

# Finance and Performance Committee

Thu 21 December 2023, 09:30 - 12:00

Microsoft Teams



## Agenda

---

### 1. PRELIMINARY MATTERS

#### 1.1. Welcome and Introductions

Oral      Chair

#### 1.2. Apologies for Absence

Oral      Chair

#### 1.3. Declarations of Interest

Oral      Chair

#### 1.4. Draft Minutes of the Last Meeting held on 7th of September 2023

Attached      Chair

 1.4 Draft Minutes FP&C - 07.09.23 approved by RC.pdf (10 pages)

#### 1.5. Committee Action Log

Attached      Chair

 1.5 Finance & Performance Committee Action Log - December 2023.pdf (5 pages)

---

### 2. ITEMS FOR APPROVAL/RATIFICATION/DECISION

#### 2.1. Review of Committee Programme of Business - Draft Forward Workplan

Attached      Director of Corporate Governance

 2.1 DRAFT Finance & Performance\_Committee Work Programme 2023-24.pdf (5 pages)

#### 2.2. Committee Strategic Risk Report

Attached      Head of Risk and Assurance

 2.2 Finance and Performance Committee Risk Report\_Dec 23.pdf (5 pages)

 2.2a Appendix 1 Finance and Performance Committee Strategic Risk Register.pdf (1 pages)

 2.2b Appendix 2 SRR 001 G\_Financial Sustainability Risk to a Page\_Director of Finance.pdf (1 pages)

 2.2c Appendix 3 SRR 006A-C\_Service Delivery Risk to a Page\_Director of Digital.pdf (4 pages)

#### 2.3. Committee Self-Assessment

Attached      Director of Corporate Governance

 2.3 Finance and Performance Committee\_Self Assessment of Committee Effectiveness Cover Report.pdf (4 pages)

 2.3a Final FPC Self Assessment Template.pdf (11 pages)

---

## 3. ITEMS FOR DISCUSSION

### 3.1. Performance Overview Report with Exception Reporting

*Attached*                      *Director of Strategy, Planning & Partnerships*

ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT

 3.1 V2 Performance Report SBAR FP Dec FINAL.pdf (5 pages)

 3.1a V2 Performance Report FP Dec FINAL.pdf (16 pages)

### 3.2. An update on the Discharge Programme and Delays, to Include

*Attached*                      *Deputy Director of Nursing*

- Reporting against new national data sets ( Action 2106/02.3.1)
- An update on the progress and impact of the Integrated Discharge Hub (Action 2106/02.2)

ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT

 3.2 Six Goals - Performance and Finance.pdf (13 pages)


### 3.3. Stroke Improvement Plan

*Attached*                      *Director of Therapies and Health Sciences*

ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT


 3.3 Board and Committee Report GIRFT Update.pdf (10 pages)


 3.3a Appendix a. GIRFT Report.pdf (37 pages)

 3.3b Appendix B Therapy Review Review of Therapies in Stroke Services.pdf (18 pages)


 3.3c Appendix C 2023 HIW Patient Flow Review.pdf (89 pages)

 3.3d Appendix d 2023 Updated GIRFT Tracker (002).pdf (1 pages)


 3.3d1 Stroke Dashboard.pdf (1 pages)


 3.3d2 Stroke Dashboard.pdf (1 pages)

 3.3d3 Stroke Dashboard.pdf (1 pages)

 3.3d4 Stroke Dashboard.pdf (1 pages)

 3.3d5 Stroke Dashboard.pdf (1 pages)

 3.3d6 Stroke Dashboard.pdf (1 pages)

 3.3d7 Stroke Dashboard.pdf (1 pages)

 3.3e Appendix e - HIW Patient Flow Review - Improvement Plan (ABUHB).pdf (19 pages)

### 3.4. Monthly Finance Report & Monitoring Returns to include- Month 7 Review

*Director of Finance & Procurement*

ASSURANCE IN RESPECT OF FINANCIAL MANAGEMENT & PERFORMANCE

#### 3.4.1. Month 7 Review

*Attached*                      *Director of Finance & Procurement*

 3.4.1 FPC Finance Report FINAL 23.12.21.pdf (38 pages)

 3.4.1a Appendix 1 Finance Report October Month 7 2023-24 Pay Summary.pdf (27 pages)

 3.4.1b Appendix 2 FPC appendix 2 MMR 23-24 M7.pdf (19 pages)

#### 3.4.2. Month 8 Early Briefing

*Attached*                      *Director of Finance*

 3.4.2 FPC Financial position brief Month 8.pdf (5 pages)

### 3.5. Efficiency Opportunities

*Director of Finance & Procurement*

ASSURANCE IN RESPECT OF FINANCIAL MANAGEMENT & PERFORMANCE


#### 3.5.1. Bench-marking

*Attached*                      *Director of Finance & Procurement*

 3.5.1 Efficiency Opportunities- FPC Benchmarking FINAL.pdf (11 pages)

### **3.5.2. Operational Control Checklist**

*Attached*                      *Director of Finance & Procurement*

 3.5.2 Governance Control Escalation - Operational Control Checklist (002).pdf (6 pages)

### **3.6. To Receive an Update of IT Systems**

*Attached*                      *Director of Digital*

ASSURANCE IN RESPECT OF FINANCIAL MANAGEMENT & PERFORMANCE

 3.6 F&P Digital Financial Assessment.pdf (9 pages)

---

## **4. ITEMS FOR INFORMATION**

There are no items for inclusion of this section

---

## **5. OTHER MATTERS**

### **5.1. Items to be Brought to the Attention of the Board and Other Committees**

*Oral*                      *Chair*

### **5.2. Any Other Urgent Business**

*Oral*                      *Chair*

### **5.3. Date of the Next Meeting is the 14th March 2024**

*Oral*                      *Chair*

|                        |   |
|------------------------|---|
| <b>DATE OF MEETING</b> | Thursday 7 <sup>th</sup> September 2023 |
| <b>VENUE</b>           | Via Microsoft Teams                     |

|                      |  |
|----------------------|--|
| <b>PRESENT</b>       | Richard Clark, Independent Member (Committee Chair)        |
|                      | Shelley Bosson, Independent Member                         |
|                      | Dafydd Vaughan, Independent Member                         |
| <b>IN ATTENDANCE</b> | Iwan Jones, Independent Member                             |
|                      | Robert Holcombe, Director of Finance and Procurement       |
|                      | Hannah Evan, Director of Strategy, Planning & Partnerships |
|                      | Rani Dash, Director of Corporate Governance                |
|                      | Nicola Prygodzicz, Chief Executive                         |
|                      | Leanne Watkins, Chief Operating Officer                    |
|                      | Paul Solloway, Director of Digital                         |
|                      | Alison Maguire, Programme Director Diagnostics             |
|                      | Gareth Cooke, National Programme Lead RISP                 |
|                      | Greg Bowen, Assistant Finance Director                     |
|                      | Fay Lewis, Finance Manager                                 |
|                      | Mark Ross, Assistant Finance Director - Corporate          |
|                      | Caroline Hobbs, Head of Management Accounting and Costing  |
|                      | Nathan Couch, Audit Wales                                  |

|                      |  |
|----------------------|--|
| <b>FPC 0709/01</b>   | <b>Preliminary Matters</b>   |
| <b>FPC 0709/01.1</b> | <b>Welcome and Introductions</b>   |
|                      | The Chair welcomed everyone to the meeting.  |
| <b>FPC 0709/01.2</b> | <b>Apologies for Absence</b>   |
|                      | The Chair noted that there were no apologies for absence.  |
| <b>FPC 0709/01.3</b> | <b>Declarations of Interest</b>  |
|                      | There were no declarations of interest raised to record.   |
| <b>FPC 0709/01.4</b> | <b>Draft minutes of the last meeting held on the 21<sup>st</sup> of June 2023</b>  |
|                      | The minutes of the meeting held on the 21 <sup>st</sup> of June 2023 were agreed as a true and accurate record of the meeting, |





|                      |   |
|----------------------|---|
|                      | <p>subject to changing the title for Hannah Evans, Director of Strategy, Planning &amp; Partnerships title.</p> <p>Shelley Bosson (BS), Independent Member, noted a section on page 4 of the minutes “The reenergised discharge planning framework (goal five of the six goals for urgent and emergency care), launched in January 2023” and requested an update on progress. SB questioned why the item would be coming to Decembers Committee as noted on the Action log. Leanne Watkins (LW), Chief Operating Officer provided the Committee with assurance that the following work was on going:</p> <ul style="list-style-type: none"> <li>• Patient Safety event – End of September.</li> <li>• Weekly task and finish meetings.</li> </ul> <p>LW offered to provide an update on the discharge planning framework at next Board Development Session. <b>Action Chief Operating Officer</b></p> |
| <b>FPC 0709/01.5</b> | <p><b>Committee Action Log</b></p> <p>The Committee reviewed the action log. Members were assured by the following:</p> <ul style="list-style-type: none"> <li>• <b>FPC 2106/02.3</b> – Shelley Bosson (SB), Independent Member raised a concern in the enhanced report and requested there was a comparison of enhanced care usage between Aneurin Bevan University Health Board and other organisations. Rob Holcombe (RH), Director of Finance and Procurement assured SB that he would get his team to look at the costs and provide her with an update outside of the meeting. <b>Action Director of Finance and Procurement</b></li> </ul>  |
| <b>FPC 0709/02</b>   | <p><b>Items for Approval/Ratification/Decision</b></p>  |
|                      | <p>There were no items for inclusion in this section.</p>   |
| <b>FPC 0709/03</b>   | <p><b>Items for Discussion</b></p>  |
|                      | <p><b>Assurance in Respect of Organisational Performance Management</b></p>   |
| <b>FPC 0709/03.1</b> | <p><b>Performance Overview Report with Exception Reporting- Quarter 1</b></p> <p>Hannah Evans (HE), Director of Strategy, Planning &amp; Partnerships, provided an overview of the Performance during Quarter 1 and highlighted the progress made and challenges, as outlined in the report.</p> <p><b>Quarter 1 key points:</b></p>  |



- Conclusions were being made each quarter acknowledging not all the data sets were available and data could be improved.
- Positive areas.
  - Assess to surgery for Paediatrics.
  - Increase in activity in Primary Care centres.
  - Improved ambulance handovers performance
  - Cardiology diagnostics waits had improved.
- Challenges
  - July Cancer pathway performance at 62%.
  - CAMHS
  - Mental Health & LD measures.
  - Urgent & Emergency care system – Ambulance 4hour waits.

Shelly Bosson (SB), Independent Member, queried if the shared lives initiative across adult's services were now being shared with older adult Mental Health services. Leanne Watkins (LW), Chief Operating Officer, agreed to confirm if this was the case and feedback to SB outside of the meeting. **Action Chief Operating Officer**

Iwan Jones, (IJ) Independent Member, questioned the following:

- Was there a way of improving the data that was provided within the report. It was agreed that associated financial information would be included in future reports. **Action Director of Strategy, Planning & Partnerships**
- Plans to improve sickness absence levels. LW assured Members that the following was taking place to try and make improvements of the Health Board sickness levels:
  - Divisional meetings targeting areas of peak absences.
  - Teams were managing their sickness by department.
  - Tracking of sickness levels by the divisional assurance team.

Paul Solloway, (PS) Director of Digital, informed Members that the data strategy would be presented to Executive Committee and Welsh Government were looking at how GP data could be more accessible.



Dafydd Vaughan, (DV) Independent Member, questioned if the Health Board were confident in using the WCCIS system with ensuring the data was correct. PS confirmed that he was meeting with WCCIS provider on how they can improve the system.

The Committee noted the progress made in Quarter 1.

## FPC 0709/03.2

### **Performance Against Ministerial Priorities for Planned Care**

Hannah Evans (HE), Director of Strategy, Planning & Partnerships, provided the Committee with an overview of the performance against ministerial priorities and targets for planned care.

Members noted the following key points and progress made:

- Ministerial targets had been set for outpatients 52 week for outpatients and 104 weeks wait to be eliminated by June 2023.
- The Health Board was not able to commit to achieving the ministerial targets by June 2023 due to ongoing systems pressures. Plans had been submitted to Welsh Government to show alternative targets that the Health Board could achieve by September.
- 156 weeks wait by end of September - the Health Board would have no patients waiting longer than 156 weeks for a first outpatient appointment and treatment, with the exception of a small number of patients requiring spinal treatment due to capacity within the team.
- 104 weeks wait by end September – patients would not be waiting more than 104 weeks for treatment.
- Challenged areas – Ophthalmology, Urology, Spinal ENT, Orthopaedics and Maxillo facial.

Richard Clark (RC), Independent Member, questioned if views of the Welsh Government on the Health Board's proposed timescales for achieving, which were not in line with the targets set. Nicola Prygodzicz (NP), Chief Executive, informed the Members that the Health Board had been allocated £50m funding from Welsh Government to address the waiting times in outpatients for 156 weeks and 104 weeks.



Leanne Watkins (LW) Chief Operating Officer, assured Members that monthly assurance meetings were being attended with Welsh Government to keep them updated with the progress being made for outpatient waiting times.

Shelley Bosson (SB), Independent Member, raised her concerns regarding a section in the report of having new doctors in the maxilla facial department and still being able to hit the target of September. LW assured Members that the Doctors recruited into the vacancies were at a grade of being able to deliver on the targets set.

