The establishment of the diagnostic support services division has provided an opportunity to expand work into one stop and rapid access pathways which has started in Urology and is looking to be rolled out to colorectal and gynaecology.

Delivering timely cancer care and the requirement to adhere to the 62 day cancer pathway is a priority for the Health Board and planned workshops at the end of June and July, chaired by the Medical Director and Director of Operations will bring together all services involved in the delivery of cancer care to understand the resource allocated and the work being done to shape cancer pathways, to share best practice and to develop plans to resolve the current challenges.

Stroke Care

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.

The proportion of patients with a suspected stroke who have a CT within 1 hour of arriving at the Emergency Department has been constituently in the 70% region since May with compliance in July 2022 of 75.9% which is one of the highest in Wales. This is reflected in an improvement in the processing of patients through the department as soon as they have been assessed.

The proportion of patients with a confirmed stroke directly admitted within 4 hours has remained low over the past 6 months which reflected a similar performance across Wales. The position deteriorated in July with 10.7% compared with 25.9% in June 2022.

In July 2022, the Health Board sustained its previously good performance for the percentage of patients assessed by a stroke consultant within 24 hours at 89.7% against a target of 85%.

The proportion of applicable patients assessed by at least one therapist within 24 hrs of clock start improved with 55.2% in July 2022, up from 50% in June 2022. The measure of the percentage of stroke patients receiving the required minutes for speech and language therapy was 39.4%, a compared with 39% in June 2022. 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.

There has been a sustained improvement with the percentage of patients receiving a swallow screen within four hours with 63% in July 2022. This has been due to improved communications between key stroke staff and the Emergency Department and with the YALE screen being implemented at the front door and the new training available on the Health Board's Electronic Staff Record.

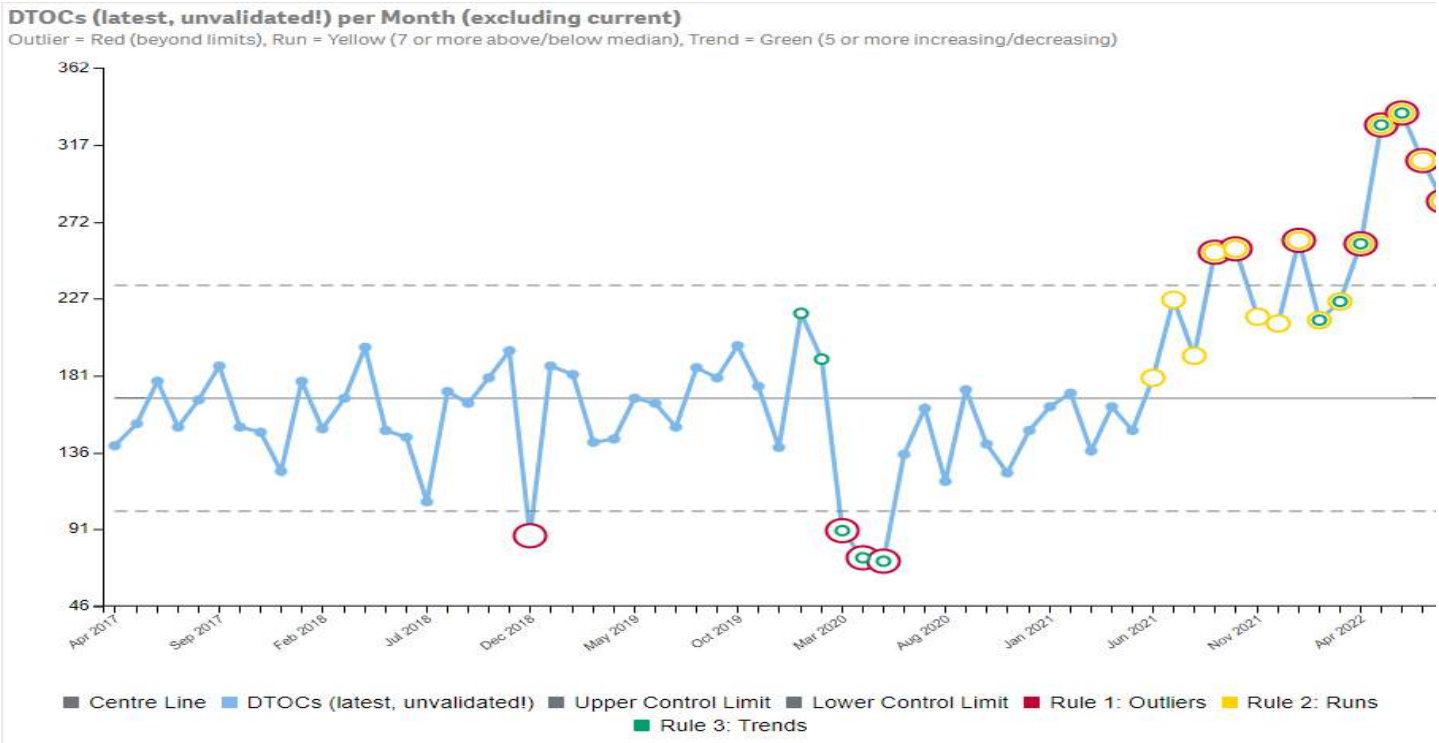
Older Adults Supported to Live Well and Independently

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 rarely dropped below 200 and at its highest in June has been in excess of 360. The position at the end of July is 308 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.



Recommendation

The Committee 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	

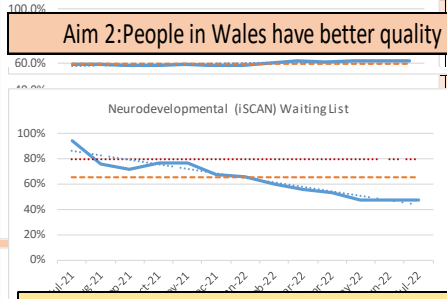
Integrated Performance Dashboard **July 22**

Appendix 1

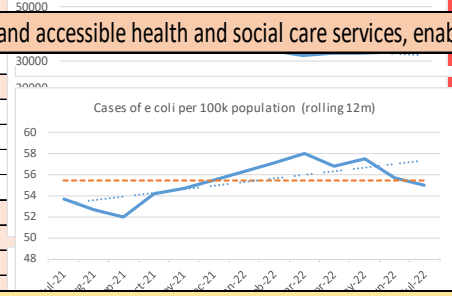
Domain	Sub Domain	Measure	Report Period	National Target	Current Performance	Previous Period Performance	In Month Trend	Performance Trend (13 Months)	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22

Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement

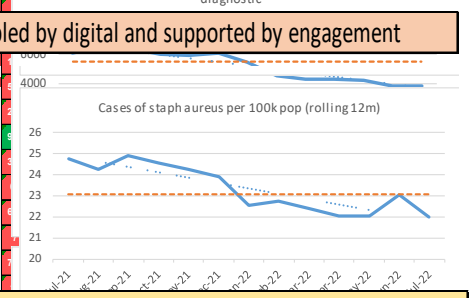
Patients waiting less than 26 weeks for treatment



Patients waiting more than 36 weeks for treatment



Patients waiting more than 8 weeks for a specified diagnostic



Aim 2:People in Wales have better quality and accessible health and social care services, enabled by digital and supported by engagement

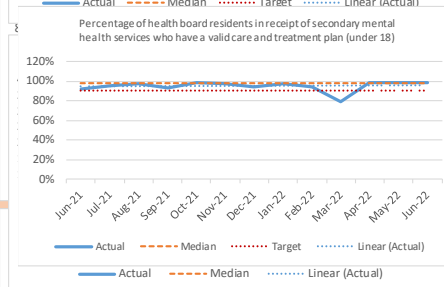
Neurodevelopmental (iSCAN) Waiting List

Cases of e coli per 100k population (rolling 12m)

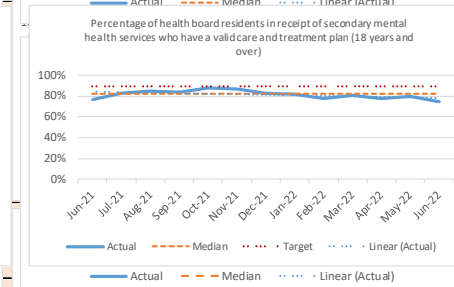
Cases of staph aureus per 100k pop (rolling 12m)

Aim 1: People in Wales have improved health and well-being with better prevention and self-management

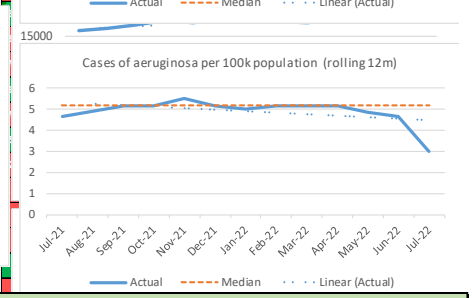
Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (under 18)



Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over)

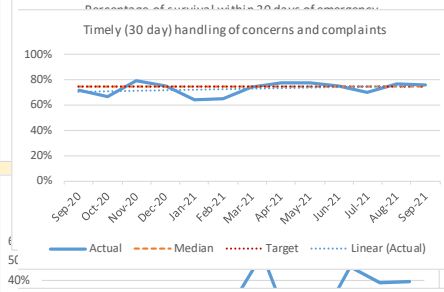


Cases of aeruginosa per 100k population (rolling 12m)

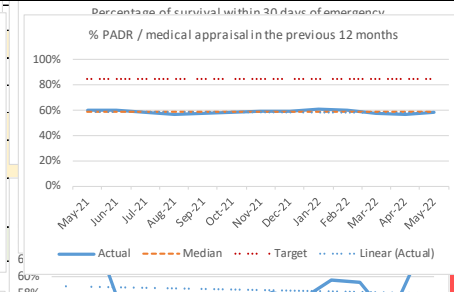


Aim 3: People in Wales have improved health and well-being with better prevention and self-management

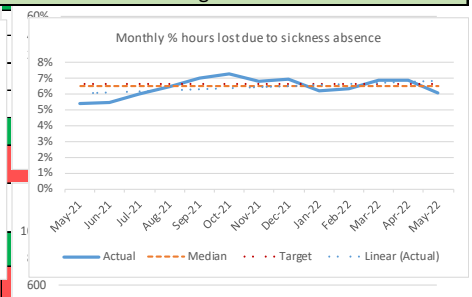
Timely (30 day) handling of concerns and complaints



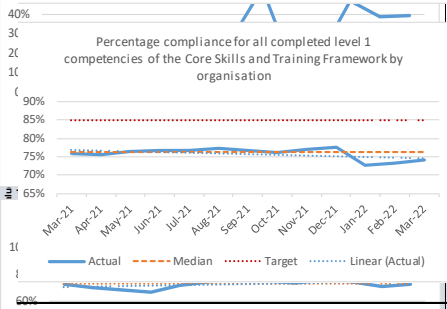
% PADR / medical appraisal in the previous 12 months



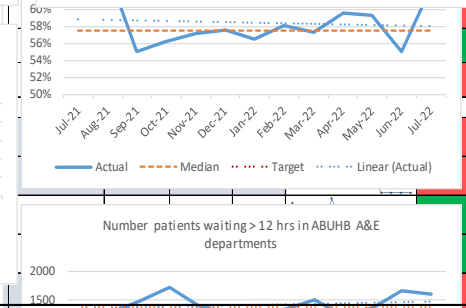
Monthly % hours lost due to sickness absence



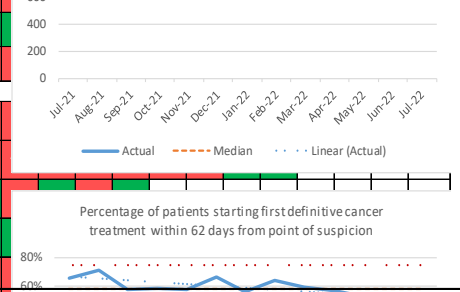
Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation



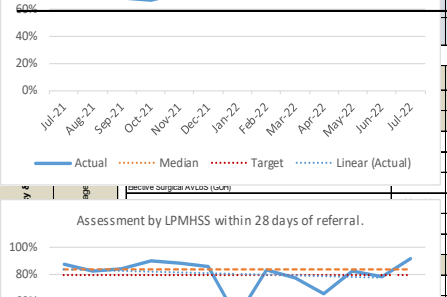
Number patients waiting > 12 hrs in ABUHB A&E departments



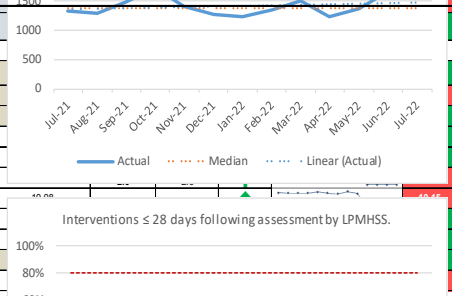
Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion



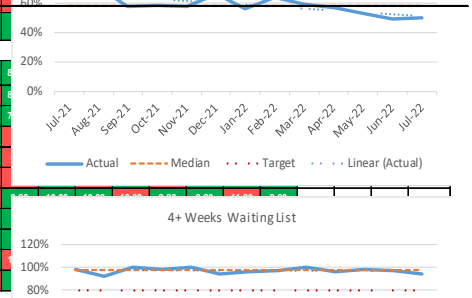
Assessment by LPMHSS within 28 days of referral.



Interventions ≤ 28 days following assessment by LPMHSS.



4+ Weeks Waiting List

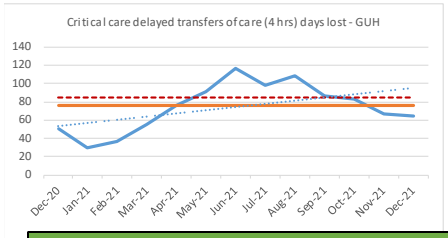


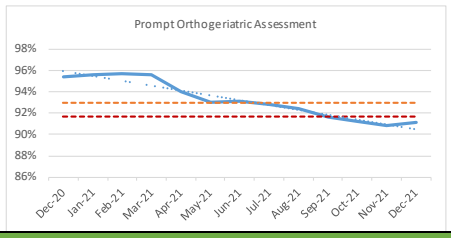
Trend Key

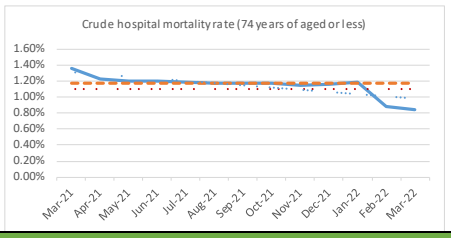
Achieving rating target and improved against previous reported position
Achieving rating target but deteriorated against previous reported position
Not achieving rating target but improved against previous reported position
Not achieving rating target and deteriorated against previous reported position

If measures are no longer in the Delivery Framework, current perfromance is measured against previous month

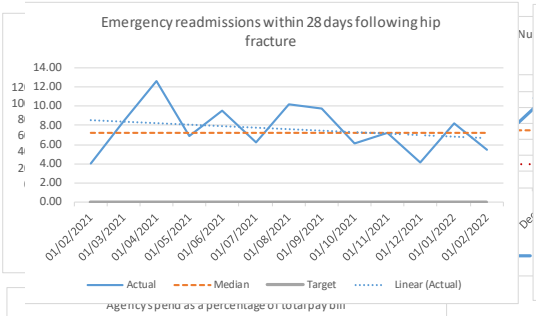
Aim 4:Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and

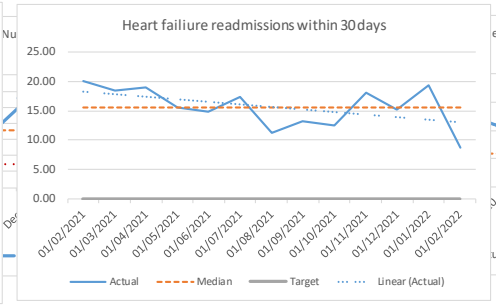


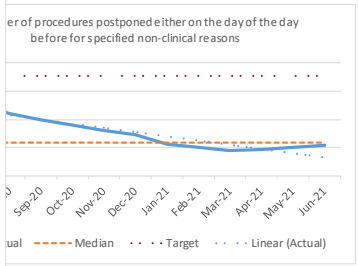


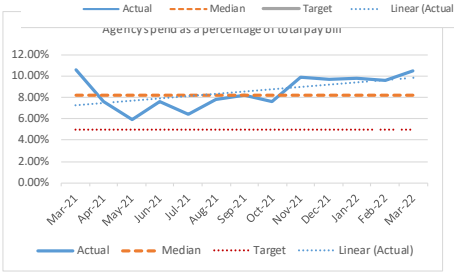


Local Measures









GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Finance & Performance Committee Wednesday 5th October 2022 Agenda Item: 4.1a

Aneurin Bevan University Health Board

Cancer Performance

The Committee is asked to: (please tick as appropriate)			
Approve the Report			
Discuss and Provide Views			
Receive the Report for Assurance/Compliance			
Note the Report for Information Only			X
Executive Sponsor: James Calvert			
Report Author: Michael Eastwell			
Report Received consideration and supported by: Cancer Services			
Executive Team		**Committee of the Board FPC**	X
Date of the Report: July 2022			
Supplementary Papers Attached:			

Executive Summary

Performance against the 62-day Single Cancer Pathway is well below the Welsh Standard which we are required to achieve. Review of performance data suggests that these difficulties will continue over the coming months due to the increasing size of the cancer backlog.

Welsh Government require that a recovery forecast is presented that outlines anticipated timeframes for the recovery of the backlog to improve our performance position.

Performance against the 62 day cancer pathway is struggling due to multiple factors – some of which are systemic and some specific to individual tumour sites.

Key issues include:
Demand has exceeded capacity on the first stages of the pathway – in both diagnostics and clinic capacity. Increasing the proportion of patients seen within 2 weeks and reducing the waiting times for endoscopy and pathology are the single highest priority if we are to reduce the backlog and forecast performance improvement.

The outcomes from 2 major cancer workshops have highlighted these as the organisational priority amongst 46 other independent improvement actions.

Purpose of the Report

To illustrate the current performance in cancer and identify improvements to address the challenges.

Background and Context

Performance overview

The ABUHB 62-day performance compliance has deteriorated considerably over the summer months. Whilst a small improvement was seen in July bringing the percentage back above 50%, the provisional August position suggests another drop which will likely fall to around 47%.

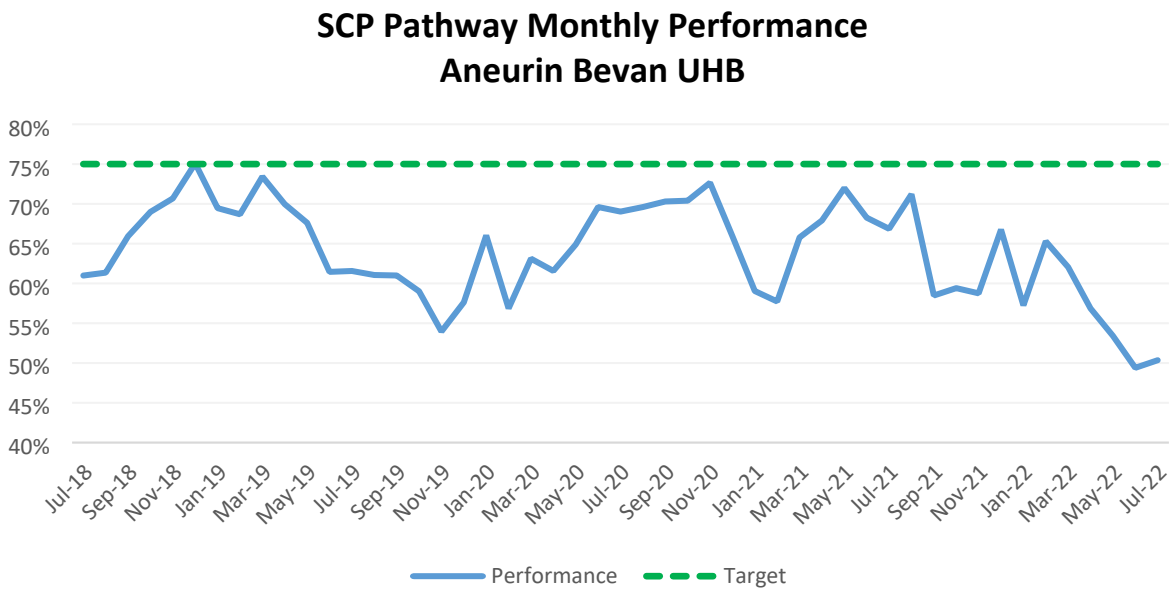


Figure 1: ABUHB Monthly SCP Cancer Performance

A negative compliance trajectory is evident in most tumour sites. However, the overall performance position for the health board is affected significantly by performance in Colorectal, Urology, Skin and Breast due to their high treatment numbers. This is most apparent in skin whose performance has deteriorated (mainly due to lack of capacity in histopathology) thus adversely impacting overall performance.

The cancer backlog numbers (patients over 62 days on their cancer pathway) can be used as a proxy measure of anticipated future performance as suspensions cannot be applied to cancer pathways, and thus the majority of backlog patients end up being recorded as a breach. The cancer backlog continues to increase and as of September exceeded 500 patients. This increase is also being seen in our longest waiting patients.

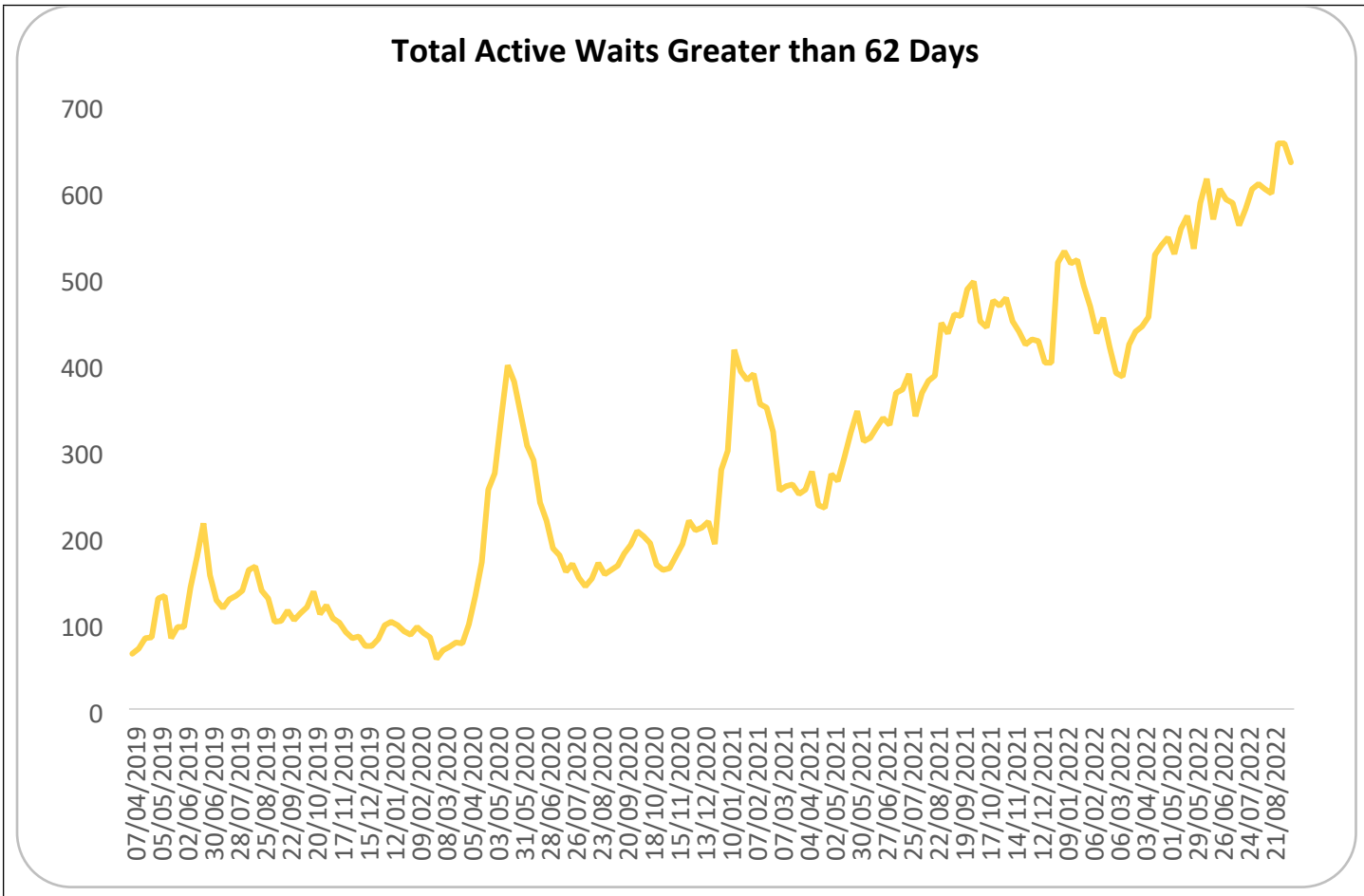


Figure 2: Total Active Cancer Backlog (patients over 62 days)

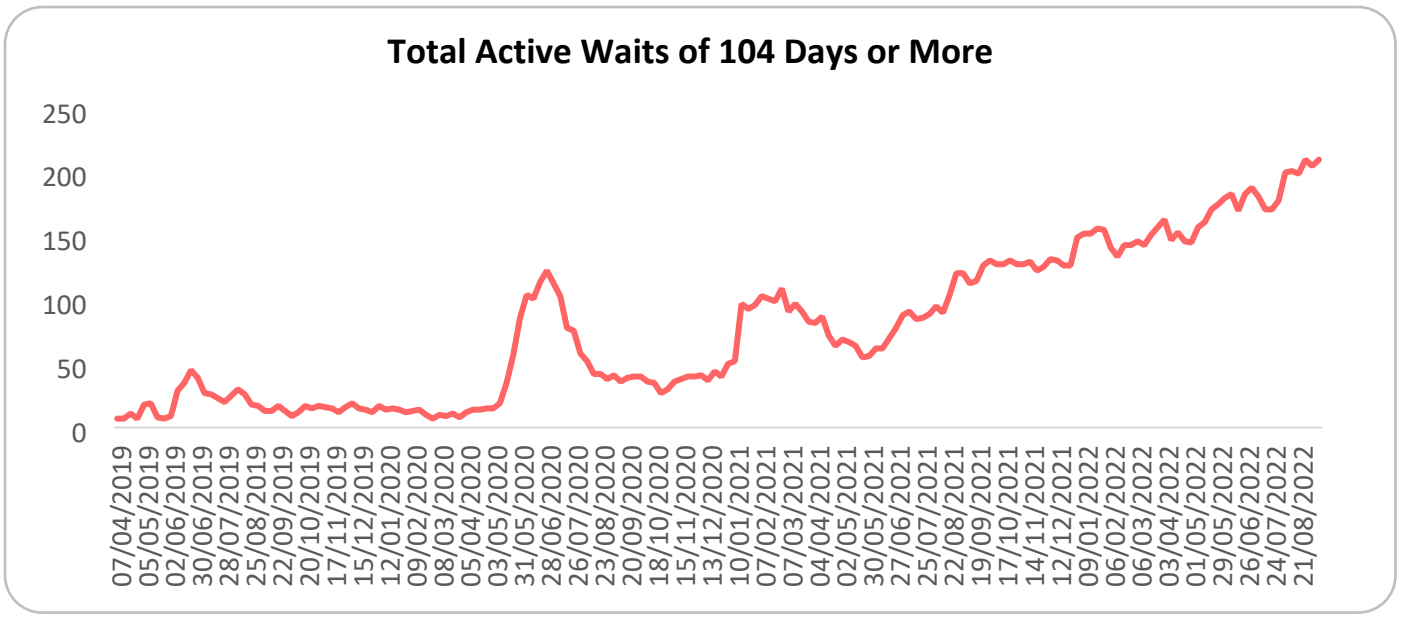


Figure 3: Total number of patients over 104 days

Reduction of the cancer backlog has been identified by Welsh Government as the single highest priority for cancer delivery, based on an assumption that a reducing backlog will equate to improved performance. As such, the health board have been tasked with modelling and identifying how and when this position will begin to reduce. Work on this is currently being undertaken by tumour sites, Cancer Services and Informatics.