The Committee noted the progress made within the report on the outpatients waiting times.

### FPC 0709/03.3

#### **To Receive a Report on the Quality of Coding**

Paul Solloway (PS), Director of Digital, presented the Quality of the Coding report.

PS informed Members that nationally there was a 95% coding completions target set within 1month; the Health Board's IMTP target was 85%. The service was struggling to achieve the target due to activity increases.

The clinical coding site covered all hospitals within the Health Board. Members noted that processes had changed since the opening of the Grange University Hospital with the scan case notes being moved to Online House and backlogs had occurred in the process which had impacted on the team being able to code within the national targets.

PS informed members that the biggest challenge within the coding team was the retention of staff. This was due to the ability to progress within the team and NHS England pay increases.

Plans had been put in place to address the workforce challenges to ensure that the Health Board would not need to fund external coding contractors, following the development of a new structure. The new structure plans had been to Executive committee for approval with the costing staying within the coding service agreed budget.

Shelley Bosson (SB), Independent Member, questioned if the Health Board had looked at using robotics as an option rather than creating the extra posts. PS advised that the



robotics could cover some areas of coding, but coding services would remain a manual process.

Iwan Jones (IJ), Independent Member, queried what the cost implications were for the additional posts within the coding service. PS advised he would share the costs with the committee outside of the meeting. **Action Director of Digital.**

The Committee noted the Quality of Coding report for assurance.

**FPC 0709/03.4**

### **Radiology Informatics Systems Procurement (RISP) Programme Update**

Paul Soloway (PS), Director of Digital, supported by Gareth Cooke (GC), National Programme Lead RISP and Alison Maguire, (AM), Programme Director Diagnostics presented the Radiology Informatics Systems Procurement Programme Update.

GC informed members of how RISP would impact the Health Board, with the Fuji systems contract due to end in 2023/24 and the Phillips systems being awarded the new contract with a start date of November 2025 in the Health Board.

Members were informed of the benefits and financial implications for the Health Board using the Phillips system.

#### **Benefits:**

- The hardware was stored locally.
- Images would be stored on a cloud-based system to be more accessible for clinical staff.
- 10 years in advance of the Fuji system.

#### **Finances:**

- There would be an annual saving, with current costs of Fuji being £893k compared to £780k per year with Phillips.
- There would be an overlap of systems due to Fuji contract being extended for an additional 3 years, total cost for dual payments required would be 620k.
- £1.5m funding was being provided to the Health Board for workstations, £300k for setting up data centres and £540k for digital infrastructure.





PS highlighted to members that the detailed implementation plan process was part of the next steps for the Health Board to prevent the start date of Phillips being any later which would result in more dual costs.

Dafydd Vaughan (DV), Independent Member, highlighted that the programme was going to cost more to deliver than run and that the Health Board would not benefit from the change of system for 10years. DV raised his concerns around the costs of this programme continuing to increase.

DV requested for a clear report detailing the full costs of the programme to be shared with the committee before December committee meeting. **Action: Director of Digital.**

The committee noted the report with the recommendations of having the full costs of the programme.

#### FPC 0709/03.5

#### **Robotics Process Automation – Cost and Benefit Realisation (ARAC Action)**

Paul Solloway (PS), Director of Digital, provided an overview of the Robotics Process Automation and Costs and Benefits.

PS provided an overview of what RPA can provide to a service:

- Robots were able to mimic data.
- Run 24hours a day and can undertake the work of up to 3 members of staff.
- The costing of each robot was £17.5k per year for the licence with the Health Board currently having 12 robots available across several services saving 29 WTE posts.

#### Benefits of RPA

- Allows more staff time.
- Avoid employment of staff for data management.
- Data entry more accurate.

PS informed Members of the following:

- 2 WTE were being recruited to replace the external connectors that support with the robotics service.
- RPA Steering Group was being set up.
- Digital and Governance Group being set up.



- Once the 2 WTE and Groups were established a re-launch of the service would go live on the internet.

Dafydd Vaughan, (DV), Independent Member, noted that RPA would have its place but had concerns of RPA not being a long-term solution to the Health Board and would need to be careful of which services use the RPA service. DV also raised a concern around the costs of the robots with the impact of the Health Board's financial deficit. PS explained that the Health Board was reliant on automations and RPA would enable this to stop.

Rob Holcombe, (RH) Director of Finance and Procurement, commented that the robots had had a positive impact within the Finance team; leading to the department not needing to employ 2 additional members of staff thus supporting a financial breakeven position in the department.

The Committee noted the report and supported the future development of Robotics (RPA)

### **Assurance in Respect of Financial Management & Performance**

**FPC  
0709/03.6/7**

### **Monthly Finance Report & Monitoring Returns - Month 4 / Review of savings and Action Plans**

Rob Holcombe, (RH) Director of Finance and Procurement, provided an update outlining the Health Board's financial performance for month 4. The report summarised the Health Board's performance against finance targets, savings positions and forecast position.

Key points presented to the committee:

- Month 4, the revenue position was reported at £15m deficit.
- Divisional positions – the following were reporting a balanced position:
  - Community CHC & FNC
  - Clinical Support Services
- Divisional positions – the following were reporting an off-balance position:
  - Prescribing
  - Mental Health
  - Medicine
- Saving position month 4 – Total £5.3M



|                      |  |
|----------------------|--|
|                      | The Committee noted the Month 4 Finance Report.  |
| <b>FPC 0709/03.8</b> | <p><b>Efficiency Opportunities</b></p> <p>Rob Holcombe (RH), Director of Finance and Procurement, supported by Greg Bowen (GB), Assistant Finance Director, Fay Lewis (FL), Finance Manager, Mark Ross (MR), Assistant Finance Director and Caroline Hobbs (CH), Head of Management Accounting and Costing presented the report and dashboard to the Committee.</p> <p>GB provided an overview of the Efficiency Opportunities highlighting some of the key points from the report:</p> <ul style="list-style-type: none"> <li>• Overall, £17.3m benefit opportunities from length of stay discharges.</li> <li>• Data was being used to identify where length of stay may have increased.</li> <li>• There had been positive outcomes in the following areas: <ul style="list-style-type: none"> <li>○ Cataract.</li> <li>○ Dermatology.</li> <li>○ Day surgeries – Theatre improvement programme.</li> </ul> </li> </ul> <p>FL informed members that the data within the report was taken from the Resource Allocation Dashboard and a demonstration was presented to give an insight of what was included and how the Health Board can choose options within the dashboard to focus on area for improvement. Members were provided with an overview of what the next steps were for the dashboard.</p> <p>RH explained that national work would be based on what the Finance team had achieved and would progress on a wider development across Wales.</p> <p>Shelley Bosson (SB), Independent Member, questioned how the dashboard would be incorporated into day to day working and how it would be cascaded across the Health Board. RH advised that this was a part of identifying the next steps.</p> <p>The Committee accepted the recommendations and progress made within the report.</p> |
| <b>FPC 0709/04</b>   | <b>Items for Information</b>   |
|                      | There were no items for inclusion in this section.   |
| <b>FPC 0709/05</b>   | <b>Other Matters</b>   |





|                      |   |
|----------------------|---|
| <b>FPC 0709/05.1</b> | <b>Items to be brought to the Attention of the Board and Other Committees</b><br><br>There were no items to note.     |
| <b>FPC 0709/05.2</b> | <b>Any Other Urgent Business</b><br><br>There was no urgent business to discuss.                                      |
| <b>FPC 0709/05.3</b> | <b>Date of Next Meeting</b><br><br>Dates of the next Finance & Performance Committee – 21 <sup>st</sup> December 2023 |

DRAFT



|                    |                    |                |                  |   |
|--------------------|--------------------|----------------|------------------|---|
| <b>Outstanding</b> | <b>In Progress</b> | <b>Not Due</b> | <b>Completed</b> | <b>Transferred to another Committee</b> |
|--------------------|--------------------|----------------|------------------|---|

| Committee Meeting | Minute Reference     | Agreed Action   | Lead  | Target Date          | Progress/ Completed   |
|-------------------|----------------------|---|---|----------------------|---|
| 11/01/2023        | <b>FPC/1101/3.2</b>  | <p><b>Getting it Right First Time Reviews (GIRFT): Review of Stroke Services Report</b></p> <p>To receive assurance from the action plan, the Committee requested that, following discussion at the Executive Committee meeting, an update report on the GIRFT Review of Stroke Services to come back to the Finance &amp; Performance Committee.</p> | <b>Director of Therapies &amp; Health Science</b> | <b>December 2023</b> | Included in agenda item 3.3 at the December 2023 meeting. <b>Complete</b> |
| 21/06/2023        | <b>FPC 2106/02.2</b> | <p><b>Performance Overview Report with Exception Reporting</b></p> <p>An update on the progress and impact of the Integrated Discharge Hub to be included in the next report to the Committee.</p>  | <b>Director of Nursing</b>                        | <b>December 2023</b> | Included in agenda item 3.2 at the December 2023 meeting. <b>Complete</b> |

| Committee Meeting | Minute Reference           | Agreed Action  | Lead   | Target Date          | Progress/ Completed  |
|-------------------|----------------------------|--|--|----------------------|--|
| 21/06/2023        | <b>FPC<br/>2106/02.3.1</b> | <b>Monthly Finance Report &amp; Monitoring Returns Savings Reporting- Month 2 Review</b><br>An update on the Discharge Programme and delays, including reporting against the new national data sets, to come back to a future meeting. | <b>Director of Nursing</b>   | <b>December 2023</b> | Included in agenda item 3.2 at the December 2023 meeting. <b>Complete</b>  |
| 07/09/2023        | <b>FPC<br/>0709/01.4</b>   | <b>Draft minutes of the last meeting held on the 21<sup>st</sup> of June 2023</b><br><br>LW offered to provide an update on the discharge planning framework at next Board Development Session.  | <b>Chief Operating Officer</b>                                       | <b>December 2023</b> | A Board Briefing was held on Safety Flow, including discharge planning, on the 12th of December 2023. <b>Complete</b>              |
| 07/09/2023        | <b>FPC<br/>0709/01.5</b>   | <b>Committee Action Log ref 2106/02.3</b><br><br>Additional information was requested on Enhanced Care levels and costings in comparison to other Health Boards. Information to be   | <b>Deputy Director of Nursing/<br/>Assistant Director of Finance</b> | <b>March 2024</b>    | Deputy Director of Nursing and Assistant Director of Finance liaising with workforce colleagues to gather data. <b>In progress</b> |

| Committee Meeting | Minute Reference         | Agreed Action  | Lead   | Target Date          | Progress/ Completed  |
|-------------------|--------------------------|--|--|----------------------|--|
|                   |                          | shared with members outside of the meeting.  |  |                      |  |
| 07/09/2023        | <b>FPC<br/>0709/03.1</b> | <p><b>Performance Overview Report with Exception Reporting- Quarter 1</b></p> <p>SB queried if the shared lives initiative across adult's services were now being shared with older adult Mental Health services. LW agreed to confirm if this was the case and feedback to SB outside of the meeting.</p> | <b>Chief Operating Officer</b>                           | <b>December 2023</b> | Information shared with members outside of the meeting (14/12/2023).<br><b>Complete</b>  |
| 07/09/2023        | <b>FPC<br/>0709/03.1</b> | <p><b>Performance Overview Report with Exception Reporting- Quarter 1</b></p> <p>Was there a way of improving the data that was provided within the report. It was agreed that associated financial</p>  | <b>Director of Strategy, Planning &amp; Partnerships</b> | <b>December 2023</b> | Director of Strategy, Planning and Partnerships proposed that Benefits Realisation be a standing item to be included for future meetings to capture associated financial information. Benefits |

| Committee Meeting | Minute Reference         | Agreed Action   | Lead                        | Target Date          | Progress/ Completed  |
|-------------------|--------------------------|---|-----------------------------|----------------------|--|
|                   |                          | information would be included in future reports.  |                             |                      | Realisation included as a standing item in the draft forward work plan.<br><b>Complete</b>       |
| 07/09/2023        | <b>FPC<br/>0709/03.3</b> | <b>To Receive a Report on the Quality of Coding</b><br><br>IJ queried what the cost implications were for the additional posts within the coding service. PS would share the costs with the committee outside of the meeting. | <b>Director of Digital.</b> | <b>December 2023</b> | Clinical Coding data shared with members outside of the meeting (14/12/2023).<br><b>Complete</b> |
| 07/09/2023        | <b>FPC<br/>0709/03.4</b> | <b>Radiology Informatics Systems Procurement (RISP) Programme Update</b><br><br>A request for a clear report detailing the full costs of the programme to be shared with the committee before December committee meeting.     | <b>Director of Digital.</b> | <b>November 2023</b> | RISP Finance table shared with members outside of the meeting (14/12/2023).<br><b>Complete</b>   |

*All actions in this log are currently active and are either part of the Committee's forward work programme or require more immediate attention, such as an update on the action or confirmation that the item scheduled for the next Committee meeting will be ready.*

*Once the Committee is assured that an action is complete, it will be removed. This will be agreed at each Committee meeting.*



## **FINANCE AND PERFORMANCE COMMITTEE PROGRAMME OF BUSINESS 2023/24**

The purpose of the Finance & Performance Committee will be to provide advice and assurance to the Board on the achievement of the Board's aims and objectives as set out in its Integrated Medium-Term Plan, in accordance with the standards of good governance determined for the NHS in Wales. In doing so, the Committee will seek assurance that there is ongoing development of an improving performance culture which continuously strives for excellence and focuses on improvement in all aspects of the health board's business, in line with the Board's Performance Management Framework. The Committee will seek assurance that arrangements for financial management and financial performance are sufficient, effective, and robust.

This Annual Programme of Business has been developed with reference to:

- the Committee's Terms of Reference as agreed by the Board in March 2023;
- the Board's Assurance Framework (based on its Annual Objectives for 2022/23 and 2023/24);
- delivery of the IMTP 2023-25;
- key risks identified through the Corporate (Strategic) Risk Register and Operational Risk Registers.
- audit and regulatory reports identifying weaknesses in internal control (following consideration by the Audit, Risk and Assurance Committee); and
- key statutory, national and best practice requirements and reporting arrangements.

| Matter to be Considered by Committee                                 | Frequency           | Responsible Lead                                | Scheduled Committee Dates 2023/24 |             |             |             |  |  |  |
|--|---------------------|---|-----------------------------------|-------------|-------------|-------------|--|--|--|
|  |                     |   | 21 June 2023                      | 7 Sept 2023 | 21 Dec 2023 | 29 Feb 2024 |  |  |  |
| <b>Preliminary Matters</b>   |                     |   |                                   |             |             |             |  |  |  |
| Attendance and Apologies   | Standing Item       | Chair   | ✓                                 | ✓           | ✓           | ✓           |  |  |  |
| Declarations of Interest   |                     | All Members                                     | ✓                                 | ✓           | ✓           | ✓           |  |  |  |
| Minutes of the Previous Meeting                                      |                     | Chair   | ✓                                 | ✓           | ✓           | ✓           |  |  |  |
| Action Log and Matters Arising                                       |                     | Chair   | ✓                                 | ✓           | ✓           | ✓           |  |  |  |
| <b>Committee Requirements as set out in Standing Orders</b>          |                     |   |                                   |             |             |             |  |  |  |
| Development of Committee Annual Programme of Business 2023/24        | Annually (date tbc) | Chair & Director of CG                          |                                   |             |             |             |  |  |  |
| Review of Committee Programme of Business                            | Standing Item       | Chair   |                                   |             | ✓           | ✓           |  |  |  |
| Committee Strategic Risk Report                                      | Standing Item       | Director of CG                                  |                                   |             | ✓           | ✓           |  |  |  |
| Annual Review of Committee Terms of Reference 2023/24                | Annually            | Chair & Director of CG                          |                                   |             |             |             |  |  |  |
| Annual Review of Committee Effectiveness 2023/24                     | Annually            | Chair & Director of CG                          |                                   |             |             |             |  |  |  |
| Committee Annual Report 2023/24                                      | Annually            | Chair & Director of CG                          | ✓                                 |             |             |             |  |  |  |
| <b>Assurance in Respect of Organisational Performance Management</b> |                     |   |                                   |             |             |             |  |  |  |
| Performance Overview Report with Exception Reporting                 | Standing Item       | Director of Strategy, Planning and Partnerships | ✓                                 | ✓           | ✓           | ✓           |  |  |  |
| Outpatient Transformation Update                                     | tbc                 | Chief Operating Officer                         | ✓                                 |             |             |             |  |  |  |
| Performance against Ministerial Priorities for Planned Care          | tbc                 | Director of Strategy, Planning and Partnerships |                                   | ✓           |             |             |  |  |  |
| Digital and information management and technology (IM&T) systems     | tbc                 | Director of Digital                             |                                   |             |             | ✓           |  |  |  |



| Matter to be Considered by Committee   | Frequency     | Responsible Lead                                | Scheduled Committee Dates 2023/24 |             |             |             |  |  |  |
|--|---------------|---|-----------------------------------|-------------|-------------|-------------|--|--|--|
|  |               |   | 21 June 2023                      | 7 Sept 2023 | 21 Dec 2023 | 29 Feb 2024 |  |  |  |
| Capital and estates related objectives and priorities as set out in the Board's IMTP | tbc           | Director of Strategy, Planning and Partnerships |                                   |             |             | ✓           |  |  |  |
| Compliance with Health Technical Memorandums   | tbc           | Director of Strategy, Planning and Partnerships |                                   |             |             | ✓           |  |  |  |
| Capital Business Cases and programmes of work  | tbc           | Director of Strategy, Planning and Partnerships |                                   |             |             | ✓           |  |  |  |
| Commissioned Services  | tbc           | Director of Strategy, Planning and Partnerships |                                   |             |             | ✓           |  |  |  |
| Performance Management and Accountability Framework Update                           | Standing Item | Director of Strategy, Planning and Partnerships |                                   |             | ✓           | ✓           |  |  |  |
| <b>Assurance in Respect of Financial Management and Performance</b>                  |               |   |                                   |             |             |             |  |  |  |
| Monthly Finance Report and Monitoring Returns  | Standing Item | Director of Finance, Procurement and Value      | ✓                                 | ✓           | ✓           | ✓           |  |  |  |
| Efficiency Opportunities   | Standing Item | Director of Finance, Procurement and Value      | ✓                                 | ✓           | ✓           | ✓           |  |  |  |
| Value Based Healthcare Report 2022/23  | Annually      | Director of Finance, Procurement and Value      | ✓                                 |             |             |             |  |  |  |
| Financial Outlook for 2024/25, including Revenue Budget Allocation letter 2024/25    | Annually      | Director of Finance, Procurement and Value      |                                   |             |             |             |  |  |  |
| Review of Savings and Action Plans   | tbc           | Director of Finance, Procurement and Value      |                                   | ✓           |             |             |  |  |  |
| Benefits Realisation with exception reporting  | tbc           | D of S,P&P/ D of F&P                            |                                   |             |             | ✓           |  |  |  |
| <b>Items requested by Committee members/internal stakeholders</b>                    |               |   |                                   |             |             |             |  |  |  |
| ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT                        | Ad-hoc        | Director of Digital                             |                                   | ✓           |             |             |  |  |  |

| Matter to be Considered by Committee  | Frequency | Responsible Lead                                       | Scheduled Committee Dates 2023/24 |             |             |             |  |  |  |
|---|-----------|--|-----------------------------------|-------------|-------------|-------------|--|--|--|
|   |           |  | 21 June 2023                      | 7 Sept 2023 | 21 Dec 2023 | 29 Feb 2024 |  |  |  |
| To receive a report on the quality of Coding  |           |  |                                   |             |             |             |  |  |  |
| ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT adiology Informatics System Procurement (RISP) Programme Update   | Ad-hoc    | Director of Digital                                    |                                   | ✓           |             |             |  |  |  |
| ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT Robotic Process Automation- cost and benefit realisation (ARAC action)  | Ad-hoc    | Director of Digital                                    |                                   | ✓           |             |             |  |  |  |
| ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT Stroke Reconfiguration Update (Action 1101/3.2)   | Ad-hoc    | Director of Therapies and Health Sciences              |                                   |             | ✓           |             |  |  |  |
| ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT Performance Overview Report with Exception Reporting to include an update on the progress and impact of the Integrated Discharge Hub (Action 2106/02.2) | Ad-hoc    | D of S,P&P/Director of Nursing                         |                                   |             | ✓           |             |  |  |  |
| ASSURANCE IN RESPECT OF ORGANISATIONAL PERFORMANCE MANAGEMENT An update on the Discharge Programme and delays, including reporting against the new national data sets. (Action 2106/02.3.1)                           | Ad-hoc    | Director of Nursing                                    |                                   |             | ✓           |             |  |  |  |
| ASSURANCE IN RESPECT OF FINANCIAL MANAGEMENT & PERFORMANCE To Receive an Update of IT Systems- Action taken from November 2023 Board  | Ad-hoc    | Director of Finance & Procurement/ Director of Digital |                                   |             | ✓           |             |  |  |  |

| KEY        |   |
|------------|---|
| D of CG    | Director of Corporate Governance                |
| D of S,P&P | Director of Strategy, Planning and Partnerships |
| D of F&P   | Director of Finance & Procurement               |



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

|  |                                      |
|--|--------------------------------------|
| <b>DYDDIAD Y CYFARFOD:<br/>DATE OF MEETING:</b>      | 21 December 2023                     |
| <b>CYFARFOD O:<br/>MEETING OF:</b>                   | Finance and Performance Committee    |
| <b>TEITL YR ADRODDIAD:<br/>TITLE OF REPORT:</b>      | Strategic Risk and Assurance Report  |
| <b>CYFARWYDDWR<br/>ARWEINIOL:<br/>LEAD DIRECTOR:</b> | Director of Corporate Governance     |
| <b>SWYDDOG ADRODD:<br/>REPORTING OFFICER:</b>        | Head of Corporate Risk and Assurance |

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

Er Sicrwydd/For Assurance

The purpose of this report is to provide a summary of the current strategic risks that have been delegated to the Finance and Performance Committee (F&P) for monitoring, on behalf of the Board.

**ADRODDIAD SCAA  
SBAR REPORT**
**Sefyllfa / Situation & Cefndir / Background**

At its meeting in July 2023, the Board approved a refreshed assessment of its strategic risks and its approach to risk and assurance reporting arrangements.

The term 'strategic risk' is used to refer to risks which present a direct threat to the Board's strategic priorities as outlined in the Integrated Medium-Term Plan (IMTP) and as such require a level of focus which cannot be afforded by the Board; therefore, the risks are delegated to committees based on their relevance to the Committee agenda to provide the detailed scrutiny and focus. They are distinct from corporate risks, which are operational risks that necessitate a higher level of ownership than an individual Executive Director can provide but do not directly.

The F&P Committee has been given the responsibility for overseeing the management of two high-level strategic risks, which are further subdivided into four sub-risks, and as such receives and scrutinises those risks on behalf of the Board for focus and assurance.



While the Board received the full Strategic Risk Register and individual risk assessments at its meetings in September and November, this is the first time the F&P Committee has received the delegated risks for focused scrutiny.

Furthermore, work is underway on developing a Corporate Risk Register (CRR) to track all corporate risks (significant operational risks) that necessitate organisational, executive-level oversight. Where risks are relevant to the F&P Committee's agenda these will be presented in this report to provide a comprehensive overview of the strategic and significant operational risks being managed within the organisation.

## **Asesiad / Assessment**

### **Committee Risk Register**

Since July the newly developed strategic risks that comprise the Strategic Risk Register have been subjected to risk assessments to determine how those risks are treated, recorded, and monitored, with a focus on the internal control system and sources of assurance associated with each risk.

For each Risk Assessment, the following information is provided:

- A description of the main risks to achieving that objective – i.e., what are the things that might potentially impact on the Health Board's ability to deliver its objectives;
- The cause of the risks (the threat) - this is a description of why something could go wrong;
- The impact of the risks – this is the consequence should the risk occur;
- The risk appetite level and threshold set for the nature of the risk – informed by the risk appetite statement that is under development and subject to final endorsement
- The key controls in place to manage the risks – these are the actions that are in place to reduce or eliminate the risks;
- The gaps in controls – this is a description of actions that have not been taken, or where systems / processes are not in place to manage the risk;
- The sources of assurance that the risk is being managed – these are the mechanisms we have in place to test the controls are effective and are described in three levels:
  - Level 1 – Operational: the way risks are managed day to day. The assurance comes directly from those responsible for delivering specific objectives and processes.
  - Level 2 – Organisational Oversight: the way in which the organisation oversees the control framework so that it operates effectively.
  - Level 3 – Independent Assurance: objective and independent assurance (e.g., internal audit) or assurance from external independent bodies (e.g., Healthcare Inspectorate Wales and Audit Wales);
- The gaps in assurance against each level of assurance – this is where we do not have the oversight / testing mechanisms in place to give us the assurance needed to have confidence that risks are being addressed;



- The mitigating actions to address gaps in control or assurance – these are the additional actions we need to take, or mechanisms we need to put in place to address any gaps we have identified.

The two high-level strategic risks, inclusive of the four sub-risks delegated to this Committee for monitoring, are summarised in Table 1 below; the Committee Risk Register and detailed risk assessments is attached as **Appendices 1, 2 & 3**.

The risk assessments are subject to continuous review in accordance with the risk score; as a result, the risk assessment will be fluid due to changes in the operating environment and the effectiveness of the controls in place.

Table 1

| High-Level Strategic Risk  | Sub Risk   | Risk Level                   |                   | Sub-Risk Theme           |
|--|--|------------------------------|-------------------|--------------------------|
|  |  | High (8 – 12)                | Extreme (15 – 25) |                          |
| <b>SRR 006</b><br>There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.                                 | Due to the full or partial failure of existing digital infrastructure and systems.   | 3 x 5 = <b>15</b><br>Extreme |                   | Service Delivery         |
|  | Due to an adverse impact on service delivery in the implementation of new digital systems.   | 3 x 4 = <b>12</b><br>High    |                   |                          |
|  | Due to a failure to develop digital solutions that are sustainable and fit for the future  | 3 x 4 = <b>12</b><br>High    |                   |                          |
| <b>SRR 001</b><br>There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population. | Due to long term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes. | 4 x 4 = <b>16</b><br>Extreme |                   | Financial Sustainability |

An initial indication of each risk was given a RAG-rated assurance level based on a calculation of averages methodology. When determining assurance levels for audit reviews, this is consistent with Internal Audit methodology.