Delivery challenges

Demand

Suspected Cancer Referrals continue to be exceptionally high. In August, a total of 3185 referrals were received by the health board. **This figure is 26% higher than the monthly average in 2019**. Furthermore, the introduction of the Single Cancer Pathway means that, unlike 2019, every one of these patients is being tracked and managed on a 62-day pathway (compared to 80% of total demand in 2019).

Colorectal are now regularly receiving more than 600 referrals per month. This figure is **46% higher than the pre covid mean**, and as a result has prompted a **70% increase in the number of USC endoscopy requests**, and **48% increase in USC Radiology requests**.

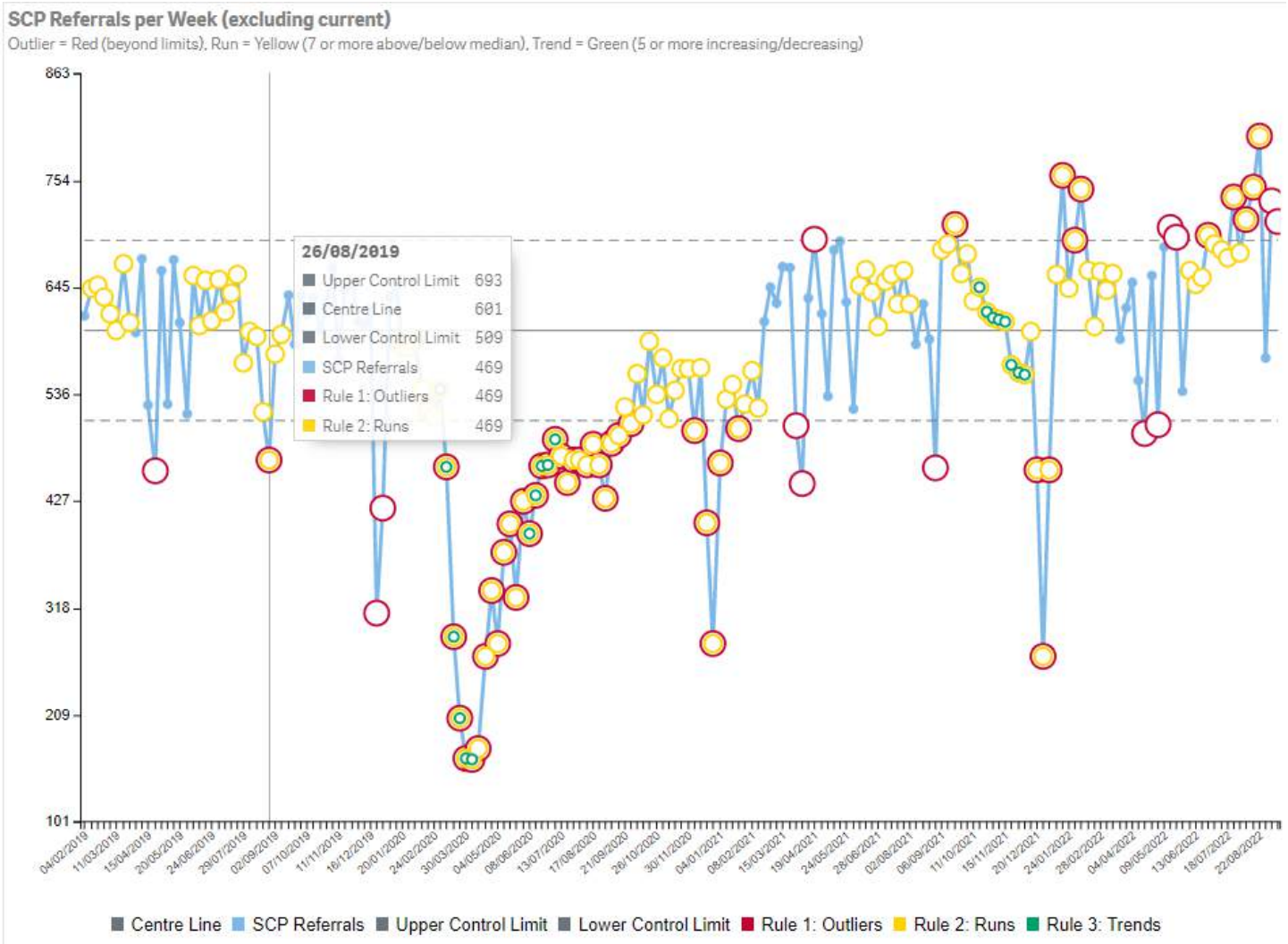


Figure 4: Weekly suspected cancer referrals

Overall, tumour site's ability to maintain sufficient capacity to accommodate this level of demand has been stretched thin. This has been impacted by recruitment difficulties, summer annual leave, pay disputes and competing clinical pressures. The result of this is that compliance against the 14 days first seen target has fallen drastically. In August only 37% of patients were seen within 14 days of point of referral.

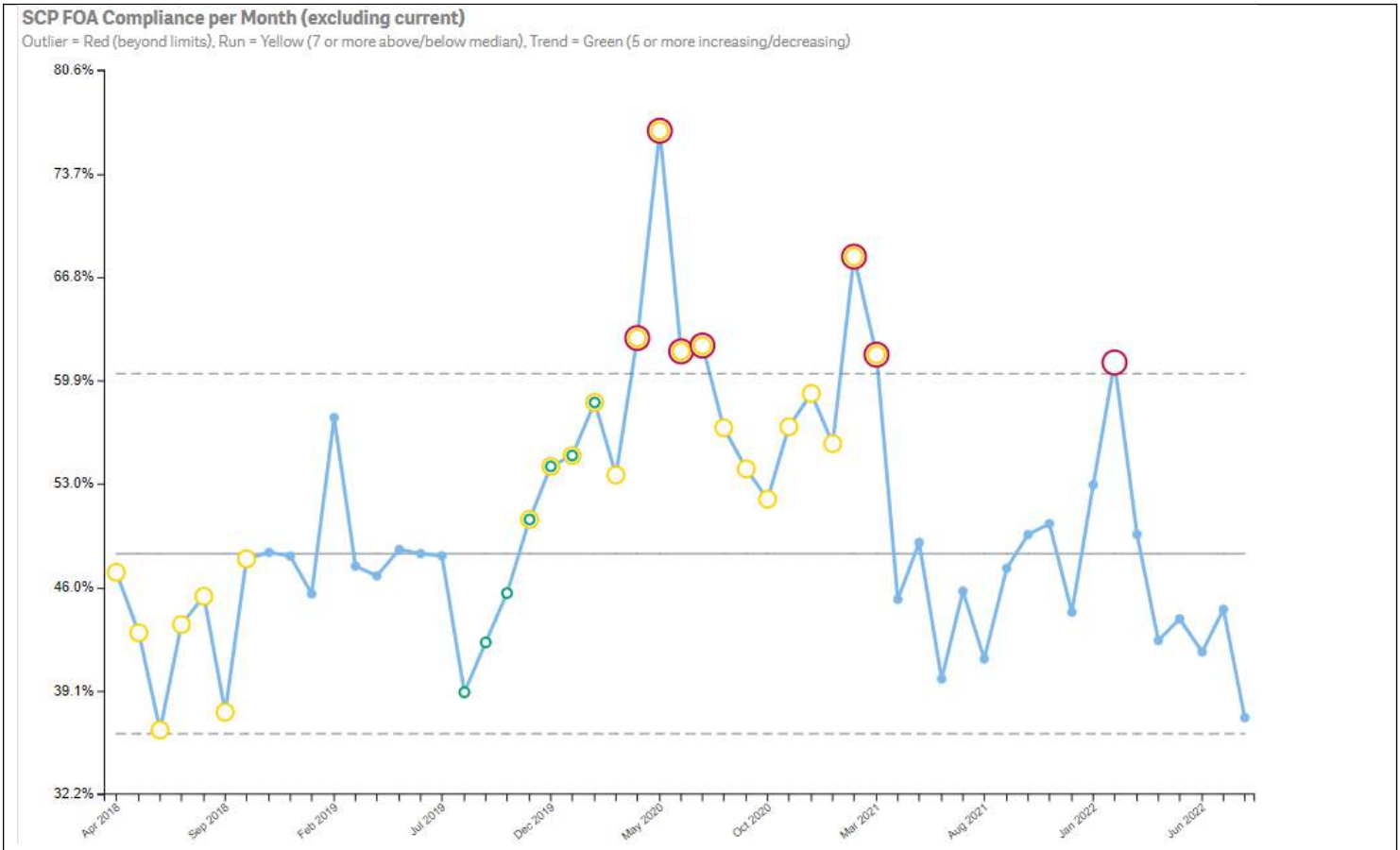


Figure 5: Monthly compliance against 14 days to first seen

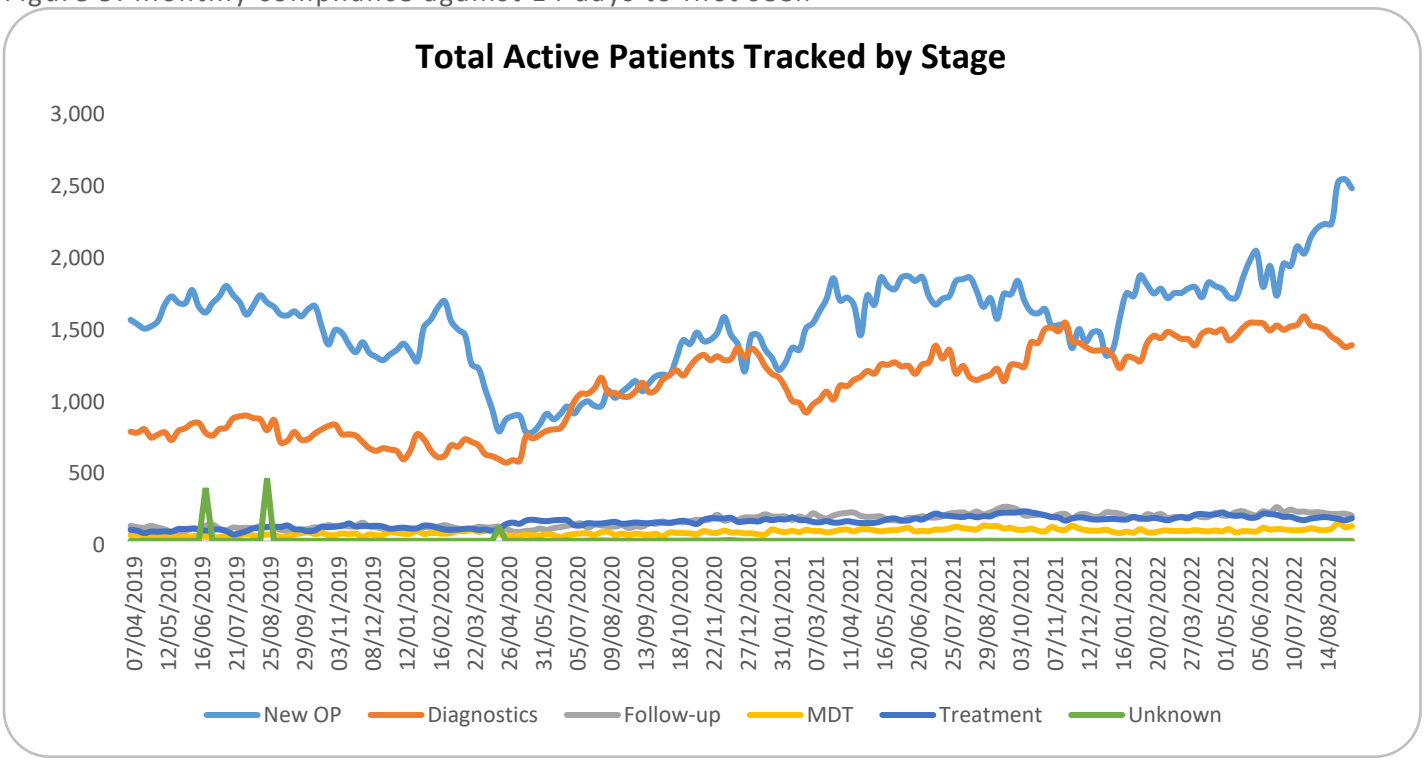


Figure 6: Volume of patients on the cancer tracker by pathway stage

Capacity

Establishing sufficient capacity to maintain wait times against the standards expected to deliver 62-day pathways is a challenge across most tumour sites. The primary challenge is maintaining sufficient capacity in light of workforce shortages, sickness/annual leave, and non-cancer recovery work. Maintaining sufficient capacity over holiday periods remains challenging. There are also limitations associated with the opening of the

Grange, and this is predominantly due to bed capacity for elective high-risk procedures and change to clinical rotas for GUH cover.

Considering staffing difficulties, alternate options are being explored to increase capacity. This includes the increased utilisation of nurse led clinics eg in Colorectal, and private providers for endoscopy and pathology. The greatest concern is currently within Colorectal considering the dramatic demand increase and the forecast expansion of screening services which is anticipated to increase the volume of cancer surgeries by 196 per annum by 2025.

Diagnostic capacity within endoscopy and pathology is also a major limiting factor in our ability to deliver the 62-day pathway. Although some improvements have been seen within the endoscopy waiting times, they remain on average 22 days from request to scope.

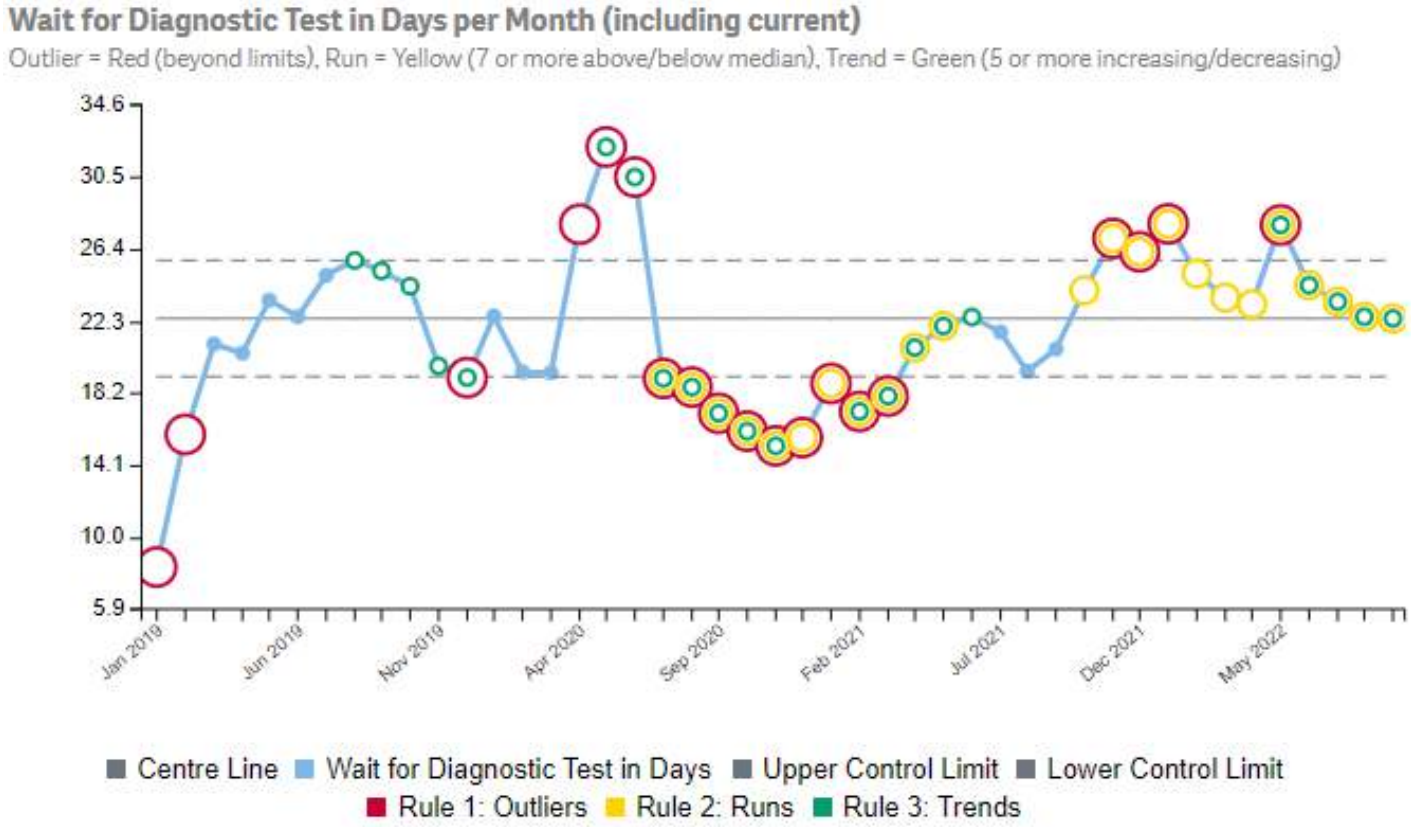


Figure 7: Monthly average wait for endoscopy procedure in days

Tertiary dependencies

ABUHB are heavily reliant on tertiary providers for both treatment and diagnostics in a variety of tumour sites. This includes all radiotherapy and chemotherapy treatment, as well as surgical treatment for our Upper GI, plastics and some urological and Gynaecological patients. PET scanning and genetic pathology testing are also provided externally.

The difficulties being faced currently in ABUHB are also reflected in these tertiary providers and increasingly we are seeing extended waiting times for these procedures. There is currently no form of breach sharing, or waiting time reallocation, and delays at tertiary centres are reflected purely in ABUHB performance.

Breaches are rarely assigned purely to delays at tertiary centres, and this is because we often are not referring for the treatments with adequate time in the pathway for tertiary

providers to realistically meet the 62 days. The delays are however regularly contributing to the extended length of wait for some patients, and this is expected to increase due to current staffing challenges within SACT delivery. Better data collection around the Welsh Model Cancer Pathways may make the root cause of delays more transparent.

Pathology

The demand facing pathology is both increasing in volume and complexity. Since April 2020, the percentage of samples marked as USC or urgent has increased from 45% to 68%, and increasingly samples are needing further work up for genetic testing and re-look. The ability to expand the service is hindered by the available working space, and the ability to recruit specialist staff. As a result, the turnaround time on USC samples has suffered, and the **7-day turnaround time has fallen from 75% to 19%** in the same time threshold. **14-day turnaround time has also seen a 24% drop**.

Solutions to the estate challenges are being explored with urgency and a business case was presented to the executive in September. Further opportunities are being explored to outsource the routine pathology work which require considerable funding that has been identified within the business case.

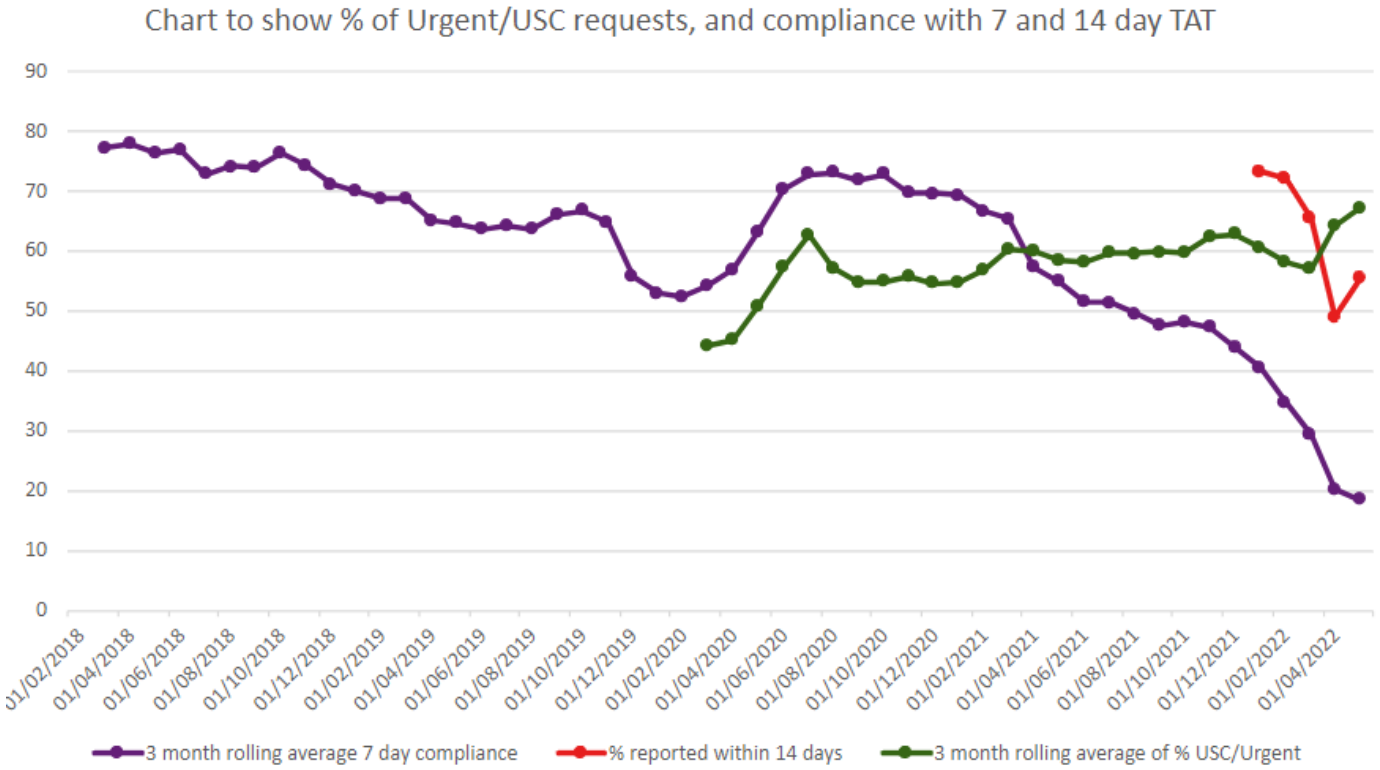


Figure 8: Percentage of Urgent/USC requests and compliance against 7 and 14 day turnaround time

Patient choice/engagement

When the single cancer pathway was embedded, a change was made to the way pathways are managed that eliminated any ability to apply suspensions to the cancer pathway. As such, performance is now an unadjusted and true representation of waits from suspicion to treatment.

With demand now at a steady state the scale of patient-initiated delays is becoming apparent, particularly the impact of non-attendances and repeated cancellations. The 146-day harm reviews have identified patient choice as the third most common reason for long waiting breaches after third party delays and inefficient or complex pathways.

Addressing this issue is a challenge that is being addressed through 2 fronts, the first being primary care input and the information being provided to patients at the point of referral. It is common for patients on the cancer pathway to be unaware of the urgency and nature of the referral and so persuading patients to prioritise the appointment can be difficult.

Secondly, admin processes are being refined to ensure patient initiated delays are acted on swiftly and appropriately, with minimal time between missed appointments. This is being addressed through a health board wide staff training programme which has now been delivered to over 100 staff and is published within the intranet.

What are we doing to address these challenges?

Recognising the difficult position cancer finds itself in, and the totality of organisational input required to recover the cancer position, a 2-part workshop was organised. This provided an opportunity for services to voice barriers to service delivery, establish the roles and responsibilities for managing patient pathways, and pull together a collective action plan focussed on addressing the challenges that are within scope to begin to improve.

Sessions ran on Wednesday the 29th of June and Wednesday the 20th of July. The output is an improvement action plan which will be the focal point of recovering cancer performance.

Since the workshops, work has begun on trialling innovative approaches to the management of patient pathways, utilising dedicated resource to ensure the timely progression of patients. A demand and capacity procedure will also be required within each specialty to accurately demonstrate the current capacity short falls (a request also received from Welsh Government).

Working groups have been established in Breast, Urology, Lower GI, and Gastroenterology focussing on pathway improvement. This work is being supported by the corporate Cancer Services team, utilising a temporarily funded Macmillan Optimal Pathway Manager amongst others.

Cancer Services have also established a collaborative group with Velindre to improve data and information sharing whilst streamlining joint work projects. Tertiary tracking meetings are in place with Cardiff and Swansea to ensure shared patients are given sufficient attention.

Whilst this work focusses predominantly on cancer waiting times, there are further branches of work being undertaken within Cancer Services focussing on patient experience, pre-habilitation and holistic support. A project is now underway focussing on the integration of a digital self-assessment tool for all patients at the start of the cancer pathway providing the opportunity for early health optimisation. This is complemented by the wider Prehabilitation project that is due to launch in August 2022 and looks to provide prehab integration for all patients on the suspected cancer pathway.

The breadth of operational challenges discussed during the cancer workshops demonstrates the challenge currently facing cancer, and the scope of improvement work needed to achieve the 62-day pathway. The greatest improvement to cancer performance will be realised by starting the cancer pathway earlier - with timely appointments and or diagnostics. Supporting services in enabling this will rely on services understanding that they have authorisation to prioritise cancer over non-cancer work in the short term. In the longer-term additional staff and facilities are likely to be required.