The overarching, high-level indication of the level of assurance the Committee could derive from the risk assessments at the time of writing this report is set out below:

|                 |                               |                 |
|-----------------|-------------------------------|-----------------|
| <b>Negative</b> | <b>Reasonable</b><br><b>X</b> | <b>Positive</b> |
|-----------------|-------------------------------|-----------------|

This means that the Committee can take a reasonable level of assurance that the strategic risks monitored by the F&P Committee are effectively managed.



Furthermore, work will continue with risk owners to assess and refine the controls and assurances, as well as to focus on the financial context and its impact on the individual strategic risks, to ensure a thorough assessment of the risk. This will be completed and documented as part of the next reporting cycle to this Committee and the Board for strategic oversight and assurance.

### **Corporate Risk Register**

As mentioned, the Corporate Risk Register is under development and at the time of writing this report there are no corporate risks (significant operational risks) on the register that requires oversight of the F&P Committee.

### **Argymhelliad / Recommendation**

The Committee is requested to:

- **DISCUSS and NOTE** the delegated Committee risks, as contained within the Strategic Risk Register.
- **NOTE** the work being progressed to present in the Committee Risk Report all risks monitored by the Committee.

### **Amcanion: (rhaid cwblhau)**

#### **Objectives: (must be completed)**

|   |  |
|---|--|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score:                                    | The Strategic Risk Register is informed by Datix, ensuring a bottom-up approach to risk escalation.                                  |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):  | Governance, Leadership and Accountability<br>2.1 Managing Risk and Promoting Health and Safety<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br><a href="#">Link to IMTP</a>  | Choose an item.<br><br>The Strategic Risk Register assesses risk that could impact achievement of all strategic priorities.          |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP  | Governance   |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br><a href="#">Strategic Equality Objectives 2020-24</a> | Choose an item.<br>Choose an item.<br>Choose an item.<br>Choose an item.   |

### **Gwybodaeth Ychwanegol:**



| <b>Further Information:</b>   |   |
|---|---|
| Ar sail tystiolaeth:<br>Evidence Base:  | N/A   |
| Rhestr Termau:<br>Glossary of Terms:  | N/A   |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: | The Board and respective Committees of the Board have considered risks contained within the Strategic Risk Register |

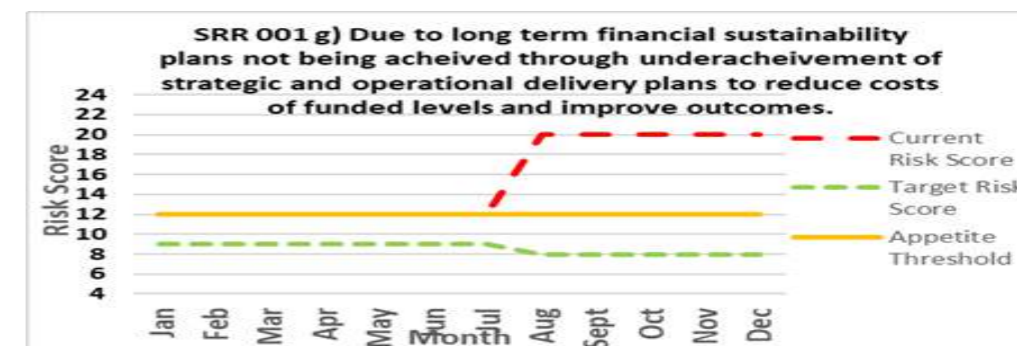
| <b>Effaith: (rhaid cwblhau)<br/>Impact: (must be completed)</b>   |  |
|---|--|
| <b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>  | <p><b>Is EIA Required and included with this paper</b><br/><b>No does not meet requirements</b></p> <p>An EQIA is required whenever we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





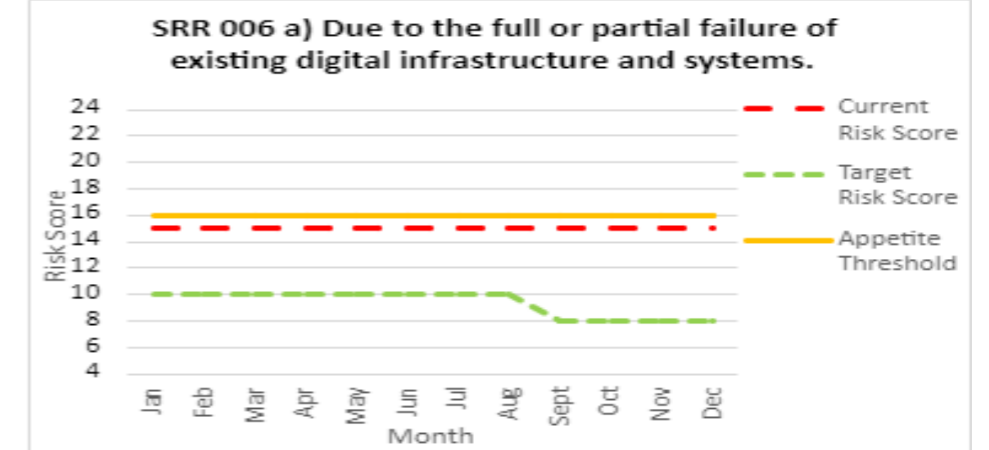
| Risk ID | Monitoring Committee            | Risk Theme               | Risk Owner                          | Risk Description  | Reason For The Risk   | Impact  | Current Risk Score               |                          |                    |            | Risk Appetite                   |  | Actions to Reduce Risk to Target   | Assurance that the Risk is being managed effectively | Target Risk Score                |                          |                   |
|---------|---------------------------------|--------------------------|-------------------------------------|---|---|---|----------------------------------|--------------------------|--------------------|------------|---------------------------------|--|--|--|----------------------------------|--------------------------|-------------------|
|         |                                 |                          |                                     |   |   |   | Likelihood Of The Risk Occurring | Impact Of Risk Occurring | Current Risk Score | Risk Level | Current Status Against Appetite | Risk Appetite and Threshold Explained  |  |  | Likelihood Of The Risk Occurring | Impact Of Risk Occurring | Target Risk Score |
| SRR 001 | Finance & Performance Committee | Financial Sustainability | Director of Finance and Procurement | There is a risk that the Health Board will be unable to deliver and maintain high quality safe and sustainable services which meet the changing needs of the population | g)Due to long term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes | <ul style="list-style-type: none"> <li>Breach of statutory duty to breakeven over 3 years</li> <li>Investigation of NHS Wales Escalation &amp; Intervention Arrangements</li> <li>Non – delivery of health board priorities, required improvements and achieve longer-term sustainability</li> <li>Prioritisation and possible disinvestment in service delivery</li> <li>Reputational damage and loss of public</li> </ul> | 5                                | 4                        | 20                 | Extreme    | Above Appetite Level            | Cautious = 12 or below - Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.               | Update performance management framework<br>Assessment of financial control environment within divisions and corporate teams.   | Medium   | 2                                | 4                        | 8                 |
| SRR 006 | Finance & Performance Committee | Service Delivery         | Director of Digital                 | There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery                                 | a)Due to the full or partial failure of existing digital infrastructure and systems   | <ul style="list-style-type: none"> <li>Harm or injury to patients and/or staff</li> <li>Adverse impacts on delivery of care to patients across acute and non-acute settings</li> <li>Data breaches</li> <li>Litigation &amp; Financial Penalties</li> <li>Reputational damage and loss of public confidence</li> </ul>  | 3                                | 5                        | 15                 | Extreme    | Below Appetite Level            | Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure. | Information Governance and Cyber Security governance and assurance processes are now under review. Governance group terms of reference agreed, and reporting arrangements discussed with Director of Corporate Governance. Meetings will commence in November with clear reporting on progress to the relevant committees on our cyber security action plan. SIRO training arranged for the 25th September for the Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO). | Medium   | 2                                | 4                        | 8                 |
|         |                                 |                          |                                     |   | b)Due to an adverse impact on service delivery in the implementation of new digital systems   | <ul style="list-style-type: none"> <li>Harm or injury to patients and/or staff</li> <li>Adverse impacts on delivery of care to patients across acute and non-acute settings</li> <li>Data breaches</li> <li>Litigation &amp; Financial Penalties</li> <li>Reputational damage and loss of public confidence</li> </ul>  | 3                                | 4                        | 12                 | High       | Below Appetite Level            | Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure. | Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance & Performance Committee  | Medium   | 2                                | 3                        | 6                 |
|         |                                 |                          |                                     |   | c)Due to a failure to develop digital solutions that are sustainable and fit for the future   | <ul style="list-style-type: none"> <li>Harm or injury to patients and/or staff</li> <li>Adverse impacts on delivery of care to patients across acute and non-acute settings</li> <li>Failure to deliver health board priorities, required improvements and achieve sustainability</li> <li>Reputational damage and loss of public confidence</li> </ul>   | 3                                | 4                        | 12                 | High       | Below Appetite Level            | Open = 16 or below - Willing to consider all potential options subject to continued application and/or establishment of controls recognising that there could be a high-risk exposure. | New governance structures to be put in place by the end of 2023. Review of New Digital Request processes considering governance changes.   | Medium   | 2                                | 4                        | 8                 |

| RISK THEME                 |   | FINANCIAL SUSTAINABILITY |                         |   |
|----------------------------|---|--------------------------|-------------------------|---|
| Strategic Risk (SRR 001)   | There is a risk that the Health Board will be unable to deliver and maintain high-quality, safe, and sustainable services that meet the needs of the population.  |                          |                         |   |
| Strategic Threat           | Due to long-term financial sustainability plans not being achieved through underachievement of strategic and operational delivery plans to reduce costs to funded levels and improve outcomes.  |                          |                         | Risk Appetite Level - Cautious.<br>Preference for safe, through accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls. |
| Impact                     | <ul style="list-style-type: none"> <li>➤ Breach of statutory duty to breakeven over 3 years.</li> <li>➤ Instigation of NHS Wales Escalation &amp; Intervention Arrangements.</li> <li>➤ Non-delivery of health board priorities, required improvements, and achieving longer-term sustainability.</li> <li>➤ Prioritisation and possible disinvestment in service delivery.</li> <li>➤ Reputational damage and loss of public confidence</li> </ul> |                          |                         | Risk Appetite Threshold - Score 12 and below<br>Risks relating to all aspects of our financial performance and our ability to manage cost and efficiencies.                         |
|                            |   |                          |                         | SUMMARY<br>the current risk level is <b>outside</b> of the target and appetite threshold. The target level to be achieved is <b>within</b> the set appetite threshold.              |
| Lead Director              | Director of Finance and Procurement   | Risk Exposure            | Current Level           | Target  |
| Monitoring Committee       | Finance & Performance Committee   | Likelihood               | 5 (Almost certain)<br>x | 2 (Unlikely)<br>x   |
| Initial Date of Assessment | 01 June 2023  | Impact                   | 4 (Major)               | 4 (Major)   |
| Last Reviewed              | 06/12/2023  | Risk rating              | = 20<br>(Extreme)       | = 8<br>(Moderate)   |



| Key Controls<br><i>(What controls/ systems &amp; processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>  | Plans to Improve Control<br><i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>   | Sources of Assurance<br><i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>  | Gaps in Assurance/ Actions to Address Gaps<br><i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>   | Assurance Rating<br><i>(Overall Assessment)</i> |
|--|--|--|--|---|
| <ul style="list-style-type: none"> <li>• IMTP 2023/24-25/26</li> <li>• IMTP Delivery Framework</li> <li>• Accountability Framework</li> <li>• Performance Framework</li> <li>• Scheme of Delegation</li> <li>• Standing Financial Instructions (SFIs)</li> <li>• Standing Orders (SOs)</li> <li>• Financial Control Procedure (FCP) Budgetary control</li> <li>• Financial Budget Intelligence (FBI)</li> <li>• Budget holder training</li> <li>• Cost intervention procedures</li> <li>• 23/24 savings plans &amp; opportunities.</li> <li>• Health Board financial escalation processes.</li> <li>• Health Board Pre-Investment Panel (PIP) process.</li> <li>• Financial assessment and review to incorporate the financial impact of COVID-19 and other key costs.</li> <li>• Quarterly financial budget plan approach agreed.</li> <li>• Executive groups and structures established to deliver statutory duties</li> </ul> | <ul style="list-style-type: none"> <li>• Update performance management framework – in place</li> <li>• Assessment of financial control environment within divisions and corporate teams. – in place</li> </ul> | <b>Level 1 Operational</b><br><i>(Implemented by the department that performs daily operation activities)</i> <ul style="list-style-type: none"> <li>• Adherence to SO/SFI/FCPs</li> <li>• Regular AFD meetings to discuss position and performance.</li> <li>• Divisional Assurance meetings are in place to implement savings plans and deliver service and workforce plans within available resources.</li> </ul>   | <b>Gaps in Assurance</b> <ul style="list-style-type: none"> <li>• Greater focus is required on service, workforce, and financial plans all balancing to achieve financial sustainability.</li> </ul> | <b>Medium Assurance</b>                         |
|  |  | <b>Level 2 Organisational</b><br><i>(Executed by risk management and compliance functions.)</i> <ul style="list-style-type: none"> <li>• Regular monitoring at the Executive Team reviewing the level of deliverable recurrent savings along with assessing cost avoidance and deferred investments.</li> <li>• Performance escalation meetings established</li> <li>• Financial assessment and review report to the Board and Finance &amp; Performance Committee</li> <li>• Financial Governance and Accounting reports to the Audit, Risk and Assurance Committee.</li> <li>• Board Briefing sessions on the financial position.</li> </ul> | <b>Action to Address Gaps in Assurance</b> <ul style="list-style-type: none"> <li>• Revise accountability arrangements being progressed as part of Executive governance. – in place</li> </ul>       |   |
|  |  | <b>Level 3 Independent</b><br><i>(Implemented by both auditors internal and external independent bodies.)</i>  |  |   |
|  |  | <b>Internal Audit Reviews 2023 - 24</b> <ol style="list-style-type: none"> <li>1. Savings Programmes - Q3 Not yet undertaken.</li> <li>2. Financial Controls – Q2 Not yet reported.</li> <li>3. Asset Management – Q3 Not yet undertaken.</li> </ol> <b>External Audit Reports 2023 -24</b> <ol style="list-style-type: none"> <li>1. Efficiency Review Q3/Q4</li> <li>2. Structured Assessment Q3/Q4</li> <li>3. Audit of Financial Statements Q4</li> </ol> Financial assessment and review reports to Welsh Government  |  |   |