Assessment and Conclusion
Recovery of the 62-day cancer backlog has been established as the highest priority by Welsh Government and the Cancer Board. Reducing this backlog will subsequently improve cancer performance and patient welfare. Improving the time to first appointment and diagnostic waiting times is the most effective way to reduce the backlog. This has been established from the cancer workshops as priority for tumour sites. Given the current position, an improvement in performance is not anticipated in the coming 2 months. This will be realised upon the successful improvement against the aforementioned priority areas, and delivery against the wider action plan assembled from the cancer workshops.

Recommendation
The Committee is requested to note the contents of this paper, and is asked to support the continued multidisciplinary efforts to address the challenges identified.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Risk level **High**
Financial Assessment, including Value for Money	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	Quality, Safety and patient experience are all high risk areas associated with the current cancer performance position. 104+ day reviews are being conducted to establish harm. Further work to develop a patient feedback group are underway. The national Cancer Patient Experience Survey is to be published in the coming months.
Equality and Diversity Impact Assessment	There are no implications for Equality and Diversity impact.

(including child impact assessment)	
Health and Care Standards	The Health and Care Standards underpin the cancer delivery plans.
Link to Integrated Medium Term Plan/Corporate Objectives	Linked to priority 3, 4 and 5. Improved cancer care delivery is a key component of the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** The Annual Cancer Plan sets out progress within a 5 year Strategy that sets out our long term ambitions for transforming cancer services**.**
	Integration – Integration is evidenced consistently throughout the Cancer Strategy, cancer services are delivered across integrated networks within the Health Board, with Specialist Cancer Service Providers across Wales, in tandem with third sector organisations including hospice services and in partnership with patients, their carers and families.
	Involvement – The Strategy takes account of feedback from our clinicians, the cancer network, and patients as represented through the Cancer Care Alliance, GAVO and our Community Health Council. We will ensure ongoing stakeholder engagement and input as the Cancer Strategy Delivery plans is developed.
	Collaboration – Only by collaborating with our partners in local government, public health, primary care and specialist care and the third sector, will we be able to deliver safe, effective and accessible services spanning prevention, early detection, timely diagnosis, and access to treatment, care and support to live with and beyond cancer.
	Prevention – Recognising that early intervention and prevention are key planks for reducing cancer inequalities the strategy has identified three of its six core themes that focus on prevention or early detection of cancers. We want to ensure that people do not get cancer at all if possible; and if they do they have prompt and accurate diagnosis to improve experience, outcomes and survivability.
Glossary of New Terms	N/A
Public Interest	This report has been written for the public domain

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Finance & Performance Committee Wednesday 5th October 2022 Agenda Item: 4.1c

Aneurin Bevan University Health Board

Six Goals For Urgent and Emergency Care – Finance and Performance

Executive Summary

This paper outlines the Health Board's "Six Goals for Urgent and Emergency Care" Programme and associated performance and financial status.

Considerable data and necessary analytical experience is available to inform decision making via a multitude of tools. Measures are presented and reviewed at SLR level and at Board level. Measures are under a constant refinement process as we continue to learn about our own system navigation and behaviors of the Population of Gwent.

Financially, the program is supported by Welsh Government Funding totaling £2.96M of which most has already been committed to UPC & SDEC Services.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	X
Executive Sponsor: Leanne Watkins , Director of Operations	
Report Author: Simon Roberts, Senior Programme Manager, Clinical Futures	
Report Received consideration and supported by :	

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

Date of the Report: 23rd September 2022
Supplementary Papers Attached: 3

Purpose of the Report

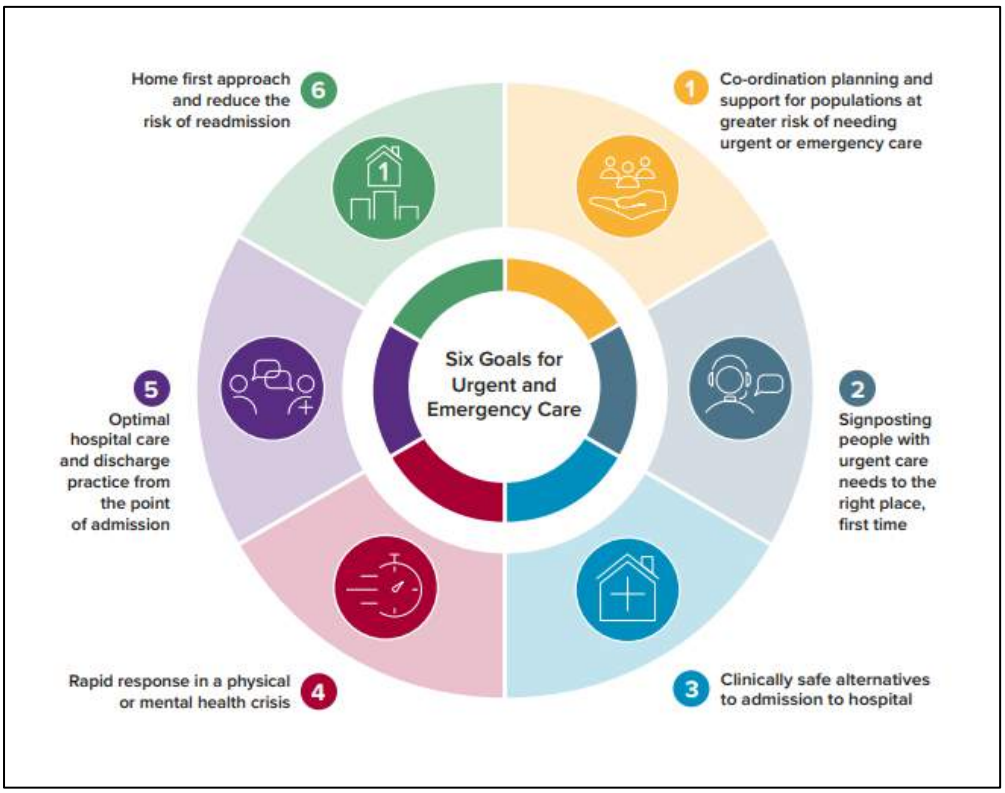
Provide the Board with an overview of the Aneurin Bevan Initial 'Six Goals' Programme and associated performance and financial status.

Detailed Update

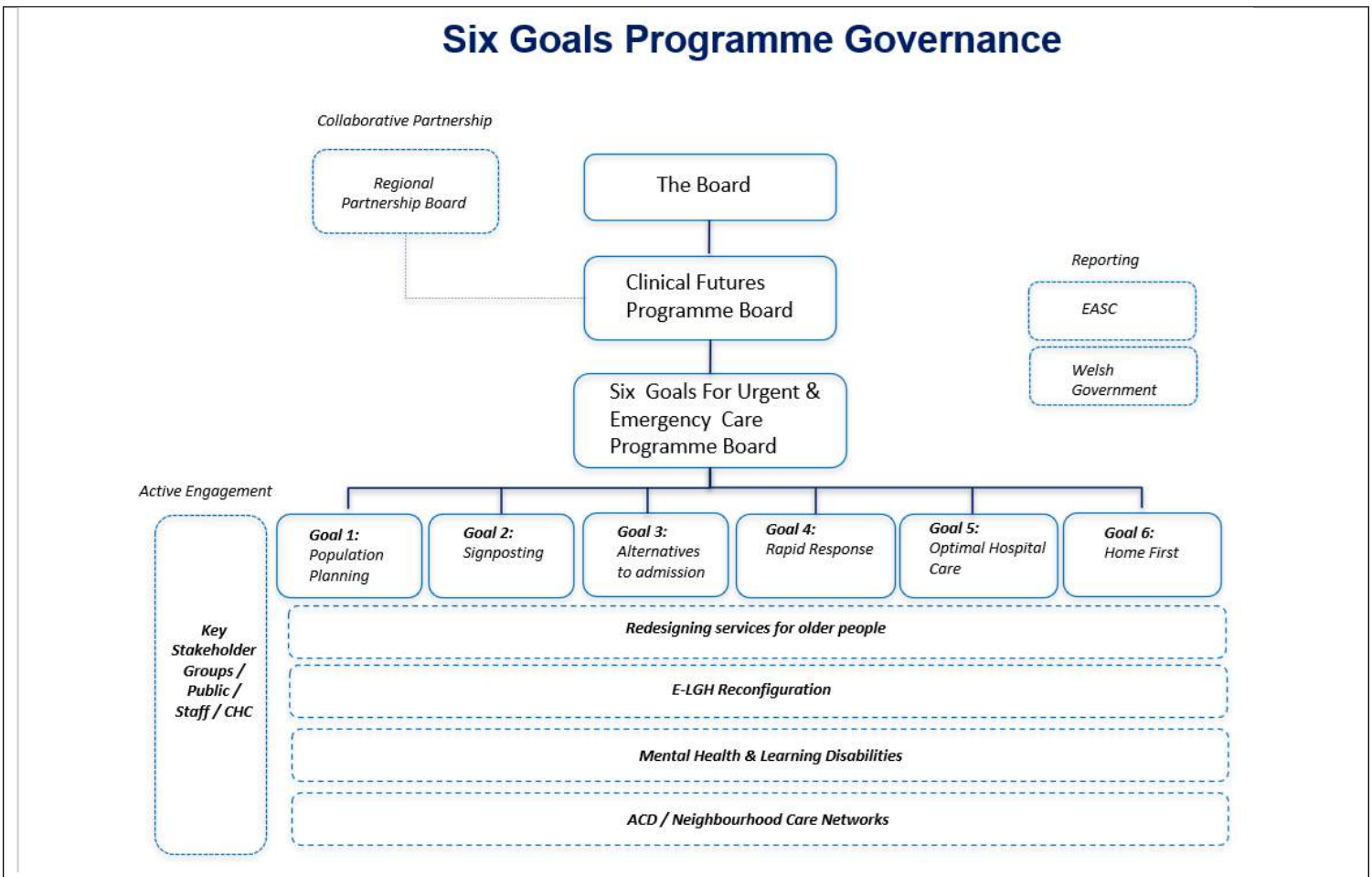
Background

Welsh Government (WG) launched it's 'Six goals for urgent and emergency care' policy handbook on 27 April 2022 (Appendix A). The document sets out expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health. It is anticipated that by delivering each of these goals through collaboration and partnership, optimal patient and staff experience, clinical outcomes and value can be achieved.

The Six workstreams are as follows:



The programme governance is as follows:



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

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

In response to the above expectations, Aneurin Bevan has a Programme plan (Appendix B) which includes:

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

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

Assessment and Conclusion

Finance

In terms of spending under the programme. There was not a dedicated fund established to implement this programme of work, however 2.96M of funding has been provided by Welsh Government to progress the following three areas:

1. Urgent Primary Care Centers (UPCC)
2. Same Day Emergency Care (SDEC)
3. Triumvirate leadership Team

The UPCC element of funding was in place prior to the launch of Six Goals (from 2020/2021). The SDEC Element was approved in Nov 2021. The triumvirate element is to come out of the UPC/SDEC funding and was notified to us from April 2022.

The current breakdown of spend is as follows:

Project	22/23 Spend	Funding Received
UPC	1,472	1,448
SDEC GUH (Part Year Aug 22 - Mar 23)	1,195	1,352
Triumvirate		160
Total Spend	**2,667**	
Six Goals Funding		**2,960**
Difference in Spend 22/23	-	293

Other projects within the Six Goals Programme have been or are in application for funding via other channels outside of substantive Health Board funding such as:

- SDEC at YYF to March 2023 – RIF
- eTriage 1 Year pilot – Welsh Government
- Front Door therapies – Recovery funds
- Proactive frailty (RSOP) – RIF
- Additional Social Care 'Quartet' leadership - RIF

Performance

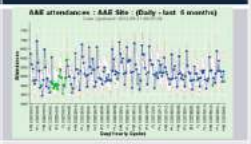
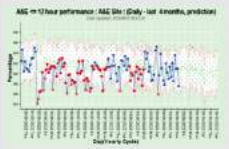
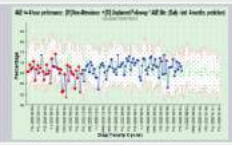
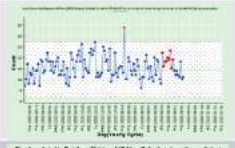
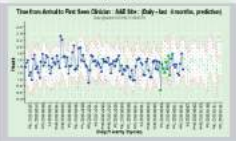
Urgent & Emergency Care Performance measures are reported on a weekly basis at the 'System Leadership and Response' meeting where key metrics are reviewed within each of the Six goals.

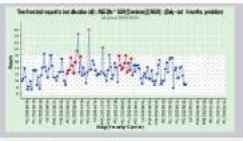
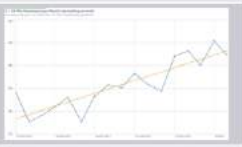
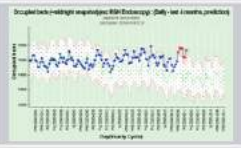
Additionally, monthly snapshots of performance are reported at the Six Goals Board with are simplified to ensure participants understand which direction of travel we require trends to go in and provide a simple RAG status per measure. This way, it is easier to assess status and improvements on a given month.

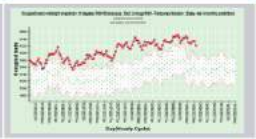
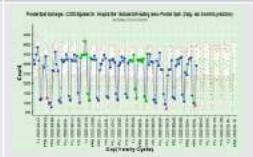
SLR Measures are included in Appendix c.

Monthly Six Goal Board Metrics as follows:

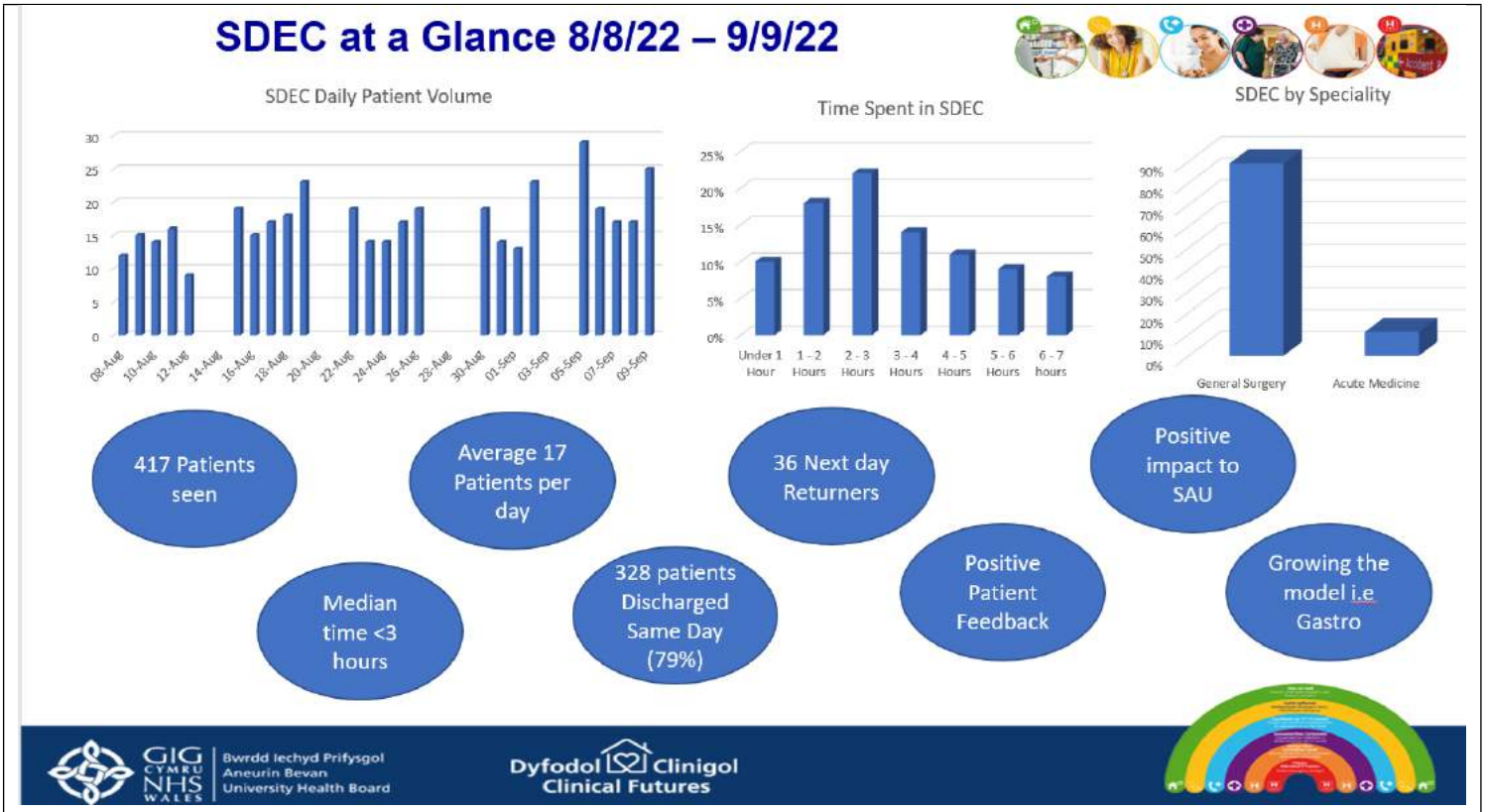
(Noting that we are unable to report UPC or 111 Metrics at this stage due to the current Adastra outage)

Goal	Key Metric	Target	Jun22	Jul22	Aug22	Signal	Signal explanation/ Comment	Chart/Graph
4	ED Attendances (all sites/daily avg)	↓	543	530	510		Gradual decrease over the last 3 months.	
4	<12 hours %	↓ 100%	89.7%	89.9%	90.4%			
4	<4 hour %	↓ 100%	64.9%	66.1%	68.7%			
4	Waits in ED over 16 hours	↓	458	539	463			
4	Time to be seen by first clinician never above 2 hours	↓ 95%	1.5 hours	1.5 hours	1.3 hours		Reduction in time to be seen. Operating below forecasted levels the first week of September.	

Goal	Key Metric	Target	Jun22	Jul22	Aug22	Signal	Signal explanation/ Comment	Chart/Graph
4	Time for bed available from request - 8 hours	↓ 95%	12.8 hours	14 hours	13.1 hours			
4	ED Triage Time	↓ 0.25 hours	0.59 hours	0.54 hours	0.49 hours		Decrease over the last 3 months.	
4	Ambulance Handovers >1 hour	↓						
4	No more than 70 Ambulance hours lost in a day (daily average)	↓ 95%	81.7 hours	87.9 hours	88.5 hours		Increase in lost hours	
5	Occupied Beds monthly av	↓	1486	1498	1511		Out of range and following forecasted seasonal trends.	

Goal	Key Metric	Target	Jun22	Jul22	Aug22	Signal	Signal explanation/ Comment	Chart/Graph
5	LOS over 21 days	↓	580	599	626		Out of range and not following forecasted seasonal trend.	
5	Ave Daily discharges	↑	251	255	252		Overall, operating as forecasted.	
6	Average daily number of Patients on Complex List	↓	382	401	408		Increasing trend	

As SDEC is one of the key priorities for Welsh Government, included below is the summary of performance of one month's activity since its opening at GUH. This update will continue monthly and is shared in a number of forums including NCN, to ensure links between Primary and Secondary remain strong.



Development of SDEC includes a phased progression for General Surgery and an expansion of Acute Medicine utilization following the programme of work to stabilize workforce. In the interim, patients from other Specialities may utilize the space such as Gastro and Acute Oncology.

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

Appendix C sets out the Weekly System Leadership & response Measures.

Recommendation

The Board is asked to note the contents of this report.

Appendix

A: Six Goals For urgent and Emergency Care Policy Handbook
B: AB Six Goals Programme Plan (September 2022)
C: SLR Measures

six-goals-for-urgen
t-and-emergency-ca

Six Goals
Programme Plan Sep

SLR Measures

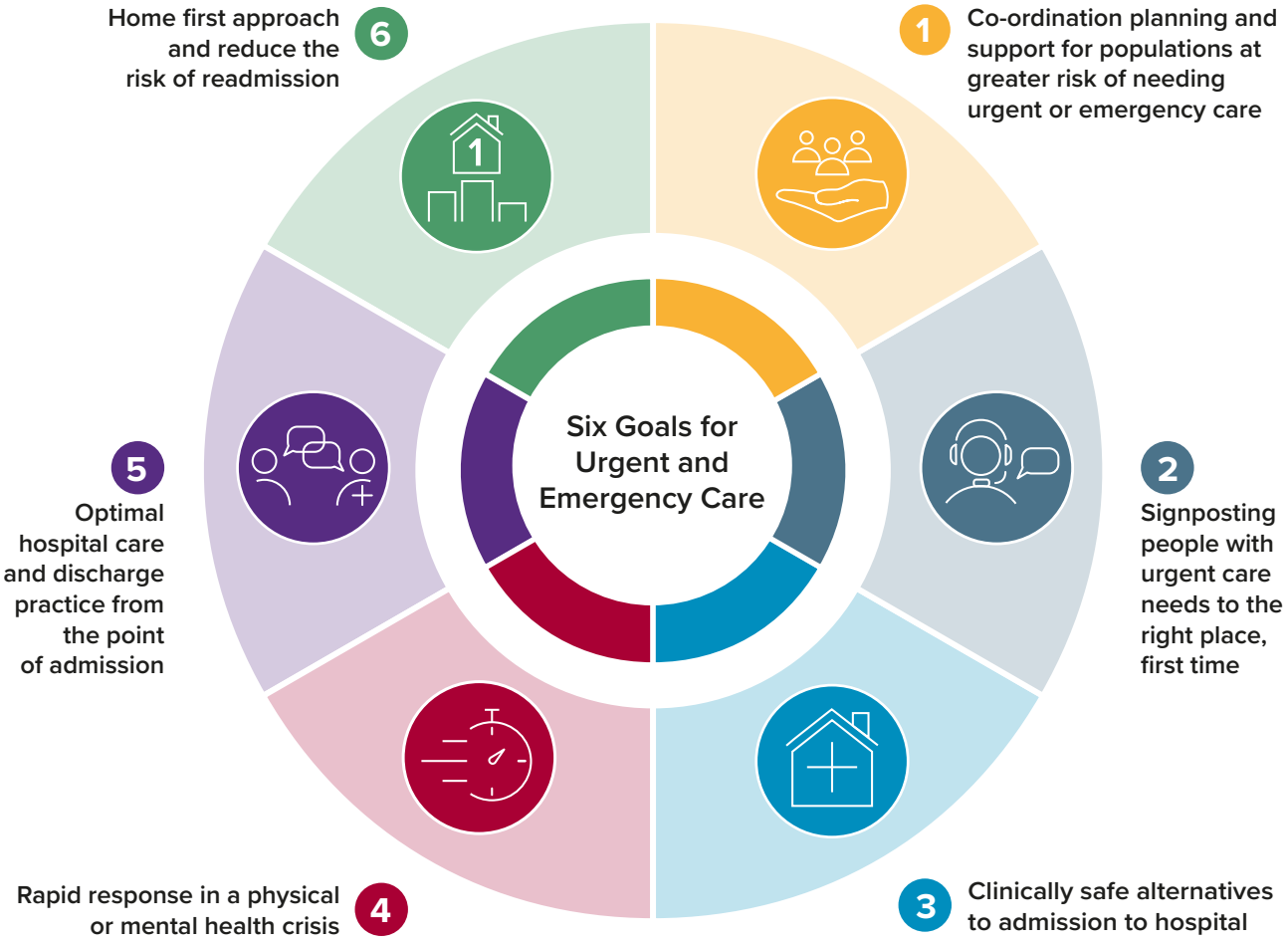
Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	The monitoring and reporting of organisational risks are a key element of the Health Boards assurance framework.
Financial Assessment, including Value for Money	This report has no financial consequence although the financial benefits are being assessed to ensure value for money.
Quality, Safety and Patient Experience Assessment	This report has no QPS consequence although the mitigation of risks or impact of realised risks may do so.
Equality and Diversity Impact Assessment (including child impact assessment)	This report has no Equality and Diversity impact but the assessments will form part of the objective setting and mitigation processes.
Health and Care Standards	This report contributes to the good governance elements of the H & CS.
Link to Integrated Medium Term Plan/Corporate Objectives	The objectives will be referenced to the IMTP
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Six Goals is part of both short and long term strategy
	Integration – It is anticipated that Six Goals will have a positive impact upon the well being of staff and population
	Involvement – Involvement of various internal and external groups is continuous
	Collaboration – Collaboration with various internal and external groups is continuous
	Prevention – Team members have the authority to raise concerns and flag problems
Glossary of New Terms	New terms are explained within the body of the document.
Public Interest	Report not to be published.

Llywodraeth Cymru
Welsh Government

Right care, right place, first time

Six Goals for Urgent and Emergency Care

A policy handbook 2021–2026



Contents

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

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

 WG42727 Digital ISBN 978-1-80391-641-5

Part one

Ministerial summary

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

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

Illustration 1: the six goals for urgent and emergency care

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

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

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

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

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

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

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

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

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

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

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

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

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

Immediate six goals priorities

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

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

We will enable this through the following initial priorities:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Eluned Morgan MS
Minister for Health
and Social Services

Julie Morgan MS
Deputy Minister for
Social Service

Lynne Neagle MS
Deputy Minister for Mental
Health and Wellbeing

Part two

Introduction

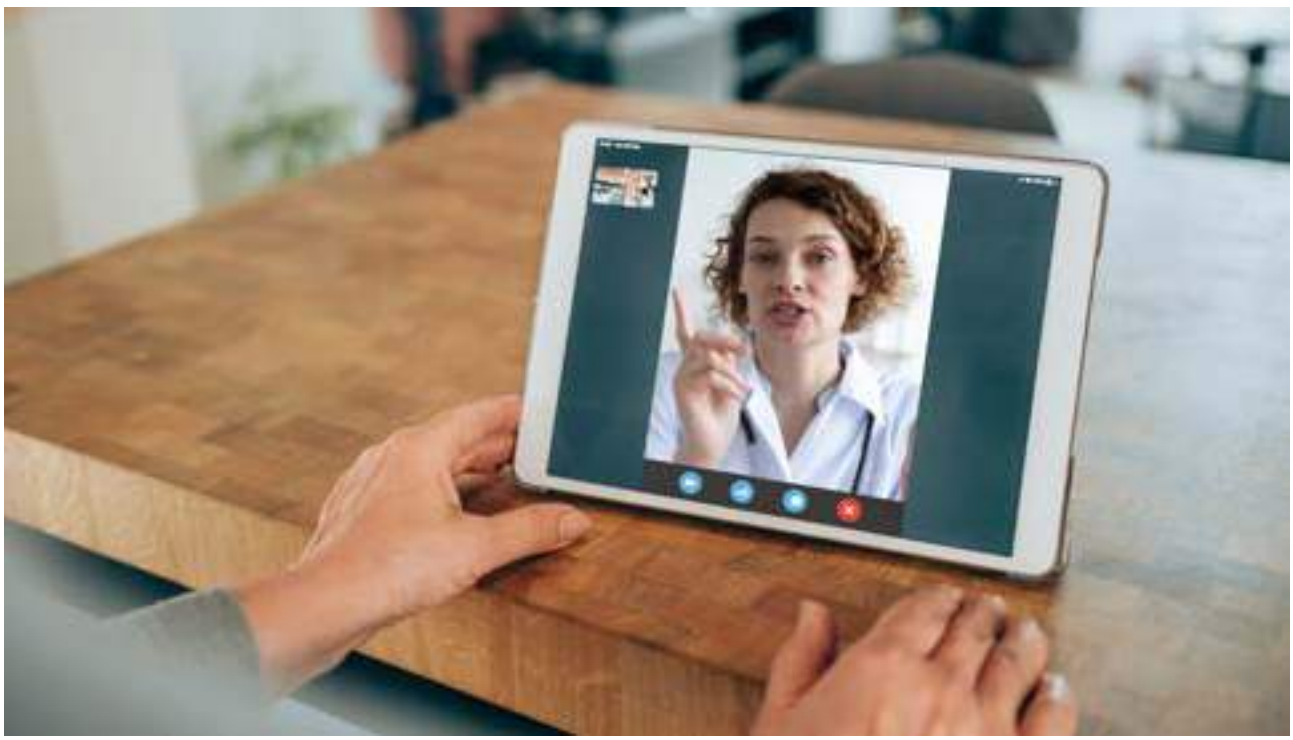
About urgent and emergency care

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

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

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

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



What is the purpose of this six goals handbook?

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

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

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

Strategic context

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

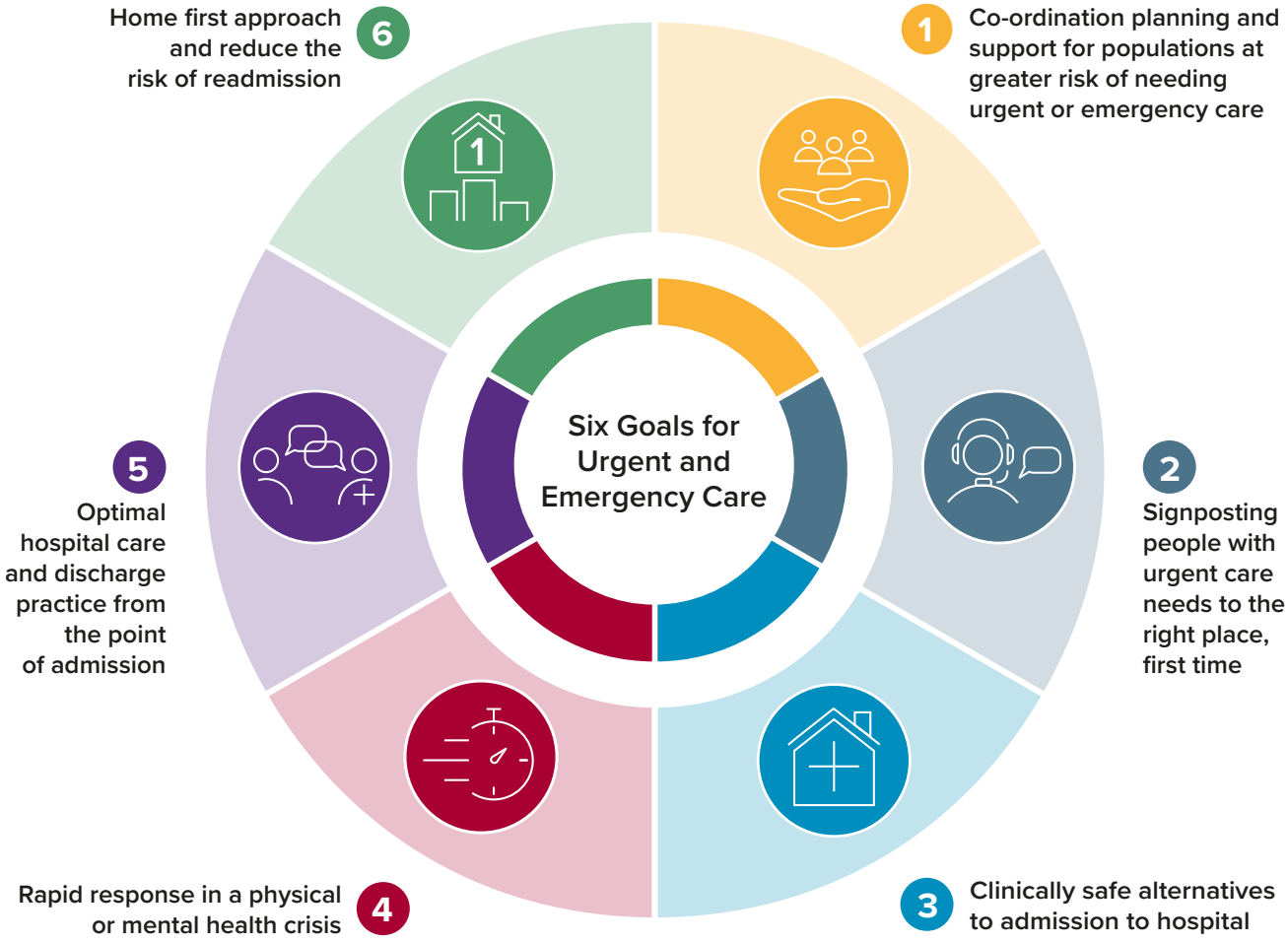
2. Picker Institute (2020) Welsh Perceptions of Urgent and Emergency Care
3. Picker Institute Service User Experience of Mental Health Care in Wales

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

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

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

At a high level, the six goals are:



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

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

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

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

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

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

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

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

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

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

What are quality statements?

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

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

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

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

What are the expectations of health and care organisations?

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

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

Review and evaluation

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

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

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

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

Quality statement

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

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

Why is this good for service users?

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

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

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

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

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

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

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

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

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

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

How will we measure success?

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

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

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

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

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

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

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

Quality statement

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

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

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

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

Why is this good for service users?

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

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

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

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

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

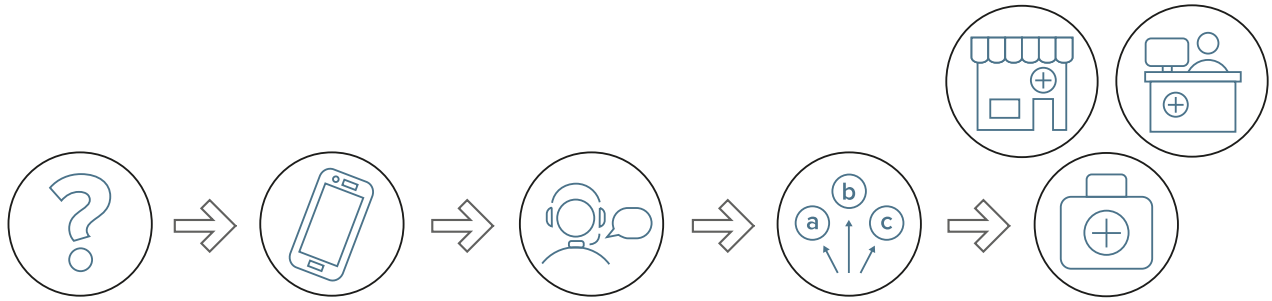
The 111 service provides information on self-care advice and how people can access medication – including repeat prescriptions. It also provides support to individuals or their carers who want or need urgent advice from a range of practitioners, including GPs, pharmacists, dentists, specialist nurses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

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

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

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

Diagram 1 – the NHS 111 Wales model



Helping people to choose

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

Accessing 111

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

Remote assessment

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

Streaming Options

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

Destination Outcomes

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

How will we measure success?

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

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

Goal 3:
Clinically safe alternatives to hospital

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

Quality statement

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

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

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

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

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

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

Why is this good for service users?

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

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

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

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

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

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

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

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

How will we measure success?

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

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

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

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

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

Quality statement

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

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

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

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

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

Why is this good for service users?

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

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

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

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

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

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

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

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

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

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

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

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

How will we measure success?

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

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

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

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

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

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

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

Quality statement

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

People admitted as an emergency to a hospital setting should:

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

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

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

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

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

Why is this good for our service users?

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

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

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

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

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

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

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

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

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

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

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

How will we measure success?

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

Goal 6:
Home first approach and reduce risk of readmission

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

Quality statement

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

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

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

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

Why is this good for our service users?

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

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

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

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

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

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

How will we measure success?

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

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

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

References

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

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

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

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

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

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

Appendix 1

Challenges for urgent and emergency care

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

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

Workforce, training and education challenges and opportunities

As with the whole system the challenges are:

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

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

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

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

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

A complex system

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

Longstanding cultural challenges

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

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

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

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

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

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

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

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

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

Appendix 2

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

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

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

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

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

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

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

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

Six Goals Programme Plan
September 2022

Six Goals Work Programme

Six Goals For Urgent & Emergency Care Programme

Goal 1: *Population Planning*

High Intensity Service Users

Falls

High Risk Adult Cohort

Goal 2: *Signposting*

Urgent Primary Care Centres

NCN Signposting

111 & Option 2

Goal 3: *Alternatives to admission*

SDEC / Hot clinics

Flow Centre

One directory

Scheduled MAU slots

Goal 4: *Rapid Response*

Physician response unit

eTriage

Mental Health services

ED referral Improvement

WAST Improvement

Goal 5: *Optimal Hospital Care*

Discharge Pathways

SAFER Principles

Education & Training

PSAG Boards

Goal 6: *Home First*

ED Therapy services

MFFD Cohort

Trusted Assessor Model

Rapid Response and Community resilience

Six Goals Plan

A high level overview of activity and deliverables planned to 2024

Workstream	2022		2023				2024	Car Park
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Goal 1 *Population Planning & Intervention*	Falls Commitee: Falls CRT Review HISU Assessment/ Business Case			RSOP 1:HRAC				
Goal 2 *Signposting*	Signposting Table top	UPC GUH Audit	111 Option 2 Development Peer Review Outcomes One Directory	GP+ ACD : ACD Development MSK 1 : Therapies MIU/UPC				• Virtual Wards • GIRFT • Care Home Remote Support • CEPOD Capacity
Goal 3 *Safe Alternatives to Admission*	SDEC GUH (Phases 1-4) SDEC YYF Pilot Scheduled AMU Slots Flow Centre APP	CF7 Pathway	FC Model review	RSOP 2: Hot Clinics				
Goal 4 *Rapid Response*	Review of MH pathways and referral E-triage enabling assessment	PRU Business Case	WAST Improvement plan					
Goal 5 *Optimal Hospital Care*	GUH Patient Pathways (1, 2, 3) Discharge Planning Reviews	Education and Training PSAG Improvement with Digital enablers Roles/Responsibilities Task & Finish eLGH: eLGH Reconfiguration						
Goal 6 *Home First*	MFFD Cohort Front Door Therapies GUH RSOP: Direct Access Pathways		RSOP 1: Community Rapid Response					

Denotes Governance outside of Six Goals Programme

Goal Leadership:

- Will Beer
- Dr Graeme Yule

Goal 1: Population, Planning, Prevention

	Work Area	Actions	Lead/Sub Lead	Timeframe	Progress
1.1	**High Intensity Users**	• Develop business for enhanced integrated model including community outreach, joining up response to frequent attenders to ED, OOHs, WAST and facilitating care plans • Integrated processes with Health Inclusion Service to support vulnerable service users (drug users, sex workers, homeless, refugees) • Further integration with other agencies via community panel meetings including Welsh refugee support, housing, The Wallich etc) • Consider hub approach to bring together support services, located near to RGH, to support redirections	Will Beer/Victoria Goodwin	Q3 2022/2023 Q3 2022/2023 Q4 2022/203 TBC/longer term plan	- Business Case is developed and will be submitted via PIP process however **funding source not yet identified** - Process meeting with Health Inclusion Service scheduled for **w/c 26th Sept**
1.2	**Proactive Frailty (High Risk Adults Cohort)** Project agreed to form part of the Redesigning Services for Older People Programme **Phase 2**	Building upon the work of the High-Risk Adults Cohort Project, implement a process to ensure multi-agency and proactive management of those who are at risk of frailty or of whose risk is increasing. • Scope pilot in one area • Plan and design systematic implementation including identifying resource requirements	Will Beer/Mel Laidler	Scoping -2022/2023 (programme resource dependant) Implementation- 2023/204	- Successful Winter Bid to Regional Integrated Fund to bring forward planning and scoping phase to Q3/Q4 2022/2023 (project manager, medical sessions, project support) -Recruitment process for project team to commence **w/c 19th Sept 2022**
1.3	**Proactive and preventative response to falls in the community** Project agreed to form part of the Redesigning Services for Older People Programme **Phase 2**	Work in partnership to develop a proactive and preventative falls programme in the community • Map the current falls provision across the CRTs • Support Monmouthshire NCN as 'test bed' Borough for Household Cavalry approach • Scope a preventative and proactive community falls programme/action plan	Will Beer/Mel Laidler	Scoping - 2022/2023 Implementation- 2023/2024	-Baseline data from Lightfoot presented to HB Community Falls Group and Falls and Bone Health Committee – **Aug 2022** -Monmouthshire proposal in development and seeking funding via Integrated Partnership Board- **Dec 2022** -Initial review of CRT Falls mapping report to formulate recommendations and next steps (Will Beer/Mel Laidler/Karen Hatch) - **Oct 2022**

Goal Leadership:

- Dr Alice Groves
- Dr Alun Walters
- Rebecca Pearce

Goal 2: Signposting

	Work Area	Actions:	Lead (s)	Timeframe	Progress
2.1	Public Communications and Engagement	- Linking to Nye Bevan Champions forum (Third Sector) - Linking to large local employers - Start local and national messaging campaign	Dr Alice Groves/Rebecca Pearce	- Pre-Winter 22	
2.2	Urgent Primary Care Centres (UPCC)C 24/7 Development	- In-hours Primary Care escalation - Re-directions review of outcomes - Scoping re-directions from GUH - GP+ (Access to diagnostics etc) - Ensuring pathway consistency	Dr Alice Groves/Rebecca Pearce	- On-going - Q2 2022 - TBC	Adastra outages has severely hampered progression during August /September
2.3	Integrated Front Door model	- RGH continued work on-going - Scoping Exercise for UPCC at GUH	Dr Alice Groves/Rebecca Pearce	- TBC - TBC	Neville Hall Implement Feb 22 (Possible future development) Ysbyty Ystrad Fawr established
2.4	Think 111	- Develop working group to review TOR and risk associated with criteria - Development of MH services via option 2	Dr Alice Groves/Rebecca Pearce	- Q2 2022 - Q3 2022	Mental Health Single point of Access to begin from November via 111 option 2
2.5	WAST Remote Support	- Initial process Commenced May 22 - Professional support out of hours	Dr Alice Groves/Rebecca Pearce	- Implemented - On-going	
2.6	NCN Signposting	- Develop signposting in the community strategy i.e IAA Team (Information, advice and assistance), booklets, practice care navigation	Dr Alice Groves/Rebecca Pearce	- On-going	

Goal Leadership:

- Paul Underwood
- Dr Paul Mizen

Goal 3: Safe Alternative to Admission

	Work Area	Actions:	Lead (s)	Timeframe	Progress
3.1	Flow Centre Advanced Paramedic Practioner (APP)	Pilot ahead of winter, an APP at the Flow centre to improve patient flow and reduce conveyance This is to test and strengthen the workforce model, senior decision-making function and provide additional advanced clinical assessment skills. Options to access existing WAST/HB pathways	Dr Paul Mizen / Paul Underwood	Q4 2022	Progressing with WAST, scope/cost model operating 9am-9pm, 7/7 aligned to the demand. 66% of WAST referrals via Flow Centre are between 9am and 9pm, with 33% occurring overnight 9pm - 9am. Training required for APP with lead consultant. Planning to commence mid October due to accommodation. Finalising SOP with WAST.
3.2	Clincal Frailty 7 Pathway	The development of an clinical frailty score pathway to improve the flow of older patients through our system via the Flow Centre. Essentially ensuring that the patient is seen at the right time, in the right place by the right person. The pathway will aim to stream patients who meet the clinical criteria to an eLGH site for initial assessment, improving flow and optimising patient outcome	Dr Paul Mizen / Paul Underwood	Q1 2023	A series of appropriate questions has been agreed following discussion with the frailty team and is based on the clinical frailty score. Plan to take proposal to Medical Leadership Group and then LMC.
3.3	Same Day Emergency Care (SDEC)	Implement SDEC at the GUH in a phased approach from Flow centre referrals in the first phase, followed by ED Streaming (General Surgery / Acute Medicine) Once established, develop the service to include multiple specialities where Same day patients are appropriate Pilot of SDEC at YYF to commence Oct 22 through to March 23 Ensure continued service of the Respiratory Ambulatory Care unit (RACU) . RACU currently sees 40- 50 patients per week directed from GPs via the Flow Centre	Dr Paul Mizen / Paul Underwood	Q4 2023	Phase 1 of SDEC GUH opened to patients on Monday 8th August 22. Gen Surgery going very well. Plan to grow Acute Med and interim options Recruiting to YYF SDEC in process to enable winter resilience with a pull model of ambulatory patients from MAU RACU funding extension in process
3.4	Scheduling of Urgent Care – MAU Royal Gwent Hospital	Five scheduled urgent care slots per day have been introduced in the Acute Medical Unit (AMU) at the Royal Gwent Hospital (RGH) for GP referred patients via the Flow Centre. This model has been introduced to improve patient flow, realign workforce with demand and reduce length of stay primarily by avoiding overnight admissions of lower acuity patients	Dr Paul Mizen / Paul Underwood	Q4 2022	A Pilot commenced end of June, opportunity to improve uptake of the scheduled slots interdependent with primary care communications and Flow centre consultant cover. Plan to review the model in September and promote with NCN leads.

Goal Leadership:

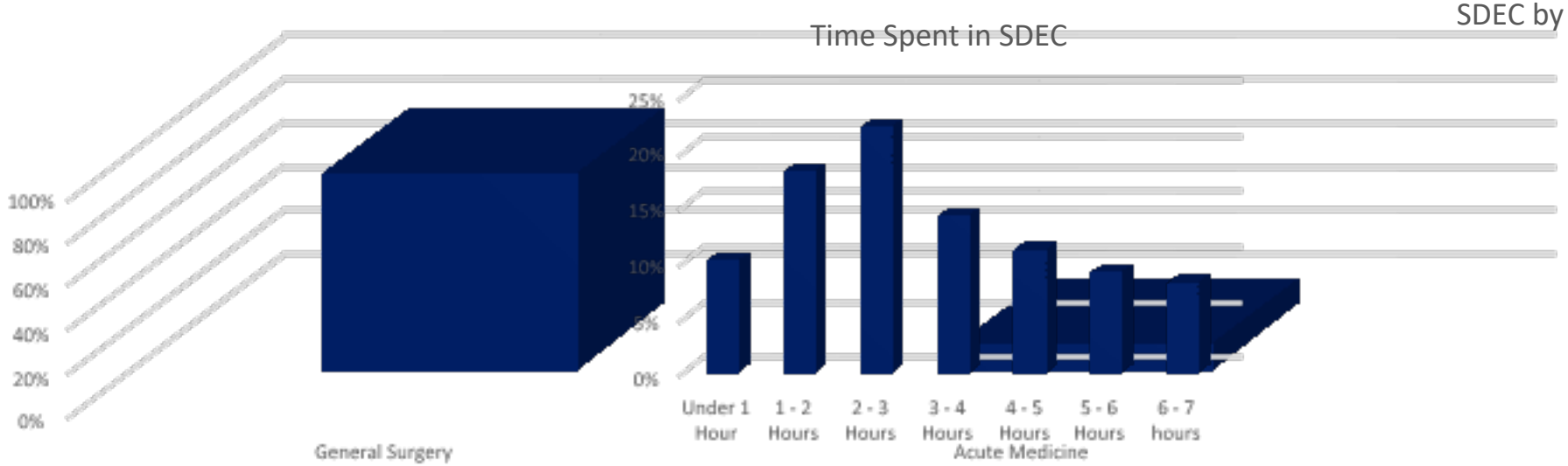
- Paul Underwood
- Dr Paul Mizen

Goal 3: Safe Alternative to Admission…continued

	Work Area	Actions:	Lead (s)	Timeframe	Progress
3.5	Service Access Points, Directory & Virtual Advice	Reviewing all entry points into the system across secondary/primary/community care. Establish a baseline of the current service provision including, how the service is accessed, operating hours, volume of activity etc This includes existing services across Single Point of access (SPA) and the Flow Centre and consideration of changes resulting from Redesigning Services for Older people Programme	Dr Paul Mizen / Paul Underwood	Q1 2023	Engagement required across primary, secondary, community and local authorities to develop an options appraisal

SDEC at a Glance 8/8/22 – 9/9/22

SDEC by Speciality



417 Patients seen

Average 17 Patients per day

36 Next day Returners

Positive impact to SAU

Median time <3 hours

328 patients Discharged Same Day (79%)

Positive Patient Feedback

Growing the model i.e Gastro

Goal Leadership:

- Dr Alastair Richards
- Steve Bonser

Goal 4: Rapid Response Actions

	Work Area	Actions:	Sub Lead (s)	Timeframe	Progress
4.1	ED Referral Improvement	Improvement of the referral to speciality process from ED. Currently a manual process with variation in process time for referral T&F group established to begin in Sept 22 to define proposed improved process	Dr Paul Mizen / Simon Roberts	Q1 2023	Date in October to be agreed to meet with nominated specialty Junior Medical staff to collectively agree the scope of a pilot
4.2	PRU Business Case development	Work with partnership with WAST to understand the shared strategy in relation to PRU Develop a business case to ensure PRU Service continuation	Steve Bonser/ Carl Ashford	Q3 2022	Business case draft in process of development to be reviewed by ED consultant team
4.3	E-Triage System	Work to seek funding to adopt and embed E-Triage technology within the GUH Emergency Department E-triage technology offers the opportunity to improve reception and nursing available time and the ability to promote redirection based on algorithm set by us	Simon Roberts/ Roxanna Williams	Q4 2022	Funding for a 1 year pilot has been agreed. T&F group to be established
4.4	HB/WAST Improvement plan integration	As part of the 6 Goals Programme, Goal 4 workstream should be developed in partnership with WAST to ensure both improvement plans are reflected and agreed upon	Steve Bonser	Q2 2022	WAST nomination received to participate in Goal 4 to support joined up approach
4.5	Mental Health Pathways Demand and Outcomes	Ensure all pathway information is available and accessible. Complete analysis on pathway demand and outcomes . Develop the MH single point of contact service to commence in November (also accessible via 111)	Michelle Forking	Q3 2022	Demand analysis on-going due to complete in October. MH Single point of access to commence in November

Goal Leadership:

- Sue Pearce
- Sandra Mason

Goal 5: Optimal Hospital Care Actions

	Work Area	Actions:	Lead (s)	Timeframe	Progress
5.1	Discharge Policy & Pathways	Update of HB discharge policy to ensure policy reflects current environment and best practices in discharge planning. This aims to provide clear definitions and guidelines in the following areas – 1) Roles & Responsibilities, 2) Escalation methods 3) Red/Green day process 4) Standard pathway terminology to be used across the HB	Sue Pearce / Sandra Mason	Q2 2023	GUH pathway clarity is already in motion, 3 clear pathways for internal navigation (Remain at GUH/Step-down /Fit for discharge) . Communications to follow in Sept. Handbook also developed. Red/Green day refresher training on-going, needs to be reflected in the policy.
5.2	Embed Safer principles	There is variable use of the SAFER principles across the Health Board and there is a need to relaunch and embed the principles of SAFER, including the importance of daily senior review, setting the EDD/MFDD at early stage and to plan discharge from admission To embed the MDT approach to Board Rounds to ensure that all care is coordinated by the whole team, with the aim to reduce 'waits' for each input to happen. Refreshing the use of red/green day processes	Sue Pearce / Sandra Mason	Q3 2023	'Optimizing discharge planning ' engagements taking place on 1 ward at NHH followed by RGH and YYF. Drawing in discharge team to refresh red/green day processes . Added MFFD to status boards , introduced afternoon huddles - driving team led idea generation
5.3	Education and Training	Education & Training package to be developed to increase discharge planning awareness and knowledge. This includes accountability, impact on flow and the wider organisation. This will cover both mandatory training and refresher training.	Sue Pearce / Annie Lewis	Q1 2023	Reviewing mandatory corporate training package, proposal of addition D2RA modules. Training days planning in Sept, Oct, Nov and Dec within Medicine.
5.4	Patient Status at a Glance Boards (PSAG)	The PSAG Boards to be standardised, across the GUH and ELGHs to Plan for every patient Review digital enhancements either STREAM or existing careflow technology	Sue Pearce / Sandra Mason	Q2 2023	PSAG Boards redesigned within Medicine at RGH. Further feedback required from tests of change as above. Further exploration required regarding digital options

Goal Leadership:

- Sue Pearce
- Sandra Mason

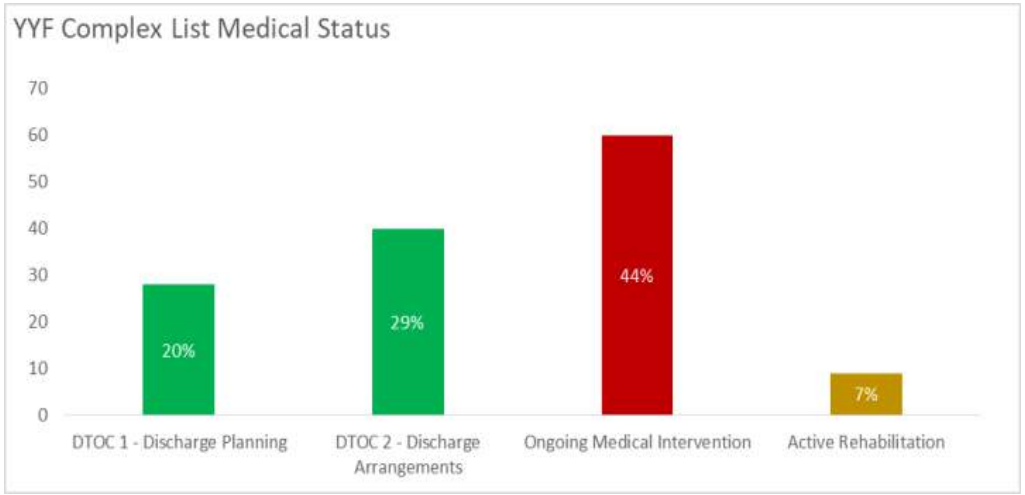
Goal 5: Optimal Hospital Care Actions …continued