| RISK THEME                 |                                 | SERVICE DELIVERY   |                   |   |
|----------------------------|---------------------------------|--|-------------------|---|
| Strategic Risk (SRR 006)   |                                 | There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.   |                   |   |
| Strategic Threat           |                                 | a) Due to the full or partial failure of existing digital infrastructure and systems.  |                   | Risk Appetite Level - OPEN<br>Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.   |
| Impact                     |                                 | <ul style="list-style-type: none"> <li>➤ Harm or injury to patients and/or staff</li> <li>➤ Adverse impacts on delivery of care to patients across acute and non-acute settings</li> <li>➤ Data breaches</li> <li>➤ Litigation &amp; Financial Penalties</li> <li>➤ Reputational damage and loss of public confidence</li> </ul> |                   | Risk Appetite Threshold - Score 17 and below<br>Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. |
|                            |                                 | SUMMARY<br>The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold.  |                   |   |
| Lead Director              | Director of Digital             | Risk Exposure  | Current Level     | Target Level  |
| Monitoring Committee       | Finance & Performance Committee | Likelihood   | 3 (Possible)<br>x | 2 (Unlikely)<br>x   |
| Initial Date of Assessment | 01/06/2023                      | Impact   | 5 (Catastrophic)  | 4 (Major)   |
| Last Reviewed              | 11/12/2023                      | Risk rating  | = 15<br>(Extreme) | = 8<br>(Moderate)   |

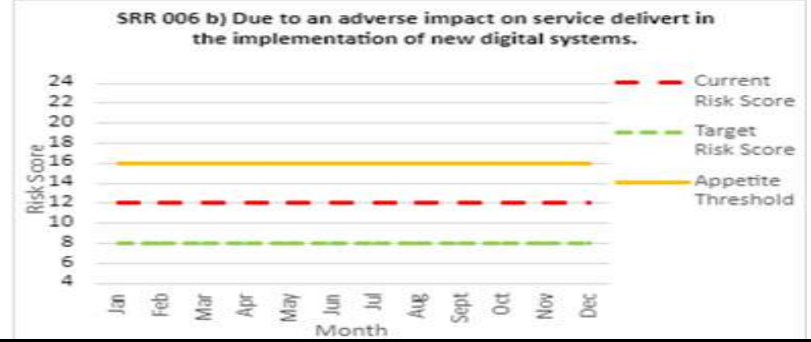


| Key Controls<br><i>(What controls/ systems &amp; processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>  | Plans to Improve Control<br><i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>   | Sources of Assurance<br><i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>  | Gaps in Assurance/ Actions to Address Gaps<br><i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>  | Assurance Rating<br><i>(Overall)</i> |
|--|--|--|---|--------------------------------------|
| <ul style="list-style-type: none"> <li>• Cyber has developed a Remedial Action Plan to address issues identified within the NIS CAF assessment 2021. This Action Plan has also supported ABUHB risk remediation responses to ABUHB's NIS CAF Risk Register which by CRU to address risks identified during the NIS CAF assessment. The remedial actions proposed have been accepted by CRU and progress will be reviewed annually.</li> <li>• Cyber is fully engaged with IG colleagues to implement the recommendations of the Templar report. Cyber now supports all the Governance and Assurance Groups intending to increase cyber security awareness and build cyberculture amongst non-ICT staff</li> <li>• Cyber now undertakes scheduled monthly vulnerability scans of all ABUHB-managed servers to include third-party servers. The results of these scans will now be reported in the Monthly Cyber Report.</li> <li>• Cyber has also worked with Business Systems and Desktop Teams to ensure that patching compliance for internally managed systems and third-party systems is monitored and reported monthly. Monthly review meetings are held between Cyber and the Teams to review compliance levels against policy. Results are captured within the monthly Cyber Report.</li> </ul> | <ul style="list-style-type: none"> <li>• Information Governance and Cyber Security governance and assurance processes are now under review. Governance group terms of reference agreed, and reporting arrangements discussed with Director of Corporate Governance. Meetings will commence in November with clear reporting on progress to the relevant committees on our cyber security action plan.</li> <li>• SIRO training arranged for the 25<sup>th</sup> September for the Director of Digital (SIRO) and Chief Information Officer (Deputy SIRO).</li> </ul> | <p><b>Level 1 Operational</b><br/><i>(Implemented by the department that performs daily operation activities)</i></p> <ul style="list-style-type: none"> <li>• Internal directorate meetings being setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.</li> </ul> <p><b>Level 2 Organisational</b><br/><i>(Executed by risk management and compliance functions.)</i></p> <ul style="list-style-type: none"> <li>• Regular Reporting to the Finance &amp; Performance Committee</li> </ul> <p><b>Level 3 Independent</b><br/><i>(Implemented by both auditors internal and external independent bodies.)</i></p> <ul style="list-style-type: none"> <li>• Internal audit for cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.</li> </ul> | <p><b>Gaps in Assurance</b></p> <ul style="list-style-type: none"> <li>• Governance and assurance groups.</li> <li>• Oversight from NHS Wales Cyber Resilience Unit.</li> </ul> <p><b>Action to Address Gaps in Assurance</b></p> | <b>Reasonable assurance</b>          |



|  |  |  |  |  |
|--|--|--|--|--|
| <ul style="list-style-type: none"><li>• Cyber has worked with ICT Support Teams and the Log4j version 2 vulnerability has been resolved within the Health Board. The less service impacting Version 1 is being managed through ICT Departmental risk management process.</li><li>• Cyber has maintained the use of Trust ware for all emails Trustwave provides inspection and protection from malicious links embedded within emails.</li><li>• Cyber has begun the roll out simulated phishing campaigns the initial phish has been tested on ICT Department and reported within the Cyber Report. Cyber will continue campaigns during 2023 to increase email security awareness among staff.</li><li>• Cyber has also introduced scenario-based incident response exercising using National Cyber Security Centre developed 'Exercise in a box' the aim is to assess our current skills in responding to real-life cyber security incident scenarios and to identify improvements. Cyber plans to run several more exercises during 2023</li></ul> |  |  |  |  |
|--|--|--|--|--|

| RISK THEME                 | SERVICE DELIVERY   |               |                   |  |
|----------------------------|--|---------------|-------------------|--|
| Strategic Risk (SRR 006)   | There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.   |               |                   |  |
| Strategic Threat           | b) Due to an adverse impact on service delivery in the implementation of the new digital systems.  |               |                   | Risk Appetite Level - OPEN<br>Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.  |
| Impact                     | <ul style="list-style-type: none"> <li>➤ Harm or injury to patients and/or staff</li> <li>➤ Adverse impacts on delivery of care to patients across acute and non-acute settings</li> <li>➤ Data breaches</li> <li>➤ Litigation &amp; Financial Penalties</li> <li>➤ Reputational damage and loss of public confidence</li> </ul> |               |                   | Risk Appetite Threshold - Score 17 and below Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. |
|                            |  |               |                   | SUMMARY<br>The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold   |
| Lead Director              | Director of Digital  | Risk Exposure | Current Level     | Target Level   |
| Monitoring Committee       | Finance & Performance Committee  | Likelihood    | 3 (Possible)<br>x | 2 (Unlikely)<br>x  |
| Initial Date of Assessment | 01/06/2023   | Impact        | 4 (Major)         | 4 (Major)  |
| Last Reviewed              | 11/12/2023   | Risk rating   | = 12<br>(High)    | = 8<br>(Moderate)  |



| Key Controls<br><i>(What controls/ systems &amp; processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)</i>  | Plans to Improve Control<br><i>(Are further controls possible to reduce risk exposure within tolerable range?)</i>  | Sources of Assurance<br><i>(Evidence that the controls/ systems which we are placing reliance on are effective)</i>  | Gaps in Assurance/ Actions to Address Gaps<br><i>(Insufficient evidence as to the effectiveness of the controls or negative assurance)</i>   | Assurance Rating<br><i>(Overall Assessment)</i> |
|--|---|--|--|---|
| <ul style="list-style-type: none"> <li>• Adoption of formal project management methodologies PRINCE 2 to ensure project plans are developed in conjunction with services.</li> <li>• Formal governance arrangements in place through project boards and programme boards where risks and issues are managed and mitigated.</li> <li>• Each project has a senior responsible officer from the service who can provide challenge and assurance over the delivery of the project works packages.</li> <li>• Each clinical project has clinical leaf who would advise and support potential impacts on service delivery caused by the implementation of new digital services.</li> <li>• Business change team in place to support services in improvement of clinical and administrative processes.</li> <li>• Benefits team in place who identify, track and ensures any benefits are realised which will ultimately improve service delivery.</li> <li>• Projects support backfilling of clinical time where required</li> </ul> | <ul style="list-style-type: none"> <li>• Additional governance being put in place with the Digital, Data and Technology Sub-Committee which will report to the Finance &amp; Performance Committee</li> </ul> | <b>Level 1 Operational</b><br><i>(Implemented by the department that performs daily operation activities)</i> <ul style="list-style-type: none"> <li>• Internal directorate meetings being setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.</li> <li>• Project Boards meet monthly and report into the quarterly Programme Delivery Board</li> <li>• Digital Directorate meetings being held monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.</li> <li>• Risk management approach and escalation processes in place in line with the Health Board's Risk Framework.</li> </ul> | <b>Gaps in Assurance</b> <ul style="list-style-type: none"> <li>• Governance and assurance groups.</li> <li>• Oversight from NHS Wales Cyber Resilience Unit.</li> </ul>   | <b>Reasonable assurance</b>                     |
|  |   | <b>Level 2 Organisational</b><br><i>(Executed by risk management and compliance functions.)</i> <ul style="list-style-type: none"> <li>• Regular Reporting to the Finance &amp; Performance Committee</li> </ul>   | <b>Action to Address Gaps in Assurance</b> <ul style="list-style-type: none"> <li>• Information Governance Sub Committee Terms of Reference have been drafted and are under review.</li> <li>• Cyber Security Subgroup ToR also drafted and membership agreed.</li> <li>• 13/12 – Information Governance Sub Committee inaugural meeting scheduled for 21<sup>st</sup> Feb 2024</li> </ul> |   |
|  |   | <b>Level 3 Independent</b><br><i>(Implemented by both auditors internal and external independent bodies.)</i> <ul style="list-style-type: none"> <li>• Internal audit for cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.</li> </ul>   |  |   |
|  |   |  |  |   |

| RISK THEME                 | SERVICE DELIVERY   |               |                   |   |
|----------------------------|--|---------------|-------------------|---|
| Strategic Risk (SRR 006)   | There is a risk that the Health Board has inadequate digital infrastructure and systems to maintain high-quality, safe service delivery.   |               |                   |   |
| Strategic Threat           | c) Due to failure to develop digital solutions that are sustainable and fit for the future.  |               |                   | Risk Appetite Level – OPEN<br>Willing to consider all potential options, subject continued application and /or establishment of controls; recognising that there could be a high-risk exposure.   |
| Impact                     | <ul style="list-style-type: none"> <li>➤ Harm or injury to patients and/or staff</li> <li>➤ Adverse impacts on delivery of care to patients across acute and non-acute settings</li> <li>➤ Data breaches</li> <li>➤ Litigation &amp; Financial Penalties</li> <li>➤ Reputational damage and loss of public confidence</li> </ul> |               |                   | Risk Appetite Threshold - Score 17 and below<br>Risk related to all aspects of our ability to deliver, manage and improve service quality and performance along with all risks relating to the current performance of our infrastructure such as IM&T and Estates including our ability to deliver associated strategy. |
|                            |  |               |                   | SUMMARY<br>The current risk level is outside of target level but within appetite threshold. The target level to be achieved is within the set appetite threshold  |
| Lead Director              | Director of Digital  | Risk Exposure | Current Level     | Target Level  |
| Monitoring Committee       | Finance & Performance Committee  | Likelihood    | 3 (Possible)<br>x | 2 (Unlikely)<br>x   |
| Initial Date of Assessment | 01/06/2023   | Impact        | 4 (Major)         | 4 (Major)   |
| Last Reviewed              | 11/12/2023   | Risk rating   | = 12<br>(High)    | = 8<br>(Moderate)   |