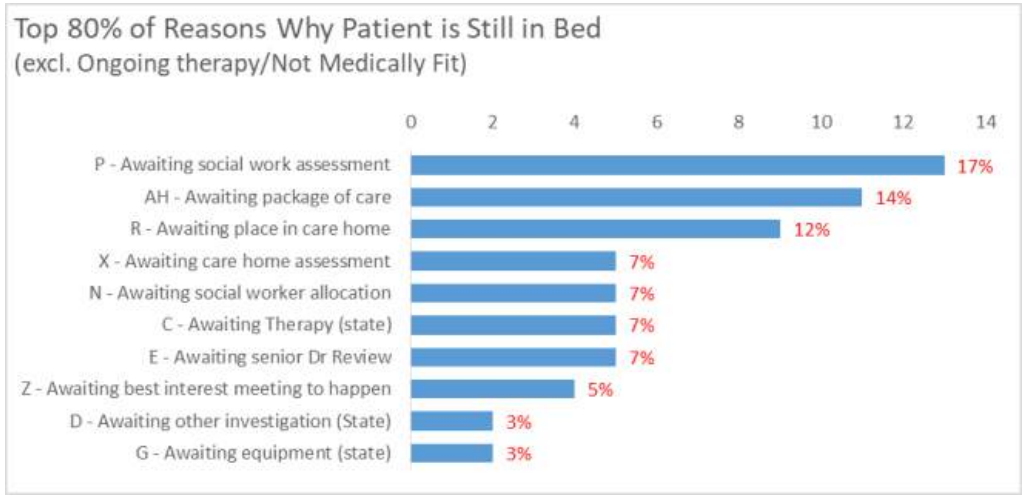
	Work Area	Actions:	Lead (s)	Timeframe	Progress
5.5	Performance monitoring	Development of Discharge dashboard to enable visibility for daily/ weekly snapshot of medically fit delays by reason, site and LOS. Also trend analysis for delay types.	Sandra Mason / Owain Sweeting	TBC	Community team currently developing the format

Goal Leadership:

- Sue Pearce
- Sandra Mason

Goal 5/6 : Ysbyty Ystrad Fawr Break The Cycle Summary





Themes

- Consistency of PSAG boards
- Times of Medical/Therapy input
- Discharge Liason capacity
- Point of care testing
- Updates to complex list
- Choice policy
- Local knowledge of services available

Next Steps

- MDT input to Estimated Discharge Date (EDD)
- Pursue Trusted assessor approach
- Develop escalation process
- Agree pathways for management of out of area patients
- Review with CHC the availability of homes unable to meet certain needs
- Continued education
- Work with partners to simplify social worker allocation

Goal leadership:

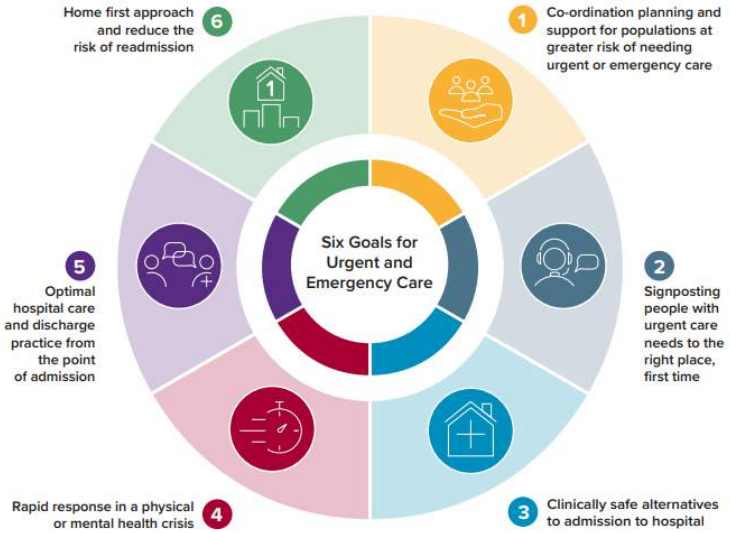
- Mel Laidler
- Collette Kiernan
- Local Authority – TBC

Goal 6 : Home First Actions

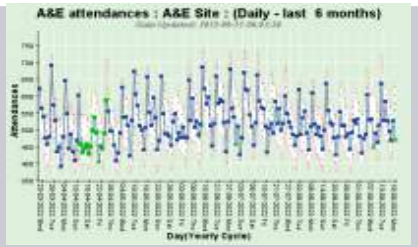
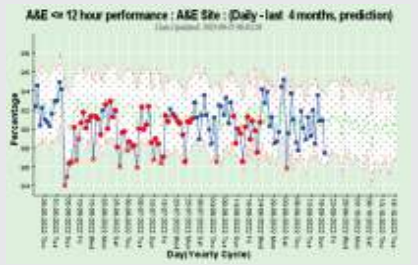
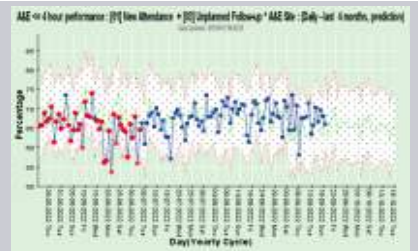
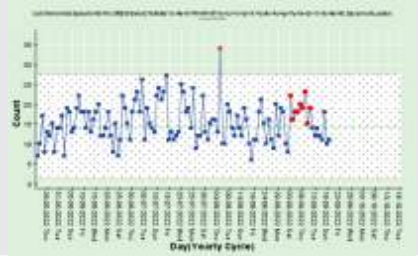
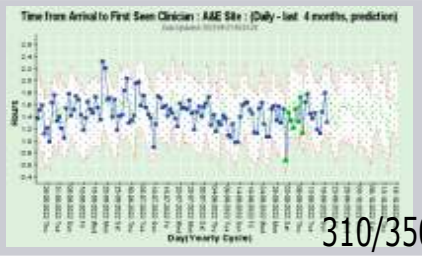
	Work Area	Actions:	Lead (s)	Timeframe	Progress
6.1	Front Door Therapies & Criteria Led Discharge	Business case development to provide ED GUH therapy provision (on a 5-day service initially) to increase the number of patients returned home direct from ED Once established, evaluate and pursue business case for 7-day coverage Once staff in place, test 'criteria led discharge ' at the front door	Collette Kiernan / Emma Ralph	Q3 2022	5-day Business case approved. Vacancies out to advert Plan to be in place by December
6.2	Additional capacity for Medically Fit for Discharge cohort of patients	Alternative bedded capacity (taking learning from the Step Closer to Home pathway to develop a centralised model of support) Identify the location and staffing requirements, plus a needs assessment of the area	Mel Laidler /Collette Kiernan	Q3 2022	Staffing and location currently in planning, paper to be drafted end of Sept with outline plan
6.3	Trusted Assessor Model	Work with partners to develop an agreeable trusted assessor model drawing on past experience and models used in other regions	Mel Laidler / Collette Kiernan	TBC	Requires partnership agreement of principles followed by a co-design of process
6.3	Urgent Response Care (Older People)	Proposal for a small-scale approach to develop two teams of HCSW working initially in the out of hours period 8 pm to 8am, seven days per week. Each team would consist of two Health Care Support Workers who are trained to undertake observations and provide personal care and support to people to enable them to stay safely in their own home	Mel Laidler / Redesigning Services for Older People Programme	TBC	Funding Application approved through RIF
6.5	Extending CRT Model	extend the operational hours for CRT rapid up to 8pm Monday to Friday, by Jan/Feb 23. It is proposed that by recruiting additional support now, it would be possible to make the existing CRT medical team more robust across all areas and develop a weekend response in the same timescale.	Mel Laidler / Redesigning Services for Older People Programme	TBC	Funding Application approved through RIF

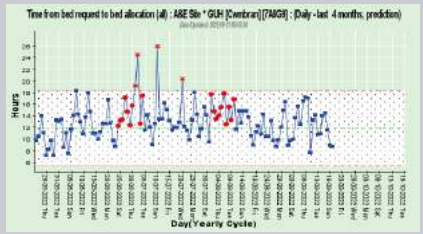
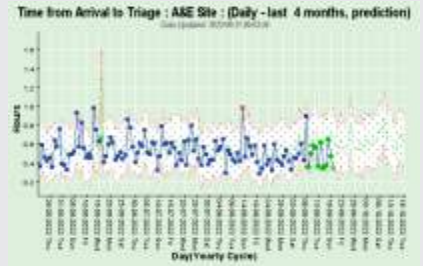
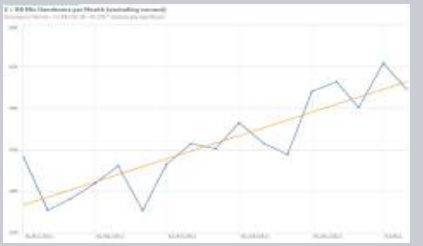
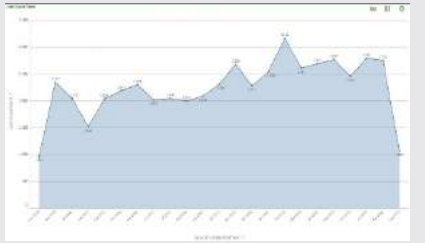
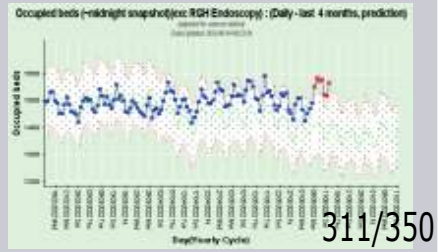
Six Goals – Urgent & Emergency Care Improvement Board

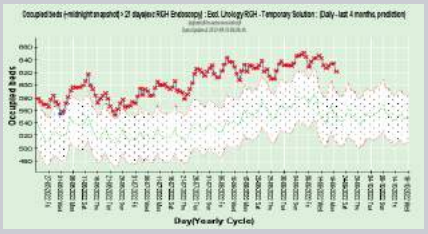
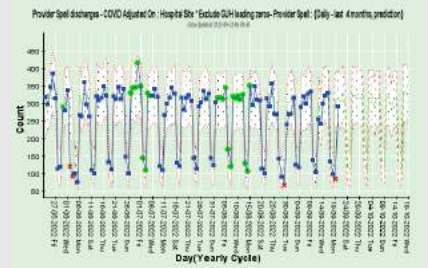
Improvement Metrics
August 2022 Status



6 Goals	Key Metric	Target	Jun22	Jul22	Aug22	Signal	Signal explanation/ Comment	Chart/Graph
2	Think 111 calls (both in and out-of-hours)	↑						
2	111 calls abandoned	↓						
2	Redirections from GUH (Count of both in and out-of-hours)	↓						
2	Redirections from MIU (Count of both in and out-of-hours)	↓						
3	UPCC Consultation / Treatment (monthly totals)	↑						

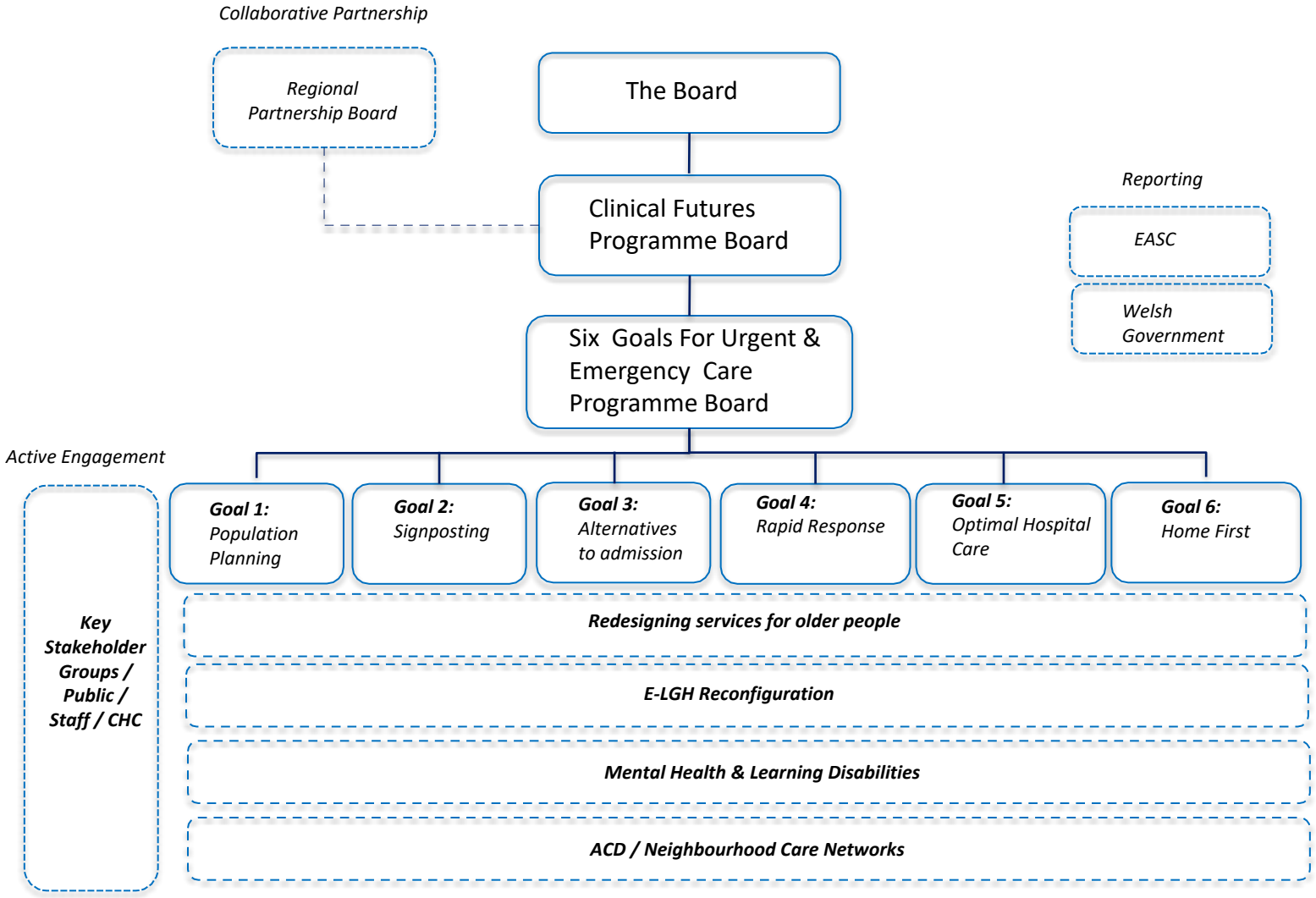
Goal	Key Metric	Target	Jun22	Jul22	Aug22	Signal	Signal explanation/ Comment	Chart/Graph
4	ED Attendances (all sites/daily avg)	↓	543	530	510		Gradual decrease over the last 3 months.	
4	<12 hours %	↓ 100%	89.7%	89.9%	90.4%			
4	<4 hour %	↓ 100%	64.9%	66.1%	68.7%			
4	Waits in ED over 16 hours	↓	458	539	463			
4	Time to be seen by first clinician never above 2 hours	↓ 95%	1.5 hours	1.5 hours	1.3 hours		Reduction in time to be seen. Operating below forecasted levels the first week of September.	

Goal	Key Metric	Target	Jun22	Jul22	Aug22	Signal	Signal explanation/ Comment	Chart/Graph
4	Time for bed available from request - 8 hours	↓ 95%	12.8 hours	14 hours	13.1 hours			
4	ED Triage Time	↓ 0.25 hours	0.59 hours	0.54 hours	0.49 hours		Decrease over the last 3 months.	
4	Ambulance Handovers >1 hour	↓						
4	No more than 70 Ambulance hours lost in a day (daily average)	↓ 95%	81.7 hours	87.9 hours	88.5 hours		Increase in lost hours	
5	Occupied Beds monthly av	↓	1486	1498	1511		Out of range and following forecasted seasonal trends.	

Goal	Key Metric	Target	Jun22	Jul22	Aug22	Signal	Signal explanation/ Comment	Chart/Graph
5	LOS over 21 days	↓	580	599	626		Out of range and not following forecasted seasonal trend.	
5	Ave Daily discharges	↑	251	255	252		Overall, operating as forecasted.	
6	Average daily number of Patients on Complex List	↓	382	401	408		Increasing trend	

Appendix

Six Goals Programme Governance



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

Six Goals Programme Leadership

Programme Leadership

Role	Lead
Executive Co-Chair	Leanne Watkins
Executive Co-Chair	Chris O'Connor
SRO	Neil Miles
Programme Lead	Simon Roberts
Clinical Lead	Dr Andy Bagwell
Social Care Lead	TBC
Regional Analytics	TBC
Local Analytics	Ben Carini
Local Analytics	Jennifer Keyte
Planning	Kate Fitzgerald
Planning	Ashleigh O' Callaghan

Goal Leadership

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

Ward/ Unit-Level Responsibilities

The Four Questions:

1. What is the matter with me
2. Am I having any tests or procedures today?
3. When am I going home?
4. What needs to happen before I can go home?

SAFER + D2RA

Board Round (am) + Huddle (pm) to review actions:

- Run by the team with an identified lead
- Variation for Acute, Community and pre-admission (SDEC Assessment Units)
- Scripted and will include D2RA pathway discussion and referrals

Make Every Day Count and Plan for Tomorrow (Red to Green):

- Action Cards with clear responsibilities and escalation processes
- Close the loop – actions and outcomes

Criteria Led Discharge

Facilitate timely discharge across 7 days

Enabling Work to Allow Optimal Patient Flow

Digital

- 1 Pt. record- Nursing/ CGA etc.
- Electronic whiteboards
- Linking systems H+ SC.
- Live patient bed management system
- Live dashboard

Workforce

- Ward-based Care Navigator for every ward
- registrants who are in non-clinical posts supporting frontline services
- Integrated posts

Training

- Exec level
- Operational management training
- Ward based
- Wider H + SC Training
- Dedicated training on flow and operational management to H+SC students

Meaningful Measures

- Patient focused
- 21 days LOS
- 7 day LOS
- (days away from home) PROMS/PREMS
- Days Red / Green
- Incorporate D2RA measures
- Incorporate other agreed goal 5 measures.

Policy Change

- What needs to be mandated?
- What does mandated mean?
  - HB
  - LA
  - WG

- SAFER
- D2RA

Copyright-authority to amend

Definitions

- Consistency
- Common Language
- Need simplified data dictionary
- Need glossary of agreed terms and their meanings

Cultural Change

- Implementation continuous improvement and processes to embed

System Leadership and Response

Rules of the briefing for Briefing:

- 60 mins max
- Short / sharp & by exception – <u>not</u> 'war & peace'
- Problems flagged for noting and dealt with / discussed <u>outside</u> the briefing
- We will start on time every time

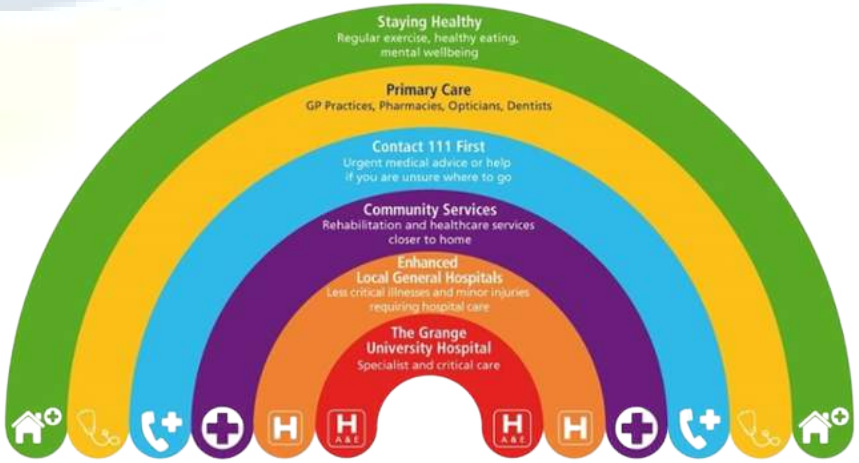
Standing Agenda

1. Immediate safety concerns
2. Review of System Wide Data
3. Escalation to Strategic
4. AOB

Current timings for Meeting

- 10:00 Tuesday

Any immediate and critical safety concerns to flag?



System Wide Review of Data

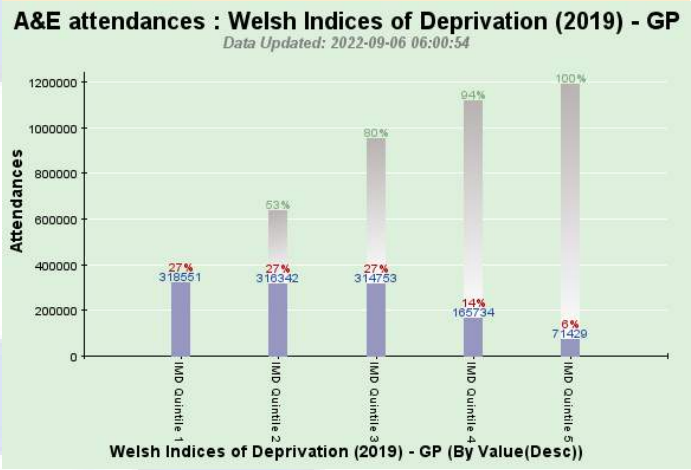
20/09/2022

Format

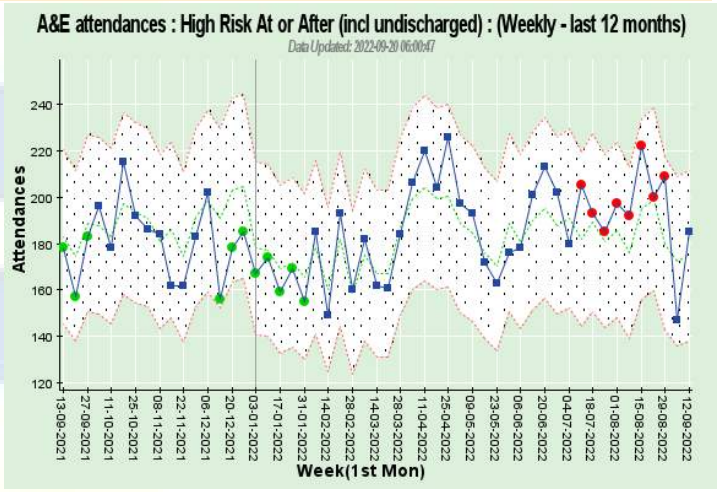
- Key messages
- Goal 1 – Populations at greatest risk
- Goal 2 – Flow Centre
- Goal 2 – UPCC Redirections
- Goal 3 – UPCC Contacts
- Goal 4 – WAST Metrics
- Goal 4 – ED Performance
- Goal 5 – Occupancy, LOS and Discharges
- Goal 6 – Complex List & DTOC

Populations at greater risk

A&E Attendances by Deprivation



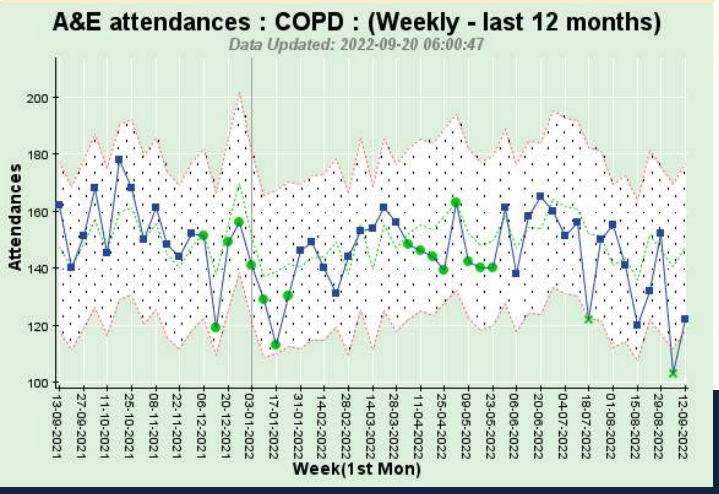
A&E Attendances High Risk



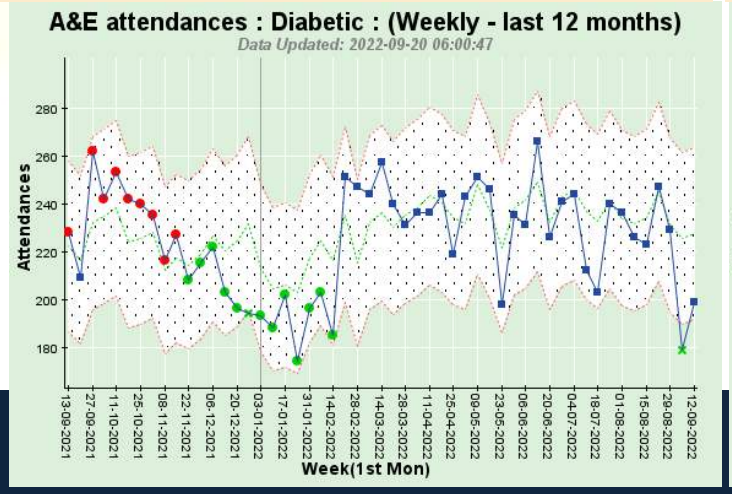
Data Updates & Forecasting:

- **Slightly higher number** of **High Risk patients** attending during July and August
- Lower numbers of **Diabetic and Heart Failure patients** than usual

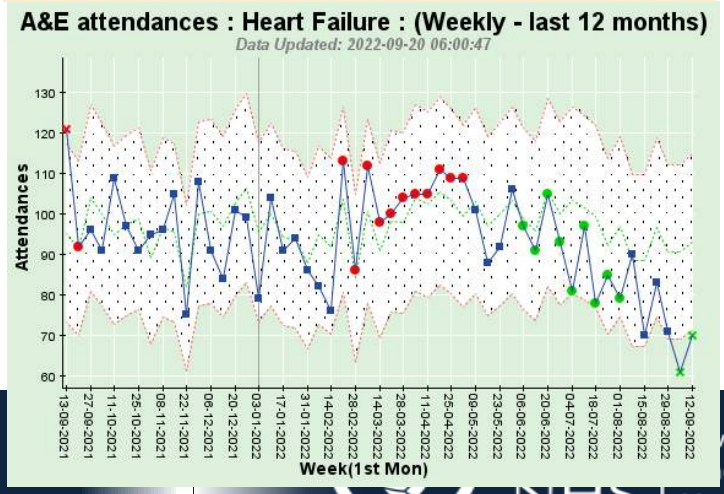
A&E Attendances COPD



A&E Attendances Diabetic



A&E Attendances Heart Failure

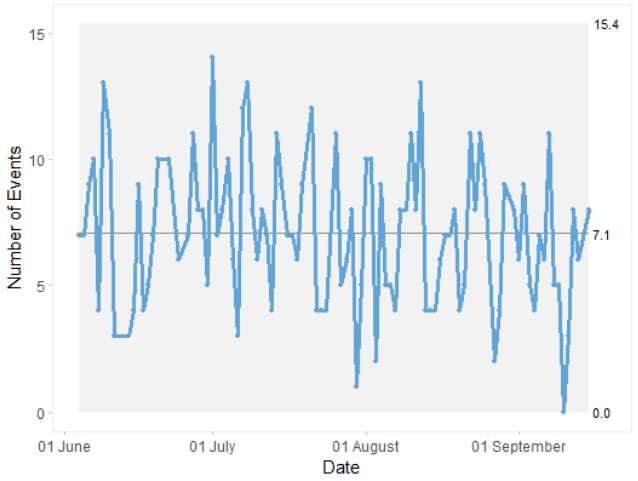


Goal 2: Signposting people with urgent care needs to the right place, first time

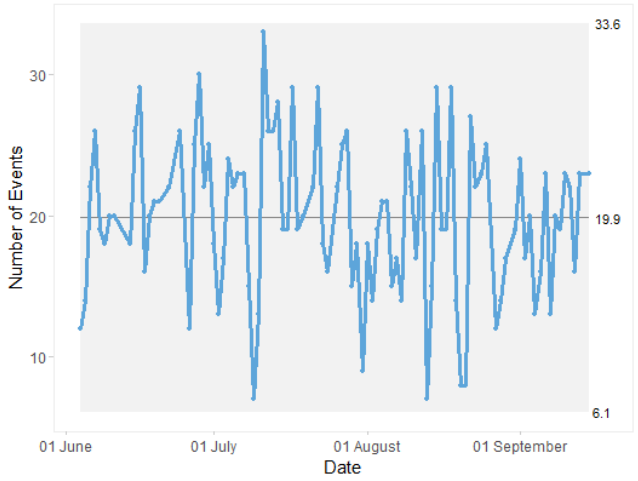
Flow Centre

Flow Centre Activity, 04/06/2022 to 15/09/2022

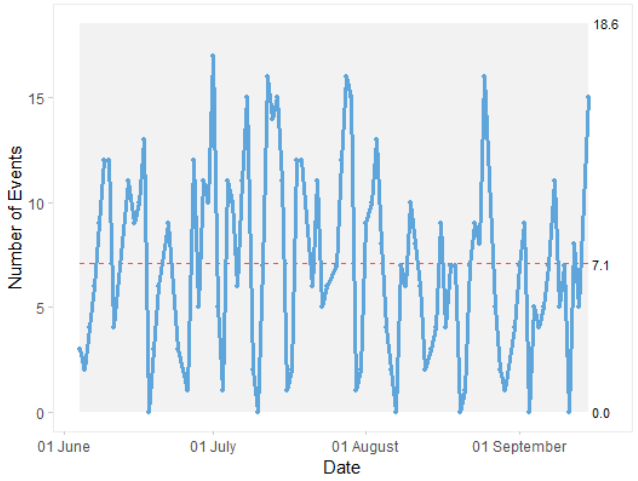
Number of Daily Step Ups



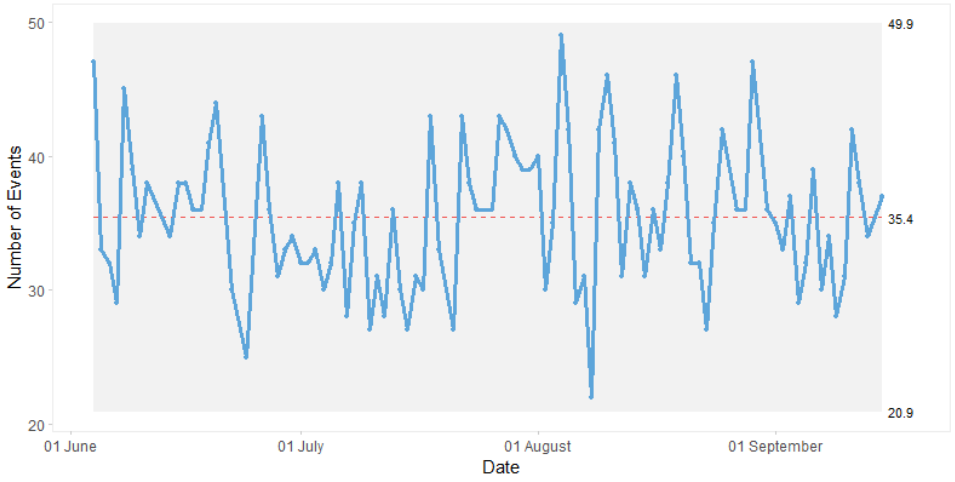
Number of Daily Step Downs



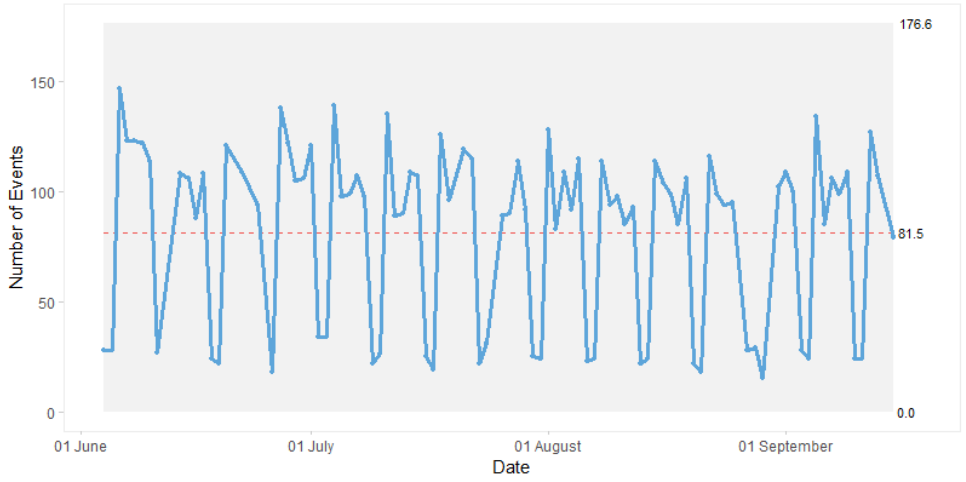
Number of Daily Step Across



Number of Daily WAST Pre-Streaming



Number of Daily Primary Care Pre-Streaming

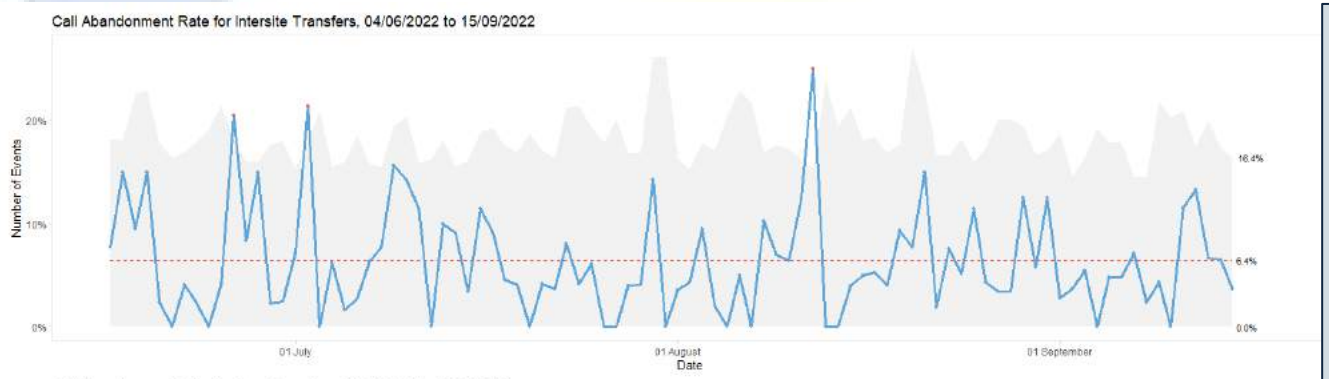


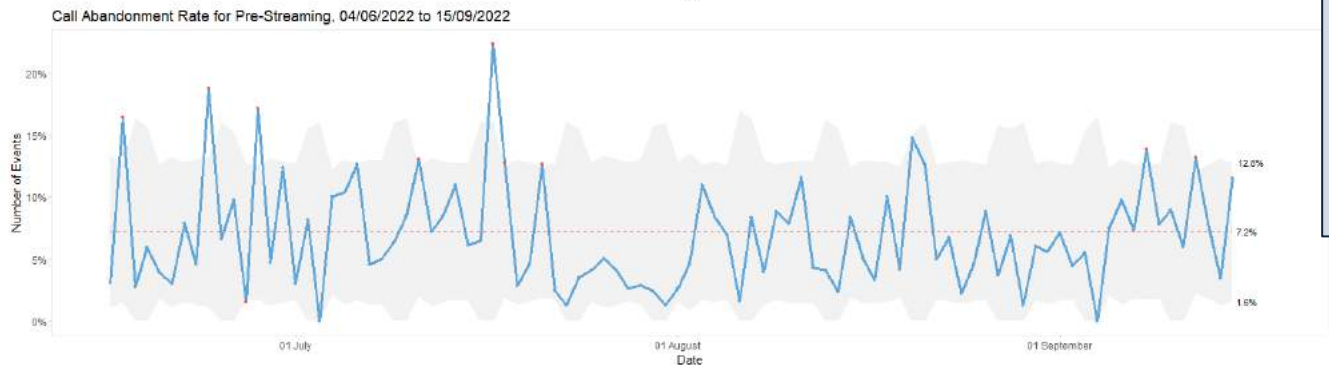
Data Updates & Forecasting:

- No Step Ups completed on the 10th Sept
- All other measures operating as normal

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

Flow Centre – Call Abandonment & Timings

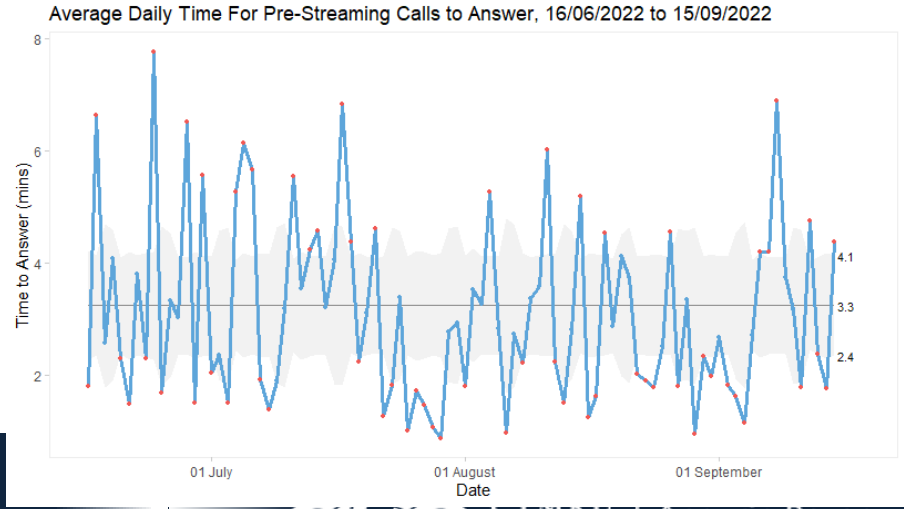




Data Updates & Forecasting:

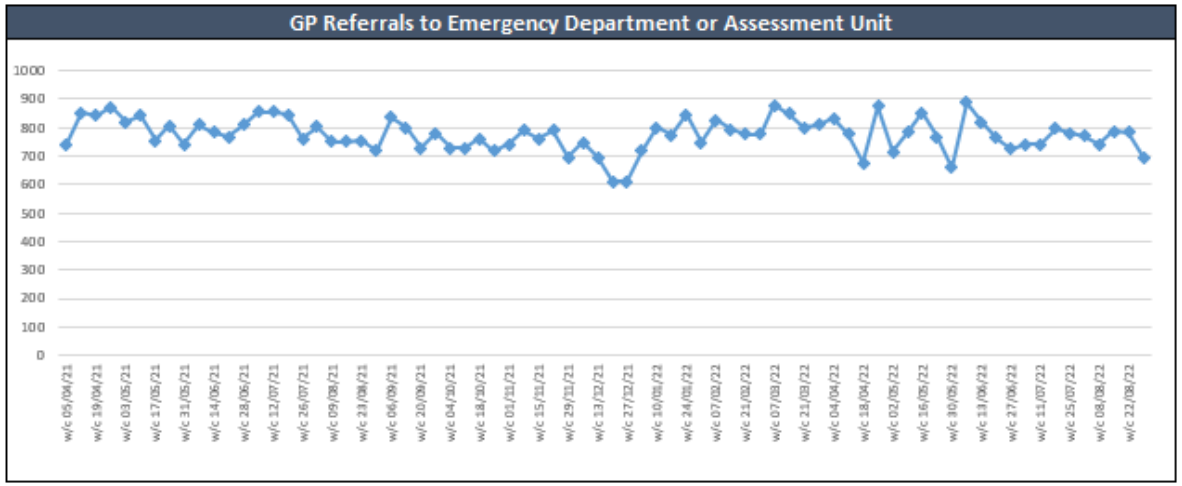
- **Call abandonment rates for transfers** is currently averaging 6.4%
- **Call abandonment rates for streaming** spiked on 8th & 12th September

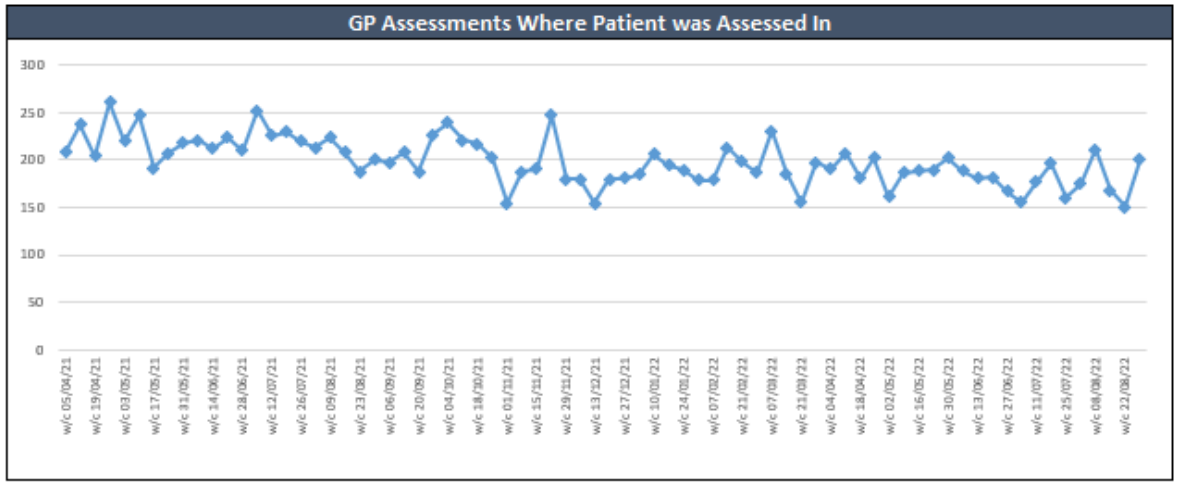
- **Time to answer** is quite variable day to day
- Around **3.2 mins to answer** (intro message is around 90 seconds of this time)
- **Avg. Answer time for Pre-Streaming** was **6mins 48s** on 8th September



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

GMS Activity



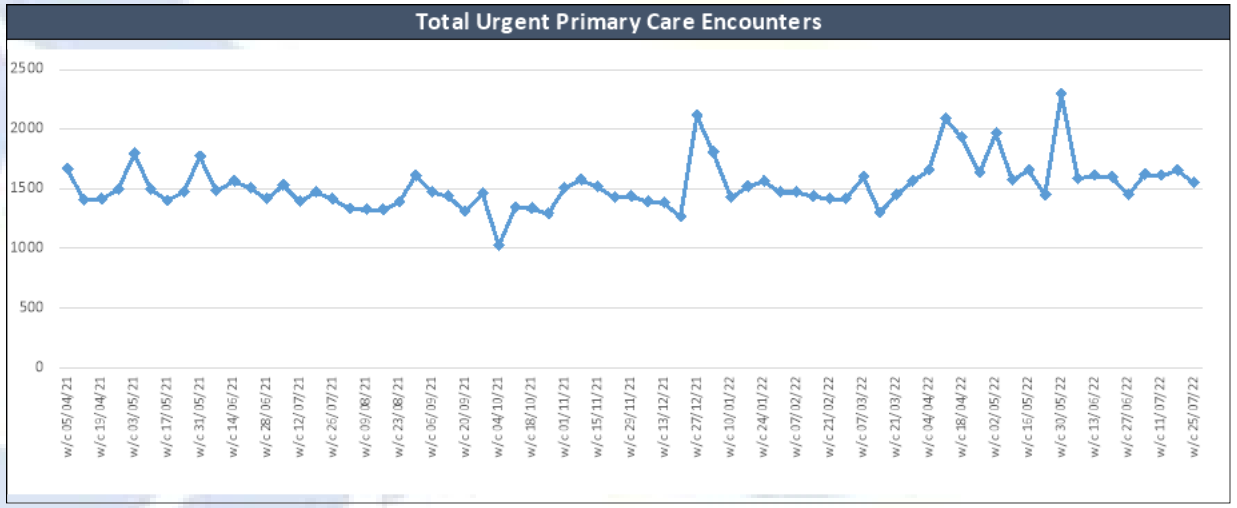


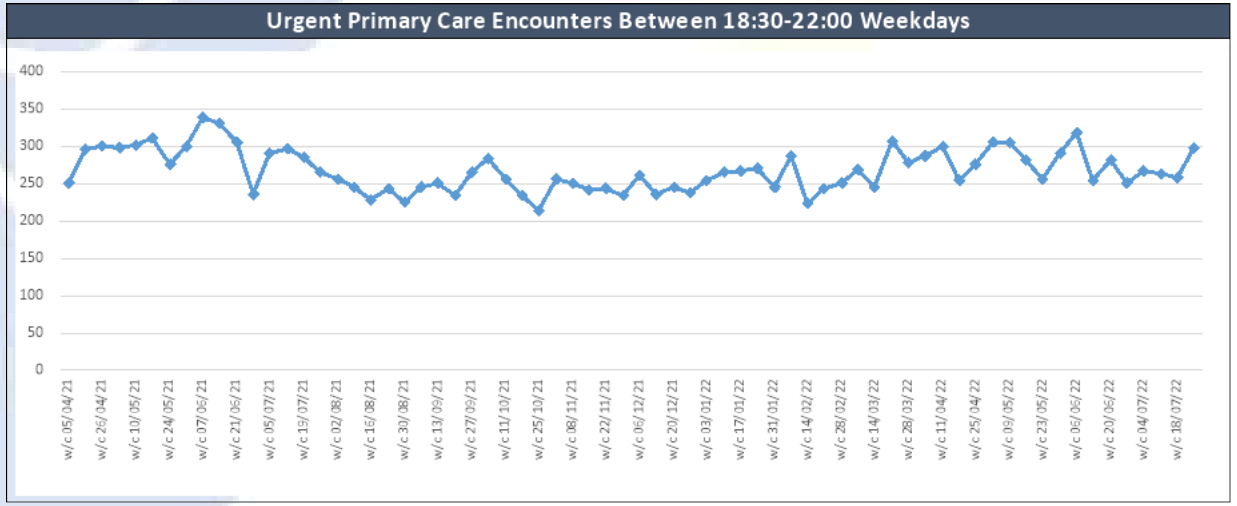
Data Updates & Forecasting:

- **694 GP referrals** to ED or Assessment Units w/c 29nd August.
- **29%** were **assessed in** (admitted)

Goal 3: Clinically safe alternatives to admissions to hospital

Urgent Primary Care Contacts

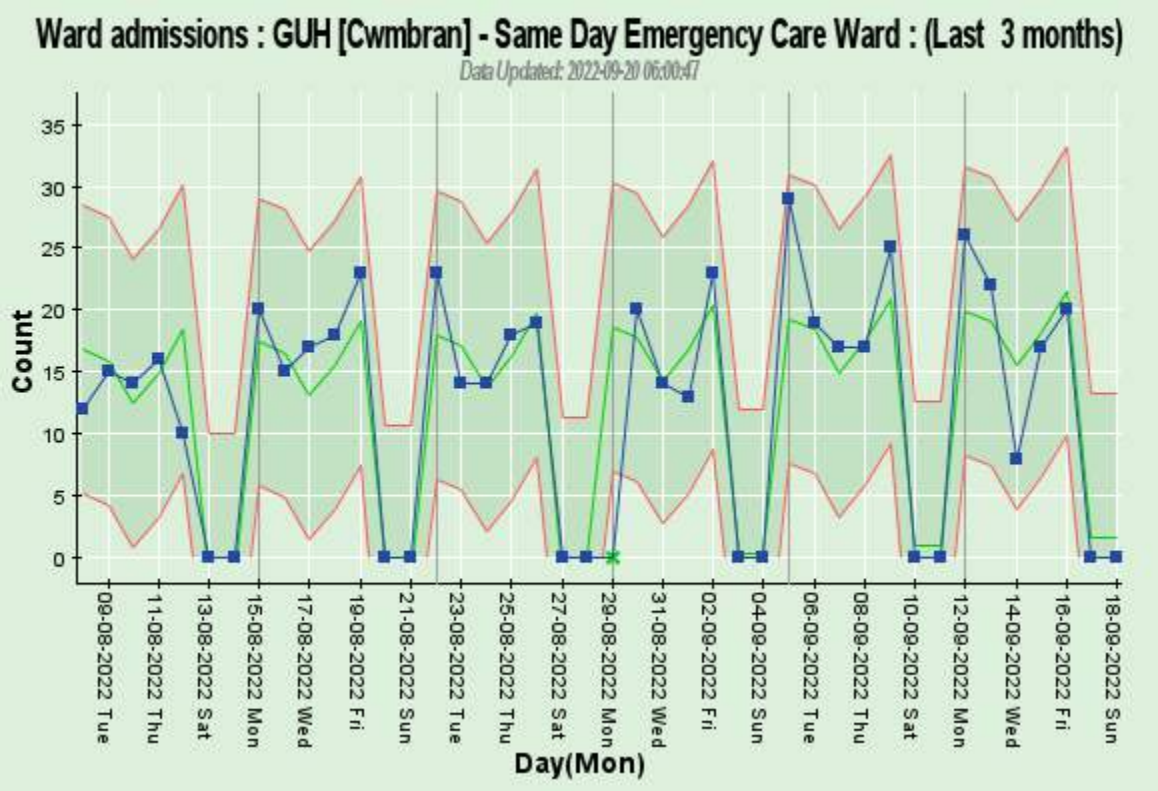


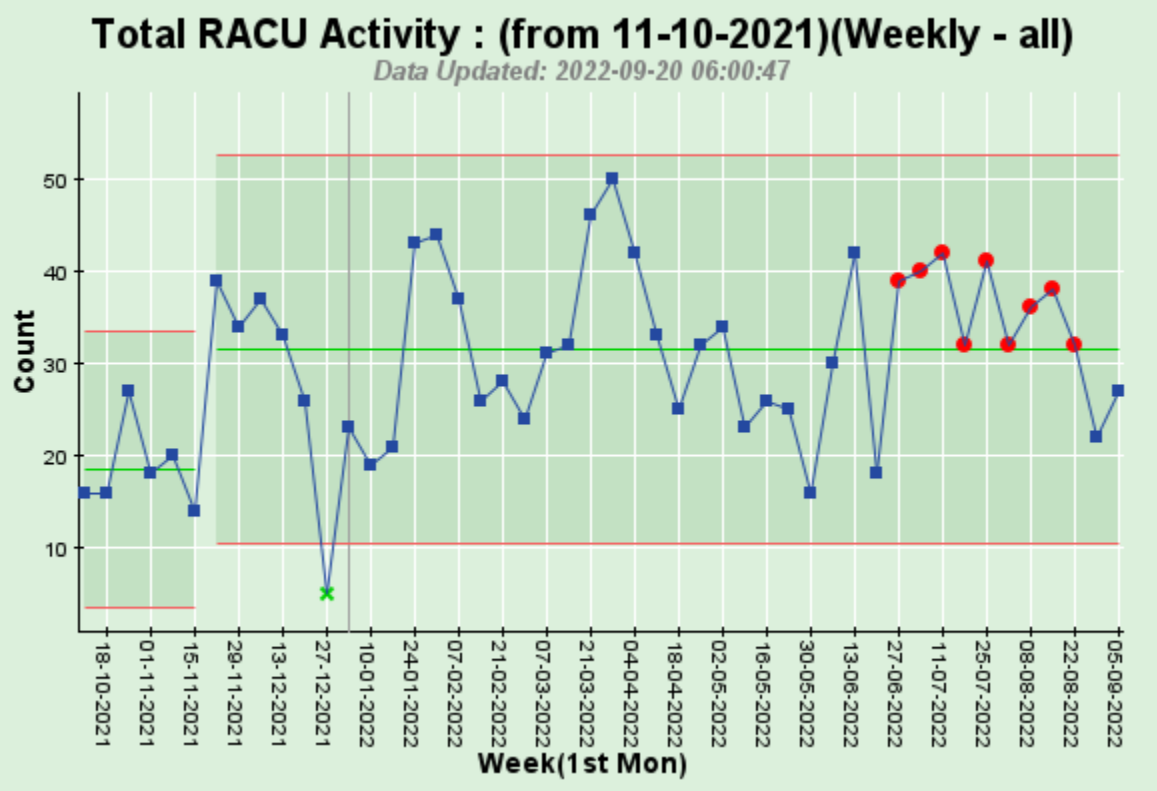


Data Updates & Forecasting:

- **1551 UPC encounters**
- Encounters forecasted to continue to **gradually increase**