| Key Controls<br>(What controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)   | Plans to Improve Control<br>(Are further controls possible to reduce risk exposure within tolerable range?)   | Sources of Assurance<br>(Evidence that the controls/ systems which we are placing reliance on are effective)  | Gaps in Assurance/ Actions to Address Gaps<br>(Insufficient evidence as to the effectiveness of the controls or negative assurance)   | Assurance Rating<br>(Overall Assessment) |
|--|---|---|---|--|
| <ul style="list-style-type: none"> <li>• New Digital Service Request process in place which provides governance in several key areas:               <ol style="list-style-type: none"> <li>1. Information Governance – ensuring new services have appropriate controls to keep patient information safe.</li> <li>2. Cyber Security – ensuring new services adopted or developed meet the requirements of the cyber assessment framework.</li> <li>3. Patient Safety – ensuring services do not introduce any patient safety risks.</li> <li>4. Records – ensuring new systems comply with the requirements of records management.</li> </ol> </li> <li>• Strong business analysis function in operation which ensures the “as-is” and “to-be” process mapping is undertaken which provides assurance that new services implemented are fit for purpose and delivery what stakeholders require.</li> <li>• Business change function which ensures implemented systems are effective and deliver the benefits required.</li> <li>• Formal framework in place for the adoption of new digital services and best practice guidance followed.</li> <li>• Operational delivery aligned to ITIL standards</li> </ul> | <ul style="list-style-type: none"> <li>• New governance structures to be put in place by the end of 2023.</li> <li>• Review of New Digital Request processes considering governance changes.</li> </ul> | <b>Level 1 Operational</b><br>(Implemented by the department that performs daily operation activities) <ul style="list-style-type: none"> <li>• Internal directorate meetings being setup monthly to monitor risks to regularly update and to provide assurance over outstanding action plans.</li> </ul>                   | Gaps in Assurance<br>To be determined   | Reasonable assurance                     |
|  |   | <b>Level 2 Organisational</b><br>(Executed by risk management and compliance functions.) <ul style="list-style-type: none"> <li>• Regular Reporting to the Finance &amp; Performance Committee</li> </ul>   | Action to Address Gaps in Assurance<br>Cyber Resilience Unit NIS CAF Assessment planned for 23-26 <sup>th</sup> Jan 2024. This will assess progress against agreed cyber security action plan |  |
|  |   | <b>Level 3 Independent</b><br>(Implemented by both auditors internal and external independent bodies.) <ul style="list-style-type: none"> <li>• Internal audit for cyber security in April 2023 provided Digital with a substantial audit for its cyber security improvement plan, reporting and backup systems.</li> </ul> |   |  |
|  |   |   |   |  |



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

|  |   |
|--|---|
| <b>DYDDIAD Y CYFARFOD:<br/>DATE OF MEETING:</b>      | 21 December 2023                                  |
| <b>CYFARFOD O:<br/>MEETING OF:</b>                   | Finance and Performance Committee                 |
| <b>TEITL YR ADRODDIAD:<br/>TITLE OF REPORT:</b>      | Finance and Performance Committee Self-Assessment |
| <b>CYFARWYDDWR<br/>ARWEINIOL:<br/>LEAD DIRECTOR:</b> | Director of Corporate Governance                  |
| <b>SWYDDOG ADRODD:<br/>REPORTING OFFICER:</b>        | Head of Board Business                            |

**Pwrpas yr Adroddiad  
Purpose of the Report**

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

The purpose of this report is to inform the Committee of the annual self-assessment process and to discuss the self-assessment template, which is appended to the report as Appendix 1.

**Cefndir / Background**

As part of the Health Board's statutory requirements, each Committee of the Board is required to conduct an annual self-evaluation of committee effectiveness. All Board Members are required to complete a self-assessment for each Committee on which they are a member, to determine its effectiveness and ability to carry out its responsibilities.

The outcome of the assessment will enable the Committee to identify areas of development and focus for the coming year, such as any training and development, as well as changes to processes and procedures.

### **Asesiad / Assessment**

Traditionally, the self-assessment is completed at the end of every financial year to determine committee members' opinions on the effectiveness of the committee throughout the year; however, it has been agreed that the self-assessment process will be completed midway through the year, (October/November) on the basis, that this will inform the Committee Annual Report, Annual Accountability Report and Governance Statement. This will also inform the Board's overall evaluation of its effectiveness.

Following discussion, if the Committee considers the self-assessment template (appendix 1) is a useful tool, which is based on the Committee's terms of reference, the template will be shared with members by the first week of January 2024 for a period of four weeks. Following this, the Corporate Governance Team will compile the responses into charts for the next Finance and Performance Committee's consideration and discussion.

### **Argymhelliad / Recommendation**

The Committee is asked to:

- NOTE the report,
- CONSIDER the self-assessment template for completion in order to inform areas of development for the forthcoming year, and;
- AGREE to the Committee undertaking the self-assessment as per the timescales set out.

### **Amcanion: (rhaid cwblhau)**

#### **Objectives: (must be completed)**

|  |   |
|--|---|
| Cyfeirnod Cofrestr Risg<br>Corfforaethol a Sgôr Cyfredol:<br>Corporate Risk Register<br>Reference and Score: | The self-assessment of committee effectiveness ensures risk is appropriately monitored and managed. |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):   | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item.  |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br><a href="#">Link to IMTP</a>                                   | Not Applicable<br>Choose an item.   |
| Galluogwyr allweddol o fewn y<br>CTCI<br>Key Enablers within the IMTP  | Governance  |



|   |   |
|---|---|
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><a href="#">Strategic Equality Objectives 2020-24</a> | Not Applicable<br>Choose an item.<br>Choose an item.<br>Choose an item. |
|---|---|

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

| <b>Effaith: (rhaid cwblhau)<br/>Impact: (must be completed)</b>  |   |
|--|---|
| <b>Resource Assessment:</b>  | A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:                    |
| • <b>Workforce</b>   | Not Applicable  |
| • <b>Service Activity &amp; Performance</b>  | Not Applicable  |
| • <b>Financial</b>   | Not Applicable  |
| <b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>   | <b>No does not meet requirements</b><br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a> |
| <b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b> | Collaboration - Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its well-being objectives<br>Choose an item.   |

<https://futuregenerations.wales/about-us/future-generations-act/>

## Finance and Performance Committee Self-Assessment Checklist

### Introduction

The self-assessment tool is a way for our Finance and Performance Committee (FPC) to develop its effectiveness. The Board and its sub-Committees should aim to assess their effectiveness against these questions on an annual basis.

To gain an overall view of FPC effectiveness, it is important that the individual views of all members are considered as a whole, therefore, each area of the effectiveness tool allows space for comments. This provides an important opportunity to expand on any considerations relating to that section of the effectiveness tool and to highlight any concerns about the Committee's performance.

At the end of the self-assessment there is an opportunity for you to provide an overall score on the Committee's effectiveness using the scoring scale below.

| Score    | Measure                     | Description   |
|----------|-----------------------------|---|
| <b>1</b> | <b>Room for improvement</b> | The FPC is falling short of requirements and should consider how it can work towards becoming more effective in this area   |
| <b>2</b> | <b>Meeting standards</b>    | The FPC is performing to the required standard in this area. There may be room for improvement, but the FPC can be seen to be discharging its responsibilities effectively. |
| <b>3</b> | <b>Excelling</b>            | This is an area where the FPC is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.               |

The completed self-assessments will enable the Corporate Governance Team to: -

1. generate an overall view of FPC effectiveness; and
2. drill down and analyse specific areas of strength or improvement on a section, sub-section, and individual question level.

The results of which will be reported to the Committee in February 2024 and used to inform the Committee Annual Report, Annual Accountability Report and Governance Statement.

## Section 1 - Committee Processes: Composition, Establishment, and Ways of Working

| Question |   | Response<br>Yes / No | Comments | Suggested Improvement Actions |
|----------|---|----------------------|----------|-------------------------------|
| 1        | Does the Committee have written terms of reference and have they been approved by the Board?  |                      |          |                               |
| 2        | Are the terms of reference reviewed annually?   |                      |          |                               |
| 3        | The number of meetings held during the year is sufficient to allow the Committee to perform as effectively as possible?   |                      |          |                               |
| 4        | Has the Committee been quorate for each meeting this year?  |                      |          |                               |
| 5        | In terms of numbers, membership of the Committee is sufficient to discharge its responsibilities?   |                      |          |                               |
| 6        | Members who have recently joined the FPC have been provided with induction training to help them understand their role and the organisation?  |                      |          |                               |
| 7        | The Committee is clear about its role in relationship to other Committees that play a role in relations to finance and performance matters?   |                      |          |                               |
| 8        | Committee members understand their responsibilities regarding identifying, declaring, and resolving conflicts of interest?  |                      |          |                               |
| 9        | The Committee uses assurance mapping to identify where assurance is required and identify any key gaps where no assurance is provided, or where the quality of the assurance is poor? |                      |          |                               |
| 10       | The Committee has an established a plan of matters to be dealt with across the year?  |                      |          |                               |

|    |   |  |  |  |
|----|---|--|--|--|
| 11 | Does the Committee consider issues at the right time and in the right level of detail?  |  |  |  |
| 12 | The Committee ensures that the relevant executive director attends meetings to enable it to understand the reports and information it receives?                 |  |  |  |
| 13 | Are the Committee's papers distributed in sufficient time for members to give them due consideration?   |  |  |  |
| 14 | The quality of the Committee's papers received allows Committee members to perform their roles effectively?   |  |  |  |
| 15 | Committee meetings are chaired effectively?   |  |  |  |
| 16 | The Committee chair allows debate to flow freely and does not assert his/her own view too strongly?   |  |  |  |
| 17 | The Committee environment enables people to express their views, doubts, and opinions?  |  |  |  |
| 18 | The Committee challenges management and other assurance providers to gain a clear understanding of their findings?  |  |  |  |
| 19 | Members hold their assurance providers (management) to account for late or missing assurance?   |  |  |  |
| 20 | Each agenda item is 'closed off' appropriately so that the Committee is clear on the conclusion; who is doing what, when and how and how it is being monitored? |  |  |  |

|    |  |  |  |  |
|----|--|--|--|--|
| 21 | At the end of each meeting the Committee discuss the outcomes and reflect on decisions made and what worked well, not so well etc? |  |  |  |
| 22 | Decisions and actions are implemented in line with the timescale agreed?   |  |  |  |
| 23 | Are the outcomes of each meeting and any issues of concern reported to the next Board meeting?                                     |  |  |  |
| 24 | Does the Committee prepare an annual report on its work and performance for the Board?   |  |  |  |
| 25 | The results of the annual self-assessment are used to inform and influence succession planning and improve effectiveness.          |  |  |  |
| 26 | The self-assessment is objective and rigorous enough for meaningful conclusions to be drawn?                                       |  |  |  |

## Section 2 – Financial Management and Financial Performance

|    | Question   | Response Yes/No | Comments | Suggested Improvement Actions |
|----|--|-----------------|----------|-------------------------------|
| 27 | Is the committee satisfied that it has received sufficient assurance in respect of the Health Board's arrangements for financial management and financial performance being sufficient, effective and robust, including: |                 |          |                               |
|    | a. The allocation of revenue budgets, based on allocation of funding and other forecast income   |                 |          |                               |
|    | b. The monitoring of financial performance against revenue budgets and statutory financial duties  |                 |          |                               |
|    | c. The monitoring of performance against capital budgets   |                 |          |                               |
|    | d. The monitoring of progress against savings plans, cost improvement programmes and implementation of the efficiency framework  |                 |          |                               |

|  |  |  |  |  |
|--|--|--|--|--|
|  | <p>e. The monitoring of budget expenditure variance and the corrective actions being taken to improve performance</p>  |  |  |  |
|  | <p>f. The monitoring of activity and financial information for external contracts to ensure performance within specified contract terms, conditions and quality thresholds</p> |  |  |  |
|  | <p>g. The monitoring of arrangements to ensure efficiency, productivity and value for money, including the delivery of the Health Board's Efficiency Framework</p>             |  |  |  |
|  | <p>h. The monitoring of delivery against the agreed Discretionary Capital Programme</p>  |  |  |  |



### Section 3 – Performance Management and Accountability

|    | Question   | Response<br>Yes / No | Comments | Suggested Improvement Actions |
|----|--|----------------------|----------|-------------------------------|
| 28 | Is the Committee sufficiently assured that the arrangements for the performance management and accountability of directly provided and commissioned services are sufficient, effective and robust, including:  |                      |          |                               |
|    | a. the implementation of the Board’s Performance Management Framework, enabling appropriate action to be taken when performance against set targets deteriorates, and support and promote continuous improvement in service delivery;  |                      |          |                               |
|    | b. the monitoring of performance information against the Board’s Priorities and Objectives and associated outcomes   |                      |          |                               |
|    | c. the monitoring of performance information against National Outcome Frameworks, including the NHS Wales Outcomes Framework, the Public Health Outcomes Framework and the Social Services Outcomes Framework, developed in-line with the Wellbeing of Future Generations Act and the Social Services Wellbeing Act; |                      |          |                               |

|  |  |  |  |  |
|--|--|--|--|--|
|  | <p>d. the monitoring of performance information across <u>directly provided</u> services including scheduled care, urgent and emergency care, medicine, family and therapies, primary, community care and mental health services;</p>        |  |  |  |
|  | <p>e. the monitoring of performance information across <u>commissioned services</u> including Primary Care Contractors, complex care, specialist mental health and CAMHS services, WHSCC, EASC and NHS Wales Shared Services Partnership</p> |  |  |  |
|  | <p>f. the monitoring of poor performance through effective and comprehensive exception reporting, including trajectories for improved performance;</p>   |  |  |  |
|  | <p>g. the review of performance through comparison to best practice and peers and identifying areas for improvement</p>  |  |  |  |