Goal 3: Clinically safe alternatives to admissions to hospital





Welsh Ambulance Service Metrics

Minor Injuries/ A&E Dashboard

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

Minor Injuries/A&E Dashboard

Dials | sCharts

Demand

Total	Predicted	Direct to AU
525	585	12

Ambulance	Self Referrals
36	489

Attendance Breakdown | Info

Major	Minor
166	270

Admitted	Discharged
57	468

Capacity

Patient Total Hours in EU

2628

Conversion Rate

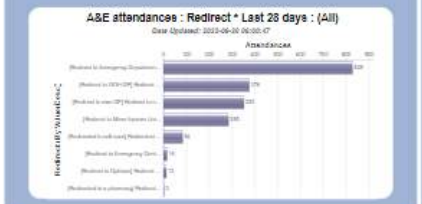
Admit Rate: 11 | Info

Performance

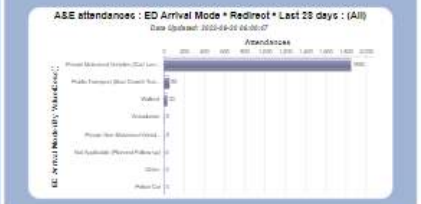
% < 4 Hours	% > 4 Hours	% < 12 Hours
68.2	30.5	91.0

% < 4 hr Discharged	% < 4 hr Admitted	% > 12 Hours
72.7	35.4	9.0

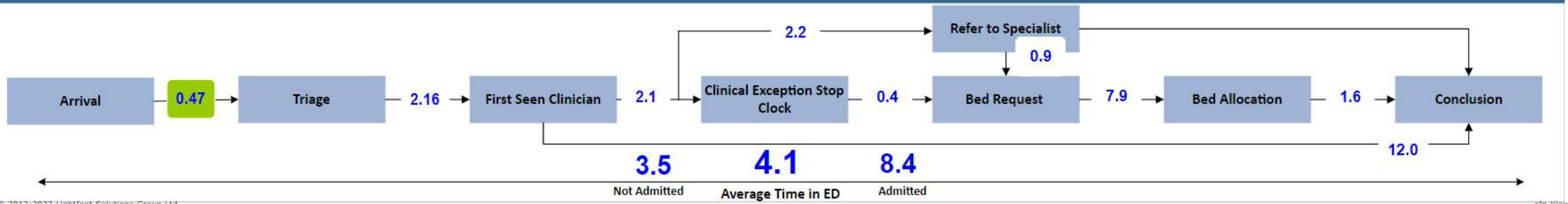
Redirected



Redirected Arrival Mode

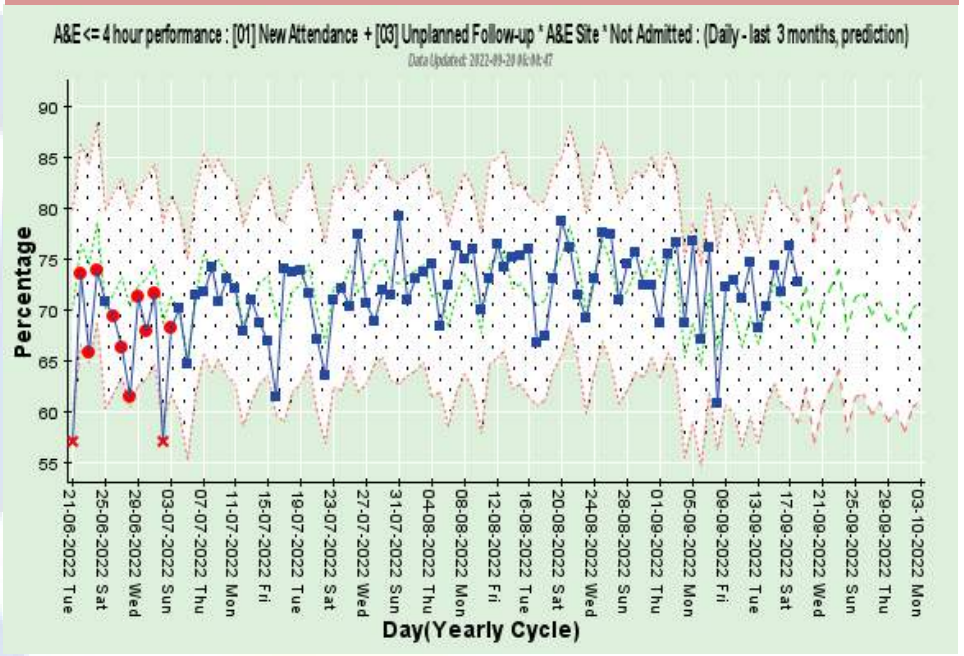


Flow

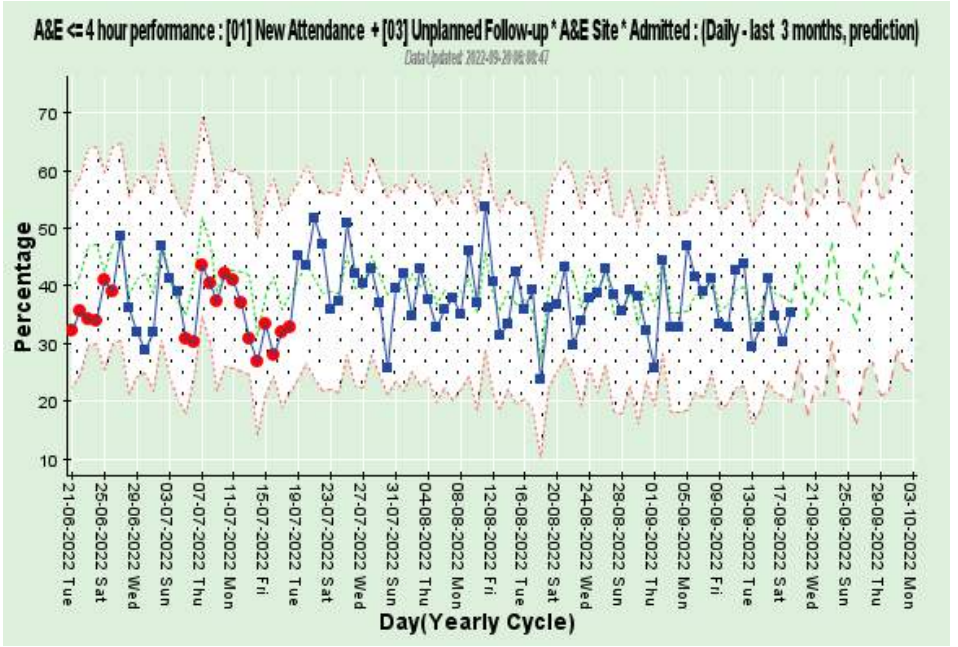


<4 hour target

<4 hour (not admitted)



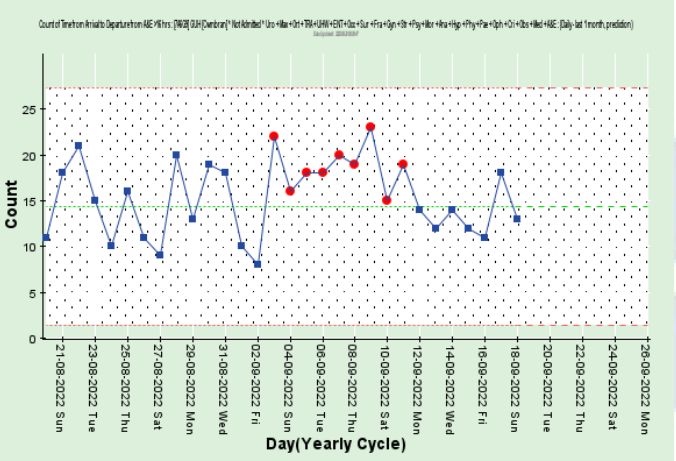
<4 hour (admitted)



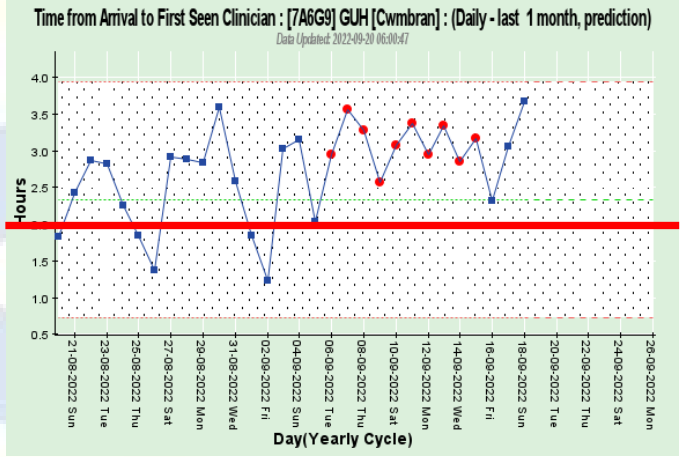
<4 hour (not admitted): The average during September so far is 72.2%
<4 hour (admitted): The average during September so far is 36.6%

ED Never Events

Waits in ED over 16 hours



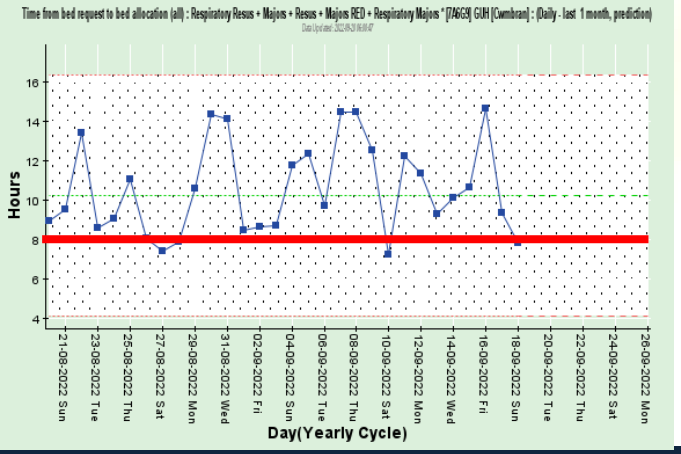
Time to be seen by first clinician (<2hr)



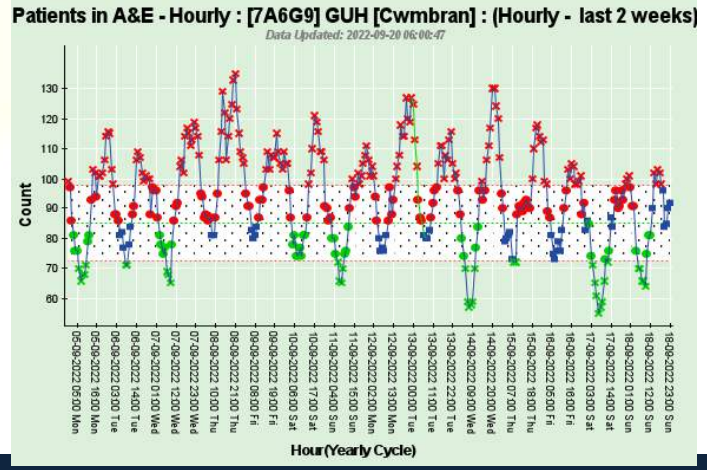
Data Updates & Forecasting:

- Updates include:
  - **Waits in ED over 16 hours** had been 15-25 each day, but had been more stable at the usual level of 14 last week
  - **Time to be seen by first clinician** has been over 2.5 hours since 6th September
  - **Bed available from request** has been operating at around 10 hours

Bed available from request hours (<8hr)



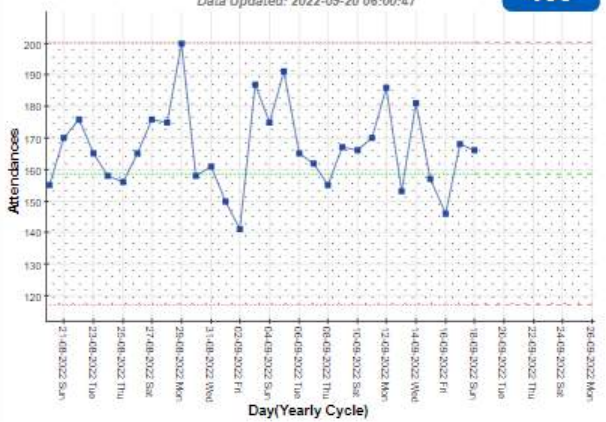
Patients in A&E - Hourly



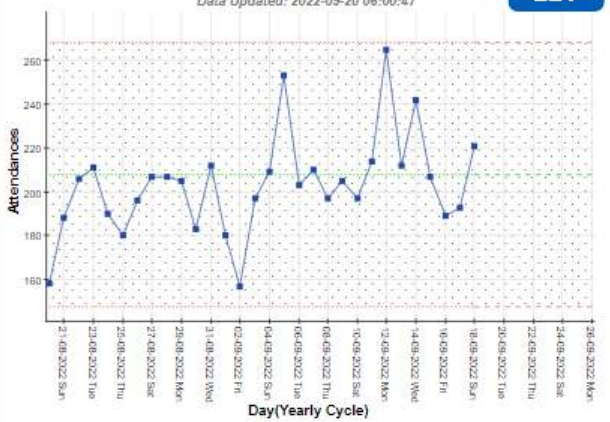
GUH ED Activity

Ambulances	36
Admitted	10

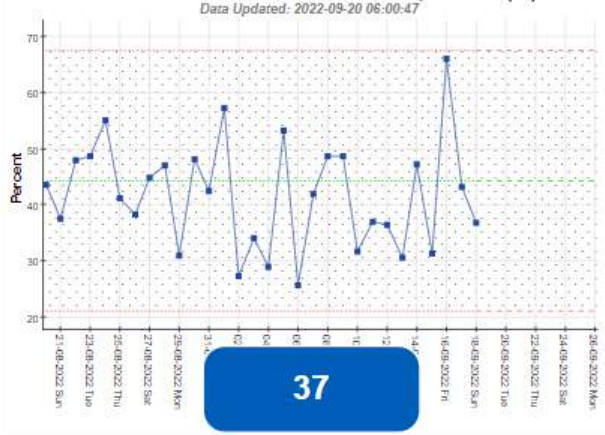
Majors Attendances — 166
Data Updated: 2022-09-20 06:00:47



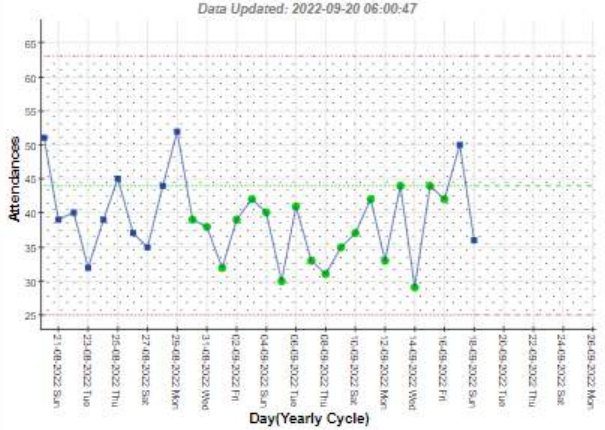
Walk-ins to ED — 221
Data Updated: 2022-09-20 06:00:47



ED Ambulance Admit Rate - ED departures (%)
Data Updated: 2022-09-20 06:00:47



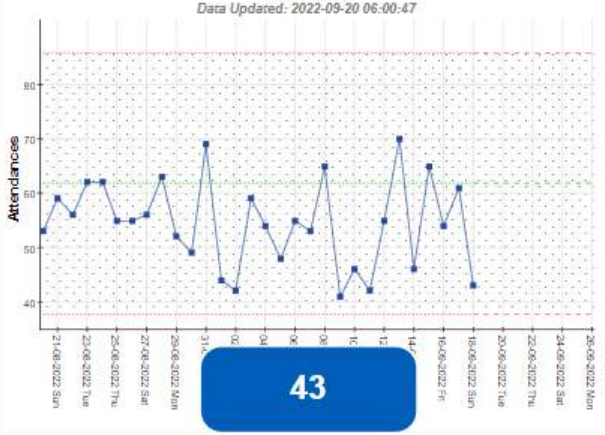
Number of Ambulances
Data Updated: 2022-09-20 06:00:47



Redirections from ED
Data Updated: 2022-09-20 06:00:47

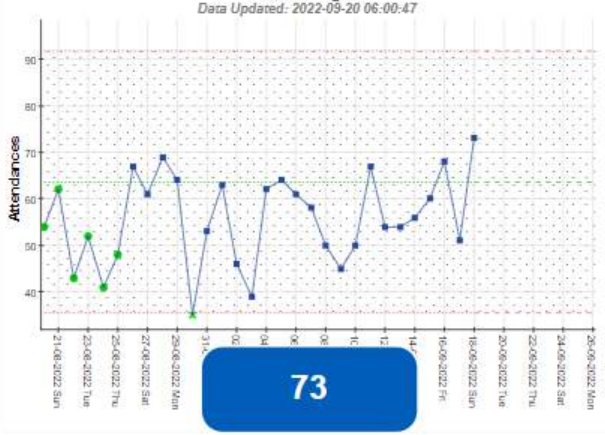
% of Attendances Redirected
Data Updated: 2022-09-20 06:00:47

Admitted
Data Updated: 2022-09-20 06:00:47



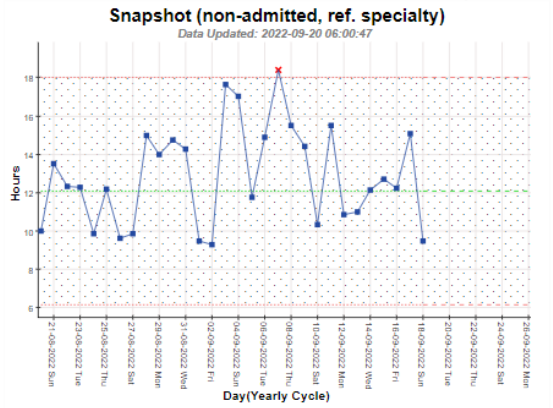
Referred and Discharged
Data Updated: 2022-09-20 06:00:47

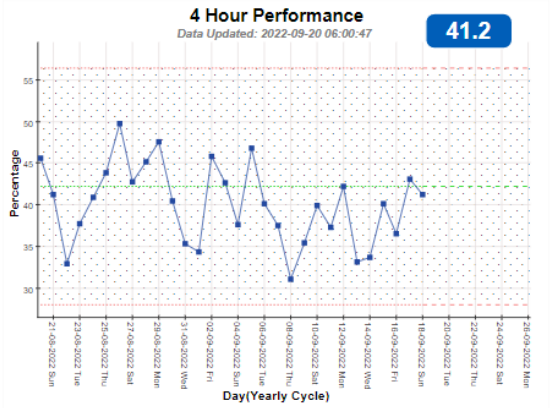
Discharged
Data Updated: 2022-09-20 06:00:47

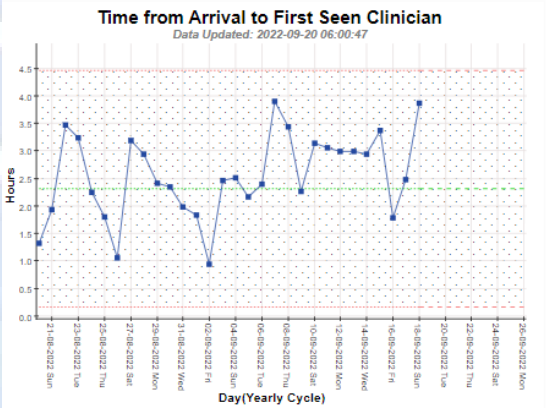


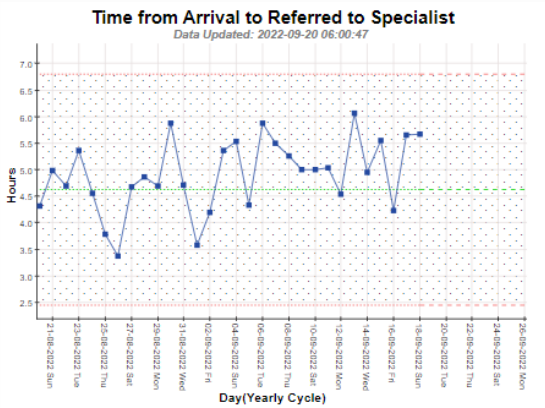
GUH ED Timings

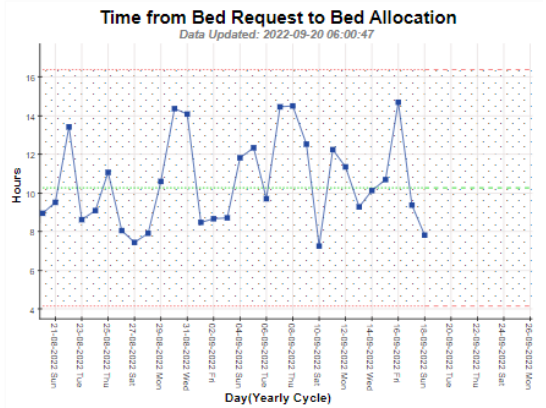
>16 hours	13
>24 hours	5







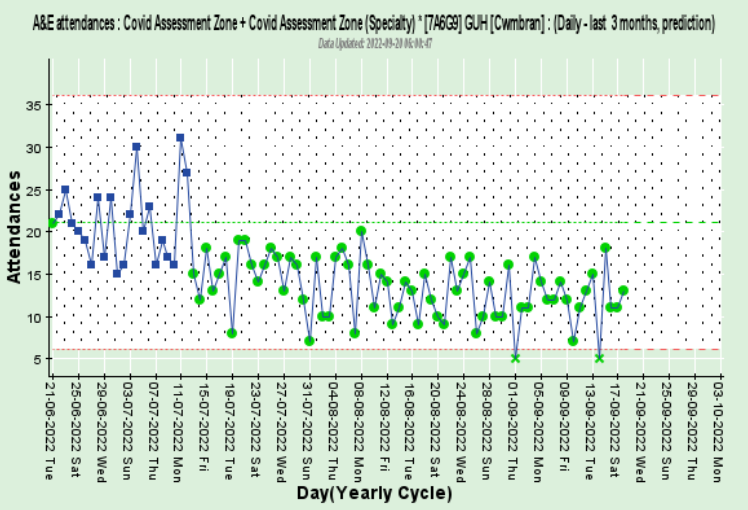


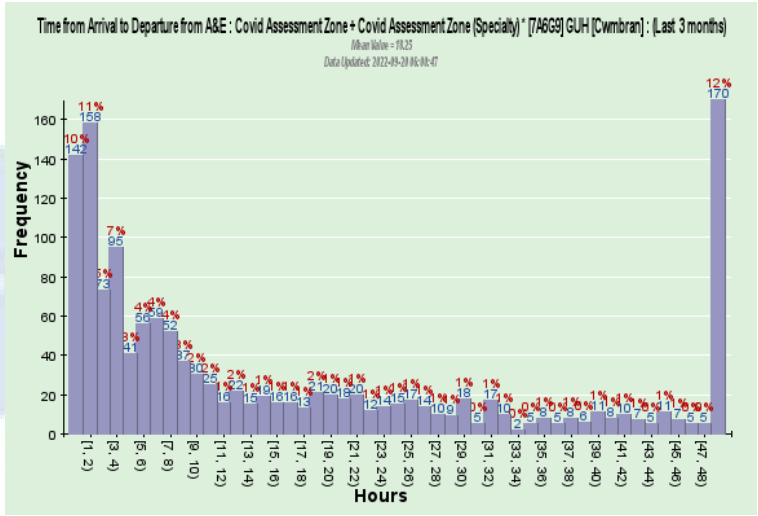


Data Updates & Forecasting:

- The percentage of patients seen within the **4 hour target** has remained stable
- Otherwise fairly stable

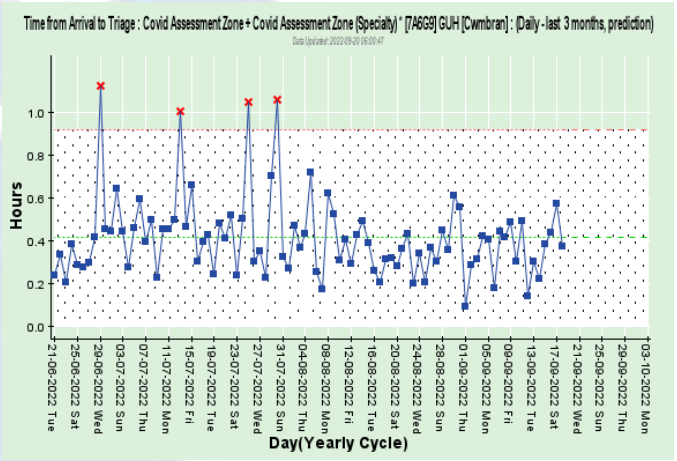
GUH Covid Assessment Zone

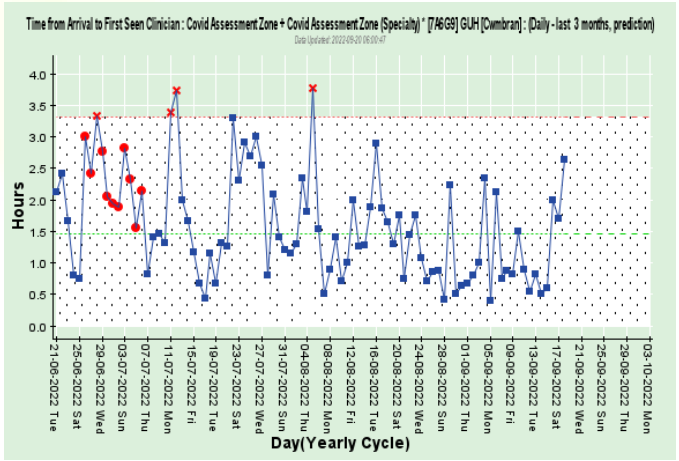


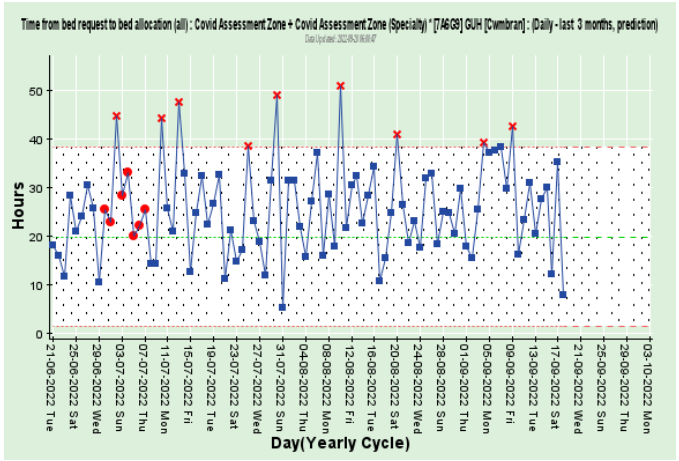


Data Updates & Forecasting:

- **Patients attending GUH CAZ** has been 8-18 per day since 14th July
- 12% of patients are spending **over 48 hours** in GUH CAZ
- **Time to see first clinician** is around 1.5 hours with occasional spikes
- **Time to bed allocation from request** is around 19 hours





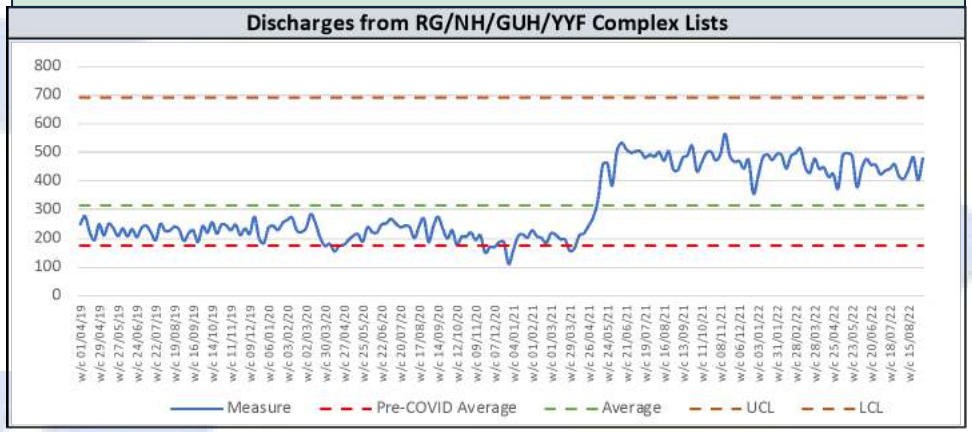


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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

Complex List & DTOCs

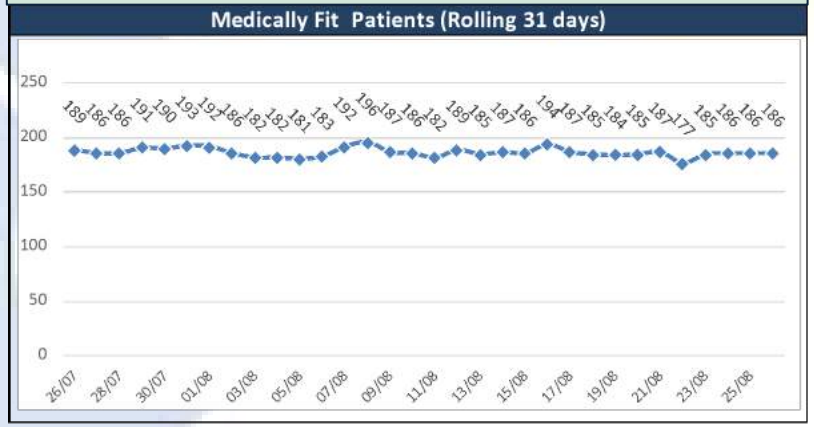
Acute Sites



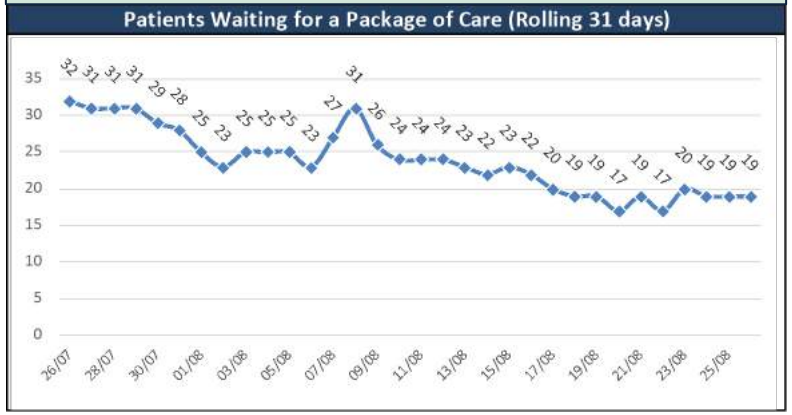
Data Update & Forecasting Trends:

- Weekly average of **455 discharges** from **acute site complex lists**
- Daily average of approx. **185 patients medically fit for discharge** at community sites
- **Patients waiting for package of care** has reduced to around 20
- **Patients waiting for permanent care home placement** is around 30

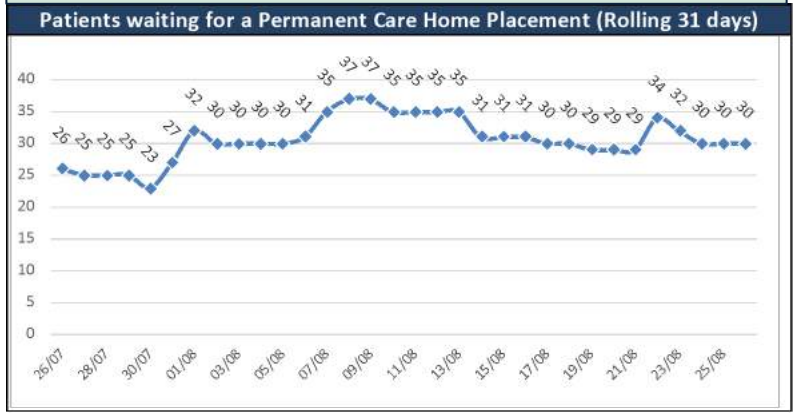
Community Sites



Community Sites



Community Sites

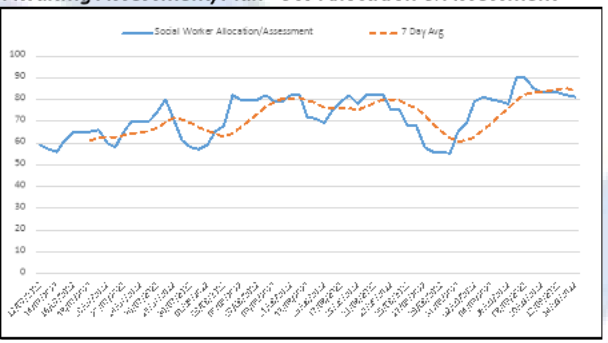


Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

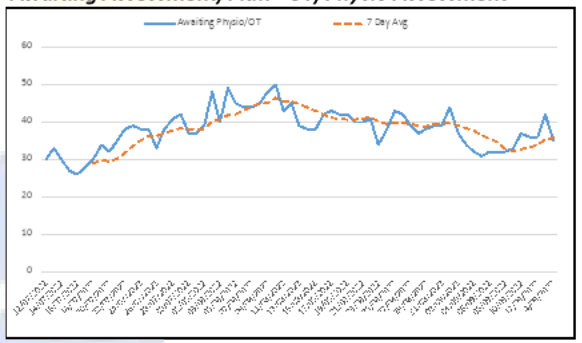
Goal 6: Home first approach and reduce the risk of readmission

Complex List & DTOCs

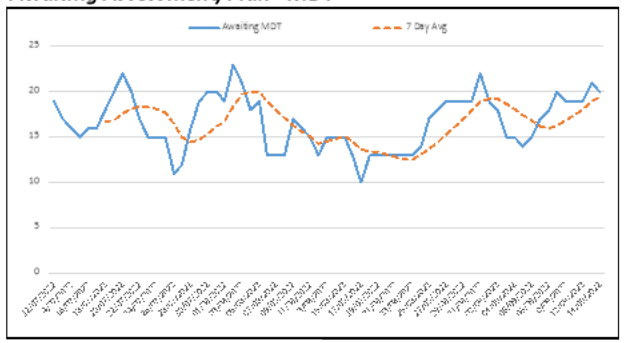
Awaiting Assessment/Plan - SW Allocation & Assessment



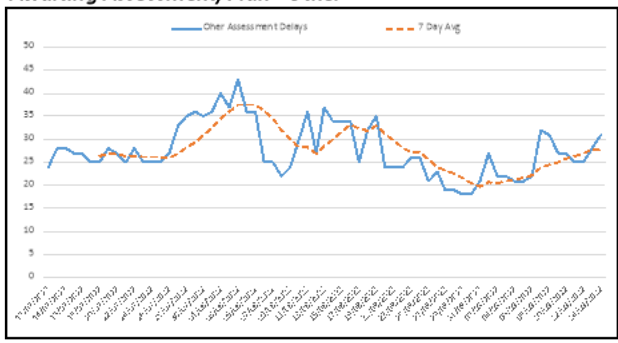
Awaiting Assessment/Plan - OT/Physio Assessment



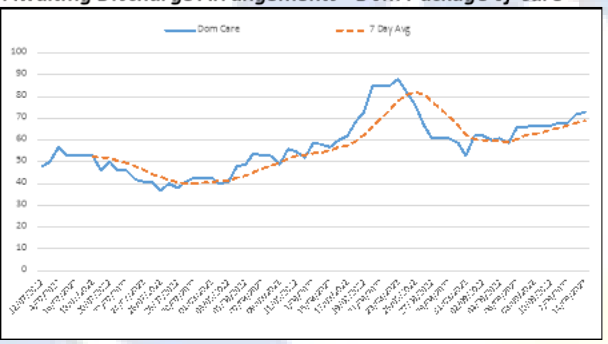
Awaiting Assessment/Plan - MDT



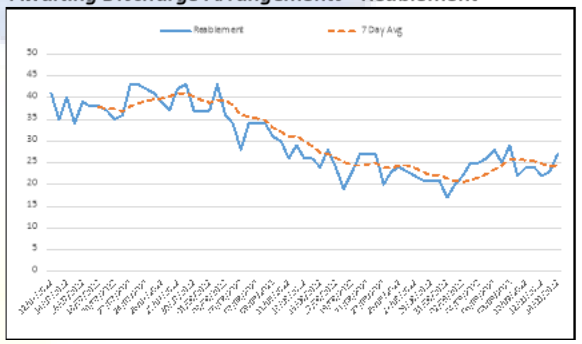
Awaiting Assessment/Plan - Other



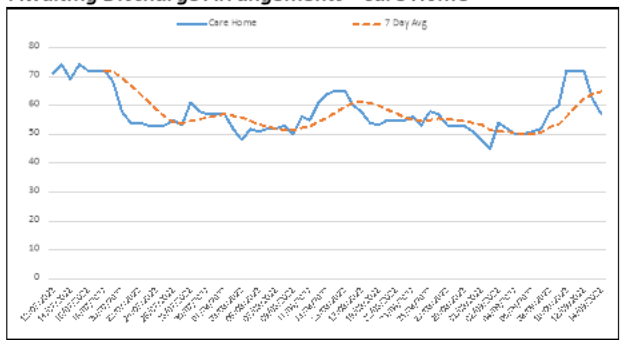
Awaiting Discharge Arrangements - Dom Package of Care



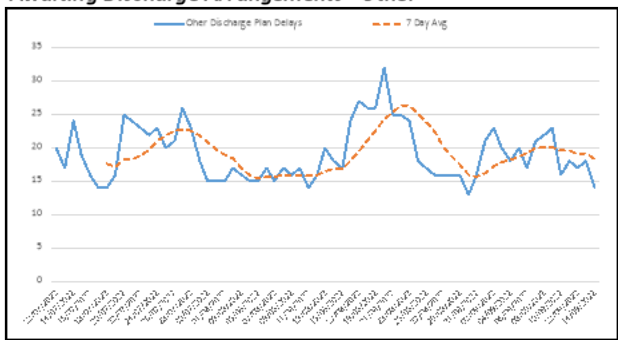
Awaiting Discharge Arrangements - Reablement



Awaiting Discharge Arrangements - Care Home



Awaiting Discharge Arrangements - Other



Complex Awaiting Assessment/Plan:

- 2 in GUH, 27 in RGH, 27 in NHH, 39 in YYF, 77 in Community (172 Total)

Complex Awaiting Discharge Arrangements:

- 4 in GUH, 24 in RGH, 24 in NHH, 43 in YYF, 89 in Community (184 Total)

***ML** - Reablement number is under-reported

Data Signals

Goal 3:

- Gradual **increase** in SDEC activity, now seeing ~100 patients a week

Goal 4:

- Waits in ED over 16 hours have returned to usual levels of 14 patients per day
    - One third of admitted patients are spending over 16 hours in ED
- Bed available from request has been operating with around 10 hours daily average waiting time, occasional spikes to 15 hours

Goal 6:

- Large numbers of patients awaiting discharge assessment/plans and arrangements – 356 total as of 14th September

6 Goals Status Update

Divisional Update

Anything for escalation to Strategic?

Any other business?

Have we…

Lived our values this meeting and in the process of going about our days:

- **People first**
- **Passion for Improvement**
- **Pride in What We Do**
- **Personal Responsibility**

One thing you are proud of?

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board 5th October, 2022 Agenda Item: 4.2

Aneurin Bevan University Health Board

Information Governance Performance and Assurance Report

Executive Summary

The report provides the IG performance reporting requirements for the Finance and Performance Committee, providing assurance about the way the Health Board manages its information about patients and staff and highlights compliance with IG legislation and standards.

There are several Key Performance Indicators used for monitoring performance against the regulations and the report shows that the Health Board is achieving an acceptable standard.

The Information Governance Unit are working closely with all the Divisions via the Governance & Assurance Groups (GAG's) to improve IG standards across the organisation.

The Committee is requested receive the report for Assurance and Compliance.

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: Nicola Prygodzicz, CEO			
Report Author: Jonathan Meredith, DPO and Head of Information Governance			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board**	**Finance & Performance Committee**
Date of the Report: 05/10/2022			
Supplementary Papers Attached: NONE			

Purpose of the Report

The report provides the mandatory and legislative reporting requirements and assurance about the way in which the Health Board manages its information about patients and staff and highlights compliance with IG legislation and standards.

Background and Context

The Finance & Performance Committee is provided with performance information regarding the Health Boards compliance with the General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 2018). The Health Board must monitor its performance against the regulations and needs to be assured that it is achieving an agreed and acceptable standard and have in place processes and procedures in order to achieve that standard.

Assessment and Conclusion

NHS Wales Information Governance Toolkit

The Welsh Information Governance Toolkit is completed by Health Boards across Wales on a yearly basis, with the submission date being the last day in March of each year.

The toolkit comprises 94 mandatory evidence items which are used to measure the Health Board performance against the following standards:

- **Business Responsibilities**
- **Business Management**
- **Individual Rights**
- **Managing and Securing Records**
- **Technical, Physical and Organisational Measures**
- **Cyber Security**
- **Information Governance Incident Management**

Compliance with the Welsh Information Governance Toolkit for Aneurin Bevan University Health Board IG Toolkit for 2021/2022 was 95%.

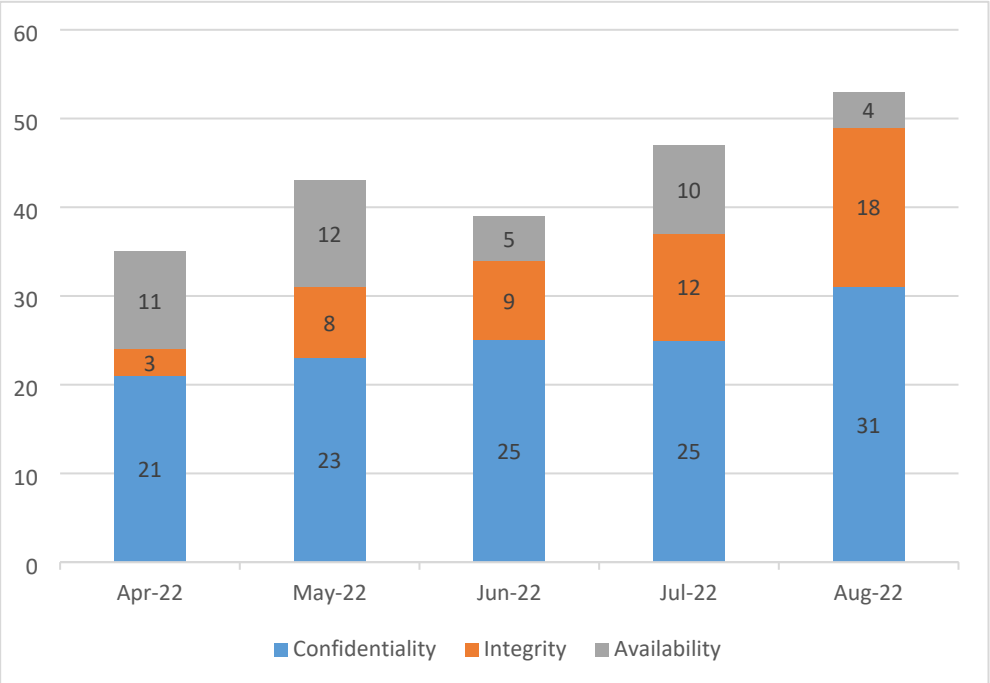
There are a few areas of where improvement can be made to ensure 100% overall compliance for example: Privacy Electronic Communications Regulations – this is currently being addressed by undertaking a review of Information Governance policies.

The Welsh IG Toolkit is currently undergoing substantial development with User Acceptance Testing being undertaken at the end of September 2022. Key change features will be:

- The ability of ABUHB to oversee the submissions of the managed GP practices.
- Toolkit Administrator will be able to delegate the of completion of elements of the IG toolkit to appropriate departments e.g. Corporate Records

- The ability to start completing the toolkit throughout the year.

Information Governance Incidents for the period April 2022 – present. These incidents comprise of incidents relating to the three cornerstones of IG; confidentiality, integrity and availability.



Confidentiality – i.e. it has been made available or disclosed to unauthorised entities.
Integrity – i.e. the accuracy and completeness of information has been compromised.
Availability – i.e. the data is not accessible when required by authorised personnel.

Since April 22, a total of 217 incidents relating to a compromise of either the Confidentiality, Integrity and Availability of patient data were raised via the Datix Incident Management System.

All have been graded low, indicating that the incidents had a minimal impact on patient clinical care or affected a small number of patients, and that all incidents were well managed and in a timely manner by the services affected.

Incidents that are graded medium or above, require consultation with the Data Protection Officer and consideration given to reporting to the Information Commissioners Office.

Complaints and Incidents reported to the ICO:

Complaints *received by the IGU for the period April – August 2022:* ***45***

	Total no (for the period)
Upheld – Evidence was found to substantiate the complaint and the matter is being taken further	27
Ongoing – Currently awaiting the outcome of investigations	15

No Further Actions – No evidence was found to substantiate complaint and no further action is to be taken	12

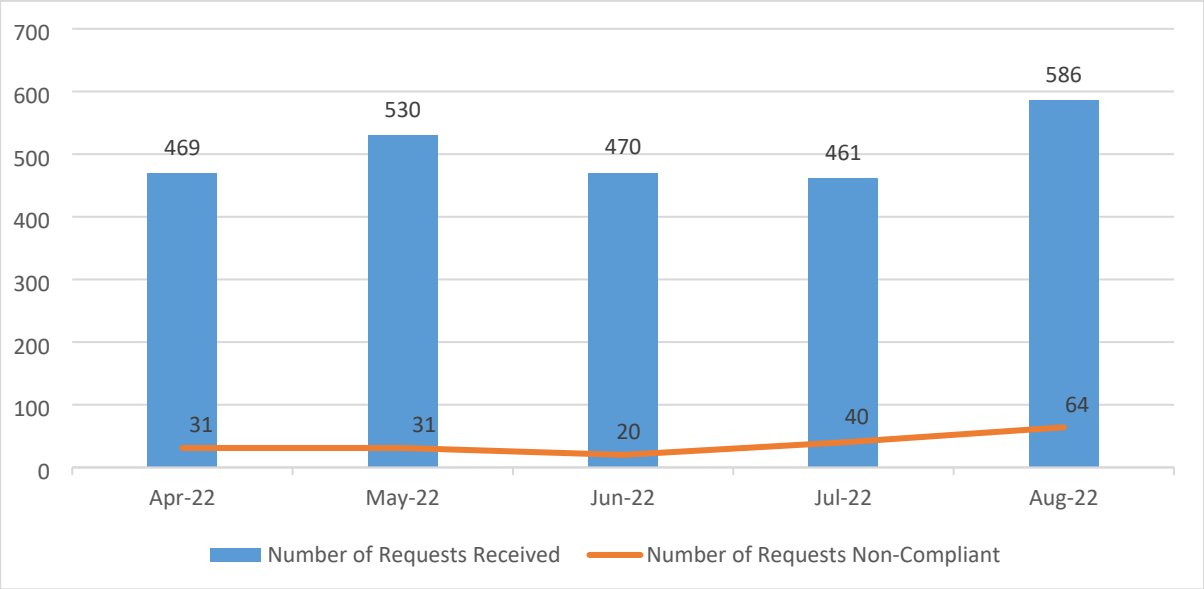
During this period incidents reported to the ICO:

- By the Health Board – 0 reports, 5 contacts for advice.
- By Others – 2 complaints both closed by the ICO as no further action required.
    - *Complaint 1 – Covid Passport not updating – now updated*
    - *Complaint 2 – EMPI updated an incorrect email address to health record - now resolved*

Subject Access Requests

GDPR and the Data Protection Act 2018 allows individuals to request a copy of information we hold about them. To comply with legislation the Health Board need to respond to these requests within 28 days.

Below shows the numbers of subject access requests received by the Access to Health Records department each month for the period April 2022 – August 2022.



Access to Health Records have seen a steady increase in requests for access to patient records. These requests come from various sources including but not limited to Police, Courts, Solicitors and from the patient themselves.

The department has a very good compliance rate however there are on some occasions where compliance with the request is not met. The main reason for the delays is receiving authorisation for disclosure from the appropriate Consultant.

The Access to Health Records Department now comes under the management of Information Governance.

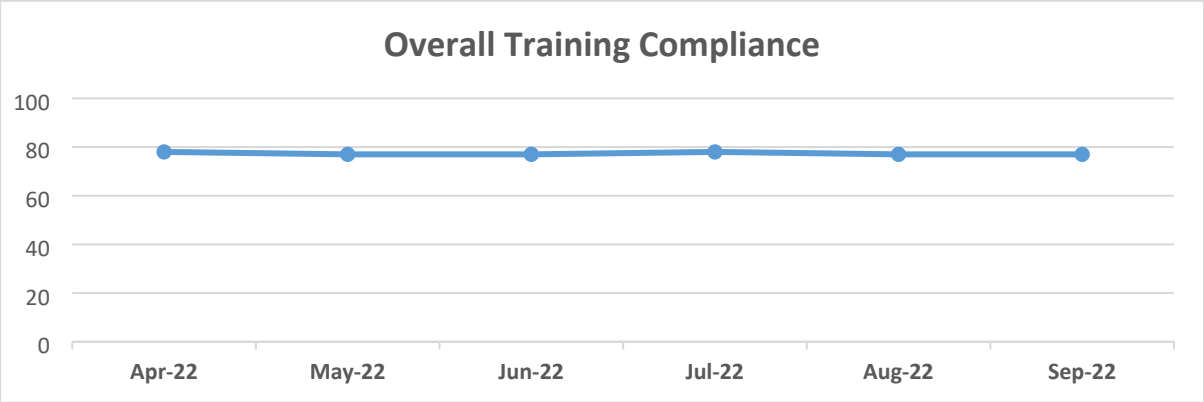
ICT Systems Access Audits - (NIIAS)

Inappropriate access to ABUHB systems is monitored consistently by Information Governance via the National Informatics Integrated Audit System (NIIAS), which monitors access to own records and those of family members.

When identified, the extent of access is graded, again in accordance with National ICO Risk Assessment Guidelines, to help to support both managers and HR with a measure of the severity of the breach. Since April 2022, a total of 28 incidents have been investigated by Information Governance, and all have been graded low, although a number are still awaiting further information from management. Any lack of response is picked up with Senior Management or via Divisional Governance Assurance Groups.

Training Compliance:

Below shows training compliance percentage across the health board for the period April 2022 to August 2022. We are slightly below the target compliance rate of 85%.



In previous years, training compliance has been measured against ABUHB's own internal training. However, following a review of the national training by Digital Health Care Wales, the training available on ESR has now been fully adopted by ABUHB, which has caused a significant upshift in compliance rates throughout the health board. Work is still ongoing to achieve the target compliance rate of 85%. The areas for improvement as detailed in the table below are within the staff group medical and dental.

STAFF GROUP	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Add Prof Scientific and Technic	78%	80%	80%	79%	79%
Additional Clinical Services	79%	79%	80%	80%	80%
Administrative and Clerical	77%	78%	79%	78%	78%
Allied Health Professionals	83%	83%	83%	82%	81%
Estates and Ancillary	68%	69%	70%	70%	63%
Healthcare Scientists	77%	79%	78%	80%	80%
Medical and Dental	32%	33%	34%	34%	33%
Nursing and Midwifery Registered	84%	85%	84%	85%	84%
Students	79%	79%	77%	77%	83%

Recommendation

The Finance and Performance Committee is requested to receive this report demonstrating Information Governance Compliance.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Links to the Informatics and Corporate Risk Register in relation to compliance rates and incident reporting to the ICO.
Financial Assessment, including Value for Money	Financial and workforce plans identified within IGU and Health Records Services
Quality, Safety and Patient Experience Assessment	Audits undertaken in conjunction with the Audit Committee (and Internal Audit) to ensure compliance with IG and legislative requirements to provide a security framework.
Equality and Diversity Impact Assessment (including child impact assessment)	All Information Governance policies and procedures have been impact assessed and do not discriminate against any patients within our service.
Health and Care Standards	**Standard 3.4 IG and ICT** Health services ensure all information is accurate, valid, reliable, timely, relevant, comprehensible and complete in delivering, managing, planning and monitoring high quality, safe services. Health services have systems in place, including information and communications technology, to ensure the effective collection, sharing and reporting of high-quality data and information within a sound information governance framework. **Standard 3.5 Record Keeping** Good record keeping is essential to ensure that people receive effective and safe care. Health services must ensure that all records are maintained in accordance with legislation and clinical standards guidance. **Standard 4.2 Patient Information** People must receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner.
Link to Integrated Medium Term Plan/Corporate Objectives	The report links to the IMTP priority areas for the IG.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** The adopted approach is a long term investment to improve Health Board compliance and to improve the patient information available to staff and improve patient and public confidence in the Health Board services.

	Integration – Working with NHS Wales IG Managers Advisory Group provides a standardised and consistent IG approach across Wales.
	Involvement – The IG Unit is public and patient facing and comments from service users and our patients are all evaluated used as opportunities to review processes and provide continuous improvement.
	Collaboration – Working with NHS Wales IG Managers Advisory Group provides a standardised and consistent IG approach across Wales.
	Prevention – The IG work provides compliance with legislation
Glossary of New Terms	
Public Interest	