## Section 4 – Information Management

|    | Question  | Response<br>Yes / No | Comments | Suggested Improvement Actions |
|----|---|----------------------|----------|-------------------------------|
| 29 | Is the Committee satisfied that arrangements for information management are sufficient, effective and robust, including:  |                      |          |                               |
|    | a. the monitoring of information related objectives and priorities as set out in the Board's IMTP and Annual Priorities;  |                      |          |                               |
|    | b. the monitoring of the implementation and application of information related legislation, policies and standards, including GDPR and Freedom of Information                                   |                      |          |                               |
|    | c. the review of arrangements to protect the integrity of data and information to ensure valid, accurate, complete and timely data and information is available for use within the organisation |                      |          |                               |
|    | d. the reporting of data breaches, incidents and complaints, ensuring lessons are learned   |                      |          |                               |

|  |  |  |  |  |
|--|--|--|--|--|
|  | e. the recommendations arising from national and local audits and self-assessments, including assessment against the Caldicott Standards |  |  |  |
|  | f. the monitoring of arrangements to support the continued development of business intelligence and capacity                             |  |  |  |

| Overall Assessment |                      |   |
|--------------------|----------------------|---|
| Score              | Measure              | Description   |
| 1                  | Room for improvement | The FPC is falling short of requirements and should consider how it can work towards becoming more effective in this area   |
| 2                  | Meeting standards    | The FPC is performing to the required standard in this area. There may be room for improvement, but the FPC can be seen to be discharging its responsibilities effectively. |
| 3                  | Excelling            | This is an area where the FPC is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.               |

**Comments:**



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

|  |   |
|--|---|
| <b>DYDDIAD Y CYFARFOD:<br/>DATE OF MEETING:</b>      | 21 December 2023  |
| <b>CYFARFOD O:<br/>MEETING OF:</b>                   | Finance and Performance Committee   |
| <b>TEITL YR ADRODDIAD:<br/>TITLE OF REPORT:</b>      | Performance Report – November 2023  |
| <b>CYFARWYDDWR<br/>ARWEINIOL:<br/>LEAD DIRECTOR:</b> | Hannah Evans (Director of Strategy, Planning and Partnerships)  |
| <b>SWYDDOG ADRODD:<br/>REPORTING OFFICER:</b>        | Marie-Claire Griffiths (Head of Strategic Planning)<br>Jennifer Keyte (Senior Corporate Planning & Service Improvement Manager) |

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

The purpose of this paper is to provide the Finance and Performance Committee with an overview of performance against the key Ministerial Priorities. It complements the IMTP Quarterly Outcomes Report that is produced each quarter and covers the broader spectrum of IMTP commitments.

This new format of the report has been developed to provide assurance on key performance deliverables on the intervening months between the fuller Quarterly Outcomes report.

**Cefndir / Background**

The IMTP for 2022/2026 sets out the vision for the organisation, that is to improve population health and reduce health inequalities experienced by our communities.

Through the templates underpinning the IMTP, the health board made a number of commitments in response to the Minister's priorities for delivery.

This report provides a high-level overview of activity and performance up until November in Quarter 3 with a focus on delivery against key national targets included within the performance dashboard.

**Asesiad / Assessment**

The report details performance and delivery across six themes.

### **1. Planned Care & Diagnostics**

The Health Board is ahead of trajectory in eliminating waits of over 156 weeks for treatment, with 70 patients waiting at the end of October 2023 compared to the March 2023 position of 553. There is an ambition to eliminate 156 waits by the end of the calendar year although there remain some challenges in ENT and spines. Improvements have also been made with 104 week waits for treatment which has reduced from 1,935 in March 2023 to 1,328 at the end of October 2023. At the end of October 2023, there were 1,949 patients waiting over 104 weeks for a first outpatient appointment. Continued insourcing of additional endoscopy capacity has supported a maintenance in the 8-week backlog with 2,049 patients waiting at the end of October 2023. For therapies, 92.6% of new attendances are seen within 14 weeks, with the average wait for first attendance being 46 days.

### **2. Cancer**

Compliance against the 62-day target for definitive cancer treatment has increased from 51.6% (Mar 23) to 58.4% at the end of October 2023, although still behind trajectory. Significant increases in demand relating to suspected cancer referrals have continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500. Whilst Single Cancer Pathway compliance is improving, this increased demand is continuing to have an impact on performance creating capacity challenges throughout the pathway for services provided by the Health Board and those provided at tertiary centres.

### **3. Children and Young People**

The number of children on the Health Board's waiting lists who have been waiting over 36 weeks increased during the pandemic and peaked during the summer of 2021. As of September 2023, there were 251 children waiting over 52 weeks for a new outpatient appointment. Child and Adolescent Mental Health Services are compliant against targets for CHOICE and Part 2 giving assurance that young people have updated care and treatment plans. Despite workforce constraints, the waiting list is reducing. At June 2023, 640 young people were waiting which has now reduced to 396 in Oct 2023. The reporting on the neuro-developmental (ND) pathway has been separated into 0-5 years and 5-18 years to reflect the differing demands and assessment processes. As of October 2023, 450 0-5-year-olds and 271 5-18-year-olds are on the waiting list. There are on average 220 new referrals a month which is a 300% increase since Covid-19.

### **4. Urgent & Emergency Care System**

The Urgent and Emergency Care system remains under significant pressures. During November, a total of 997 patients waited over 60 minutes to be transferred to the Emergency Department from an Ambulance. Whilst this remains high as a result of poor flow through the system, there has been a concerted effort to decrease the number of delayed ambulance handovers and as such this has reduced significantly from 1,497 reported in March 2023. During November there have been on average 493 daily attendances to the Emergency Department or a Minor Injury Unit and the pressure on the urgent care system has resulted in patients having extended stays in hospital.

The number of patients on the complex list has increased from the Mar 2023 baseline of 275 to 316 (Nov 23). In October 2023, the Health Board's position of the percentage of patients assessed by a stroke consultant within 24 hours has also been maintained at 86.4%, surpassing the national target of 85%.

## 5. Mental Health

The performance at the end of October remains significantly below the target of 80% for both assessment and interventions. Mental Health assessment within 28 days of referral performs at 23.9% an improvement on the previous month which was 16.6% and interventions less than 28 days following assessment at 12.6% which has declined from previous month at 16.6%. Both of these areas are significantly below target and a 90-day action plan to improve performance is in place and being monitored by Executive Committee. The percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over) is 73%, below the target of 90%.

## 6. Primary Care

Activity across General Medical Services has increased to its highest point in the year in October with 370,608 appointments seen. The trend in urgent primary care has been consistent since July. Activity in General Optometry Services (GOS) for Eye Health Examinations Wales (EHEW) has decreased slightly since July reporting 4091 compared to 4071 for August. Community Pharmacy Services (CPS) continue to deliver a consistent number of claims under the common ailments scheme since April with claims ranging between 3700 and 4150. District Nursing contacts reached their highest during October at 46407; this was higher than the same point last year, with 44268 in October 2022. Referrals in Palliative Care Services were 161 in October a very slight decrease on the previous month which were 168. Rapid Response referrals have been above 400 a month since May with 432 in October.

The committee is asked to note that this is the first quarter progress report of this style and work will continue to ensure there are meaningful measures included across all six areas. There is further work to be done to best articulate Primary Care performance with the absence of ministerial targets and at present it is not representative of impact, primarily demonstrating activity.

### Argymhelliad / Recommendation

Committee is asked to:

- Note the progress against the Ministerial Priorities.

### Amcanion: (rhaid cwblhau)

### Objectives: (must be completed)

|   |   |
|---|---|
| Cyfeirnod Cofrestr Risg Corfforaethol a Sgôr Cyfredol: Corporate Risk Register Reference and Score: | The report highlights key risks for delivery against the IMTP                                 |
| Safon(au) Gofal ac Iechyd: Health and Care Standard(s):   | Governance, Leadership and Accountability<br>1.1 Health Promotion, Protection and Improvement |



|   |   |
|---|---|
|   | 2. Safe Care<br>2.1 Managing Risk and Promoting Health and Safety   |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br><a href="#">Link to IMTP</a>  | Choose an item.<br>Choose an item.<br>This is a Quarterly report against the Integrated Medium-Term Plan and the key organisational priorities informed by our detailed understanding of how our system operates.                   |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP  | Choose an item.<br>Choose an item.  |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br><a href="#">Strategic Equality Objectives 2020-24</a> | Improve the Wellbeing and engagement of our staff<br>Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse |

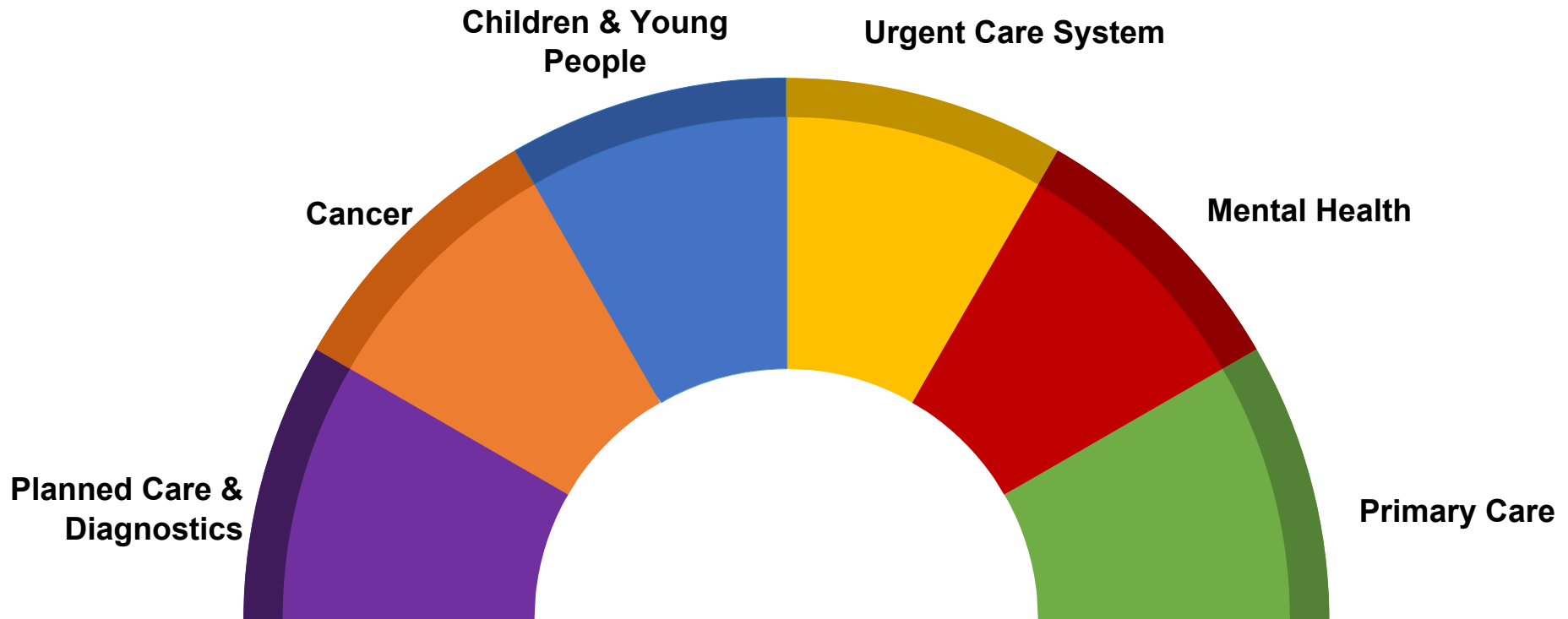
| <b>Gwybodaeth Ychwanegol:<br/>Further Information:</b>  |  |
|---|--|
| Ar sail tystiolaeth:<br>Evidence Base:  |  |
| Rhestr Termau:<br>Glossary of Terms:  |  |
| Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University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

| <b>Effaith: (rhaid cwblhau)<br/>Impact: (must be completed)</b> |  |
|---|--|
| <b>Resource Assessment:</b>                                     | A resource assessment is required to support decision making by the Board and/or Executive Committee, including: policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following: |
| • <b>Workforce</b>  | Choose an item.  |
| • <b>Service Activity &amp; Performance</b>                     | Choose an item.  |
| • <b>Financial</b>  | Choose an item.  |
| <b>Asesiad Effaith Cydraddoldeb</b>                             | <b>No does not meet requirements</b>   |

|  |  |
|--|--|
| <p><b>Equality Impact Assessment (EIA) completed</b></p>   | <p>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a></p> |
| <p><b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b></p> <p><a href="https://futuregenerations.wales/about-us/future-generations-act/">https://futuregenerations.wales/about-us/future-generations-act/</a></p> | <p>Choose an item.<br/>Choose an item.</p>   |

## Performance Report Quarter 3 Progress

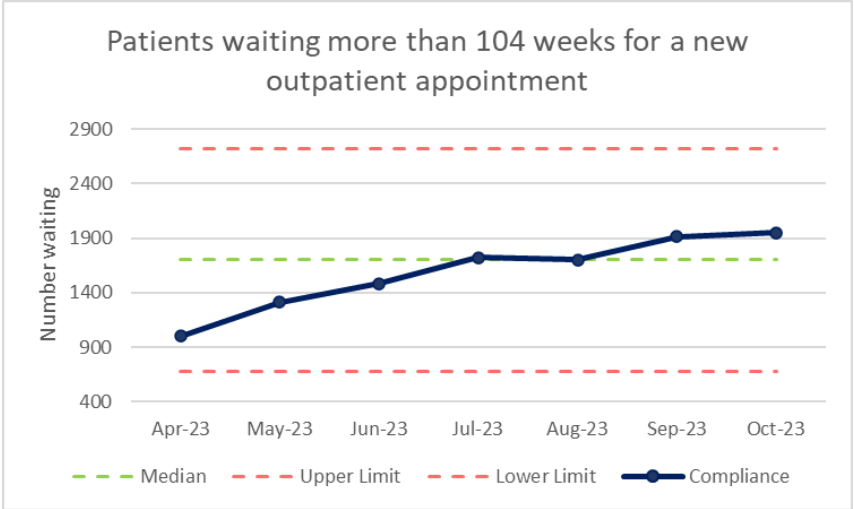
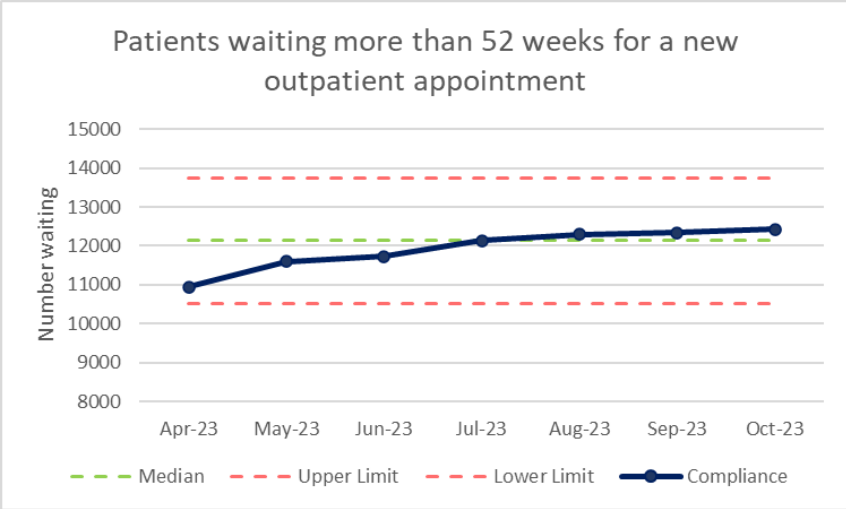
This Performance report outlines delivery against the Welsh Government Ministerial Priorities. It complements the IMTP Quarterly Outcomes Report that is produced each quarter and covers the broader spectrum of IMTP commitments



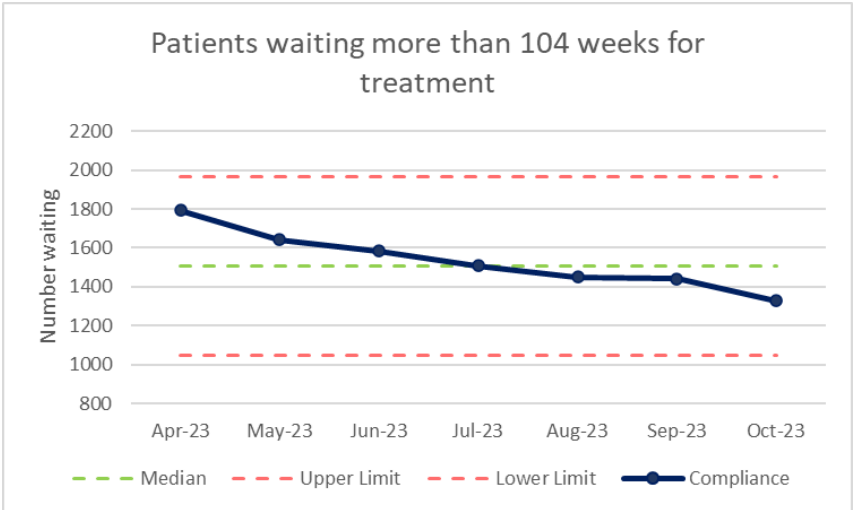
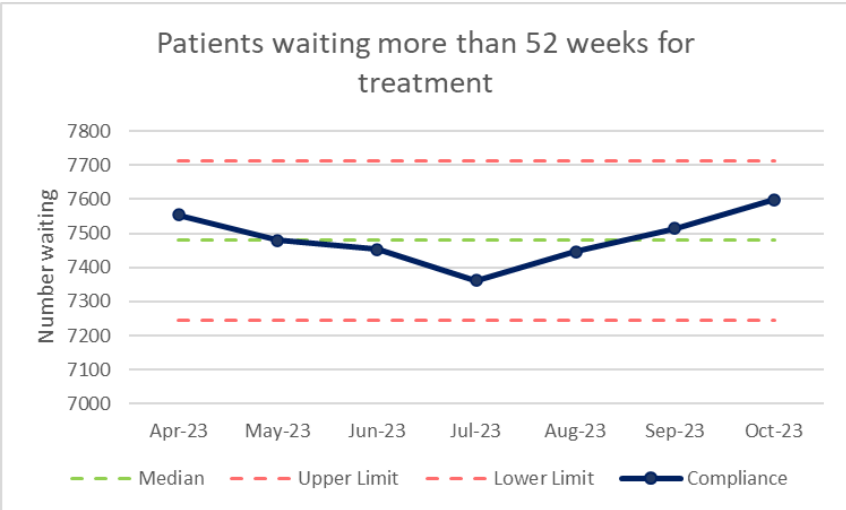
# Planned Care and Diagnostics

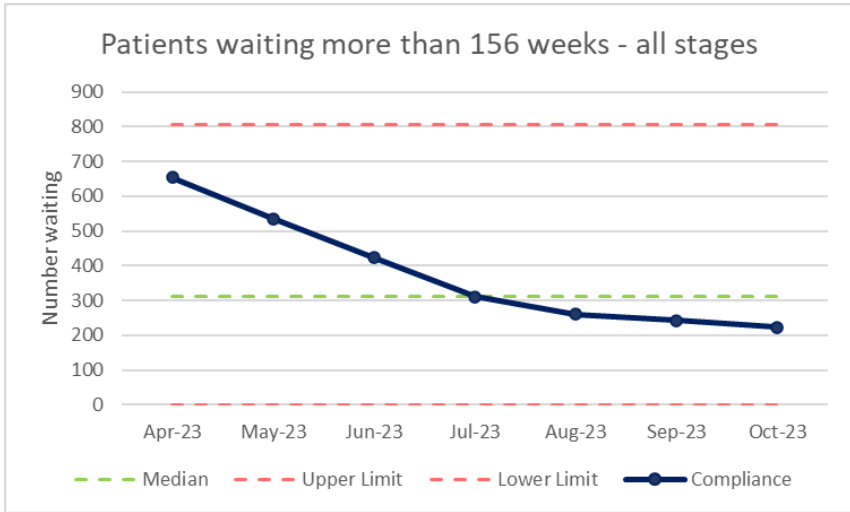
## Performance

### Outpatients

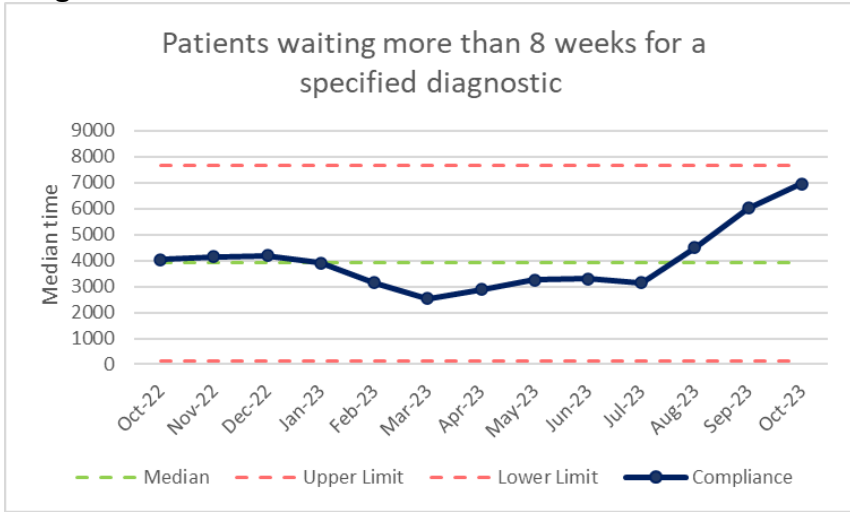


### Treatments

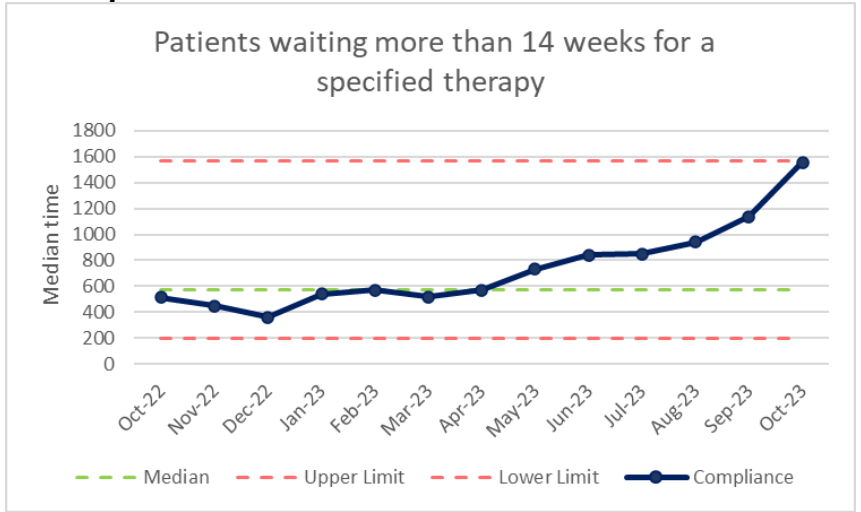




**Diagnostics**



**Therapies**



**Analysis**

**Treatment**

- The Health Board is ahead of trajectory in eliminating waits of over 156 weeks for treatment, with 70 patients waiting at the end of October 2023 compared to the March 2023 position of 553.
- Improvements have also been made with 104 week waits for treatment which has reduced from 1,935 in March 2023 to 1,328 at the end of October 2023. Despite this reduction, the Health Board remains off track to meet the October trajectories by 40.

**Outpatient**

- At the end of October 2023, there were 1,949 patients waiting over 104 weeks for a first outpatient appointment. There is mixed progress across specialities with ENT, Ophthalmology, Orthopaedics and Urology currently behind trajectory.
- The number of patients waiting over 52 weeks for a first outpatient appointment has been maintained at 12,412 as of October 2023.

**Diagnostics**

- Continued insourcing of additional endoscopy capacity has supported a maintenance in the 8-week backlog with 2,049 patients waiting at the end of October 2023.
- Radiology diagnostics have increased further during October 2023 to 3,611 due to the ceasing of outsourced MRI capacity and additionally funded sessions to support ultrasounds.

**Therapy**

- 92.6% of new attendances are seen within 14 weeks, with the average wait for first attendance being 46 days (6.6 weeks).
- Speech and Language Therapy waiting list continues to be made up of two specialty areas, Paediatrics (particularly Neuro developmental) and Transgender referrals for voice intervention.
- The transfer of patients from the ENT service to audiology has impacted on the Therapy wait times
- Breaches of the RTT target are across all sub-specialities within Dietetics.
- Weight Management Service breach accounts for 83% of breachers in Therapies.

**Actions****Treatment**

- A comprehensive plan is in place to support Ophthalmology, including a regional solution to increase regional capacity for cataract outpatient and inpatient stages to enact a collaborative regional approach to recovery and to maximise the use of our assets across the region.
- Prospective Treat in turn tool developed to ensure focus on targeting longest waiters.
- Maximising elective capacity by prioritising and focusing activity on theatre improvement opportunities, GIRFT review in progress which will support identification of opportunities for efficiency improvements.
- Services reviewing plans, focussing on treating those that have waiting the longest whilst balancing urgent and prioritised work.

**Outpatient**

- There are extensive recovery plans in place across ENT and Urology including a clinical review of patients on the waiting list along with other solution (e.g. audiology) supporting ENT and a focus on improving treat in turn prioritisation across the Board.
- The outpatient transformation programme is focussing on its outpatient Did Not Attend (DNA) plan, of which the current rate for new outpatient appointments has reduced from 6.4% (1,540) in March 2023 to 4.39% (1,533) in October 2023. Additionally, the programme is continuing to work alongside finance and divisional teams, with a particular focus to further explore opportunities of virtual activity to meet the needs of those waiting for an appointment.
- Finalise first phase of health care pathways and plan for phase 2 priority pathways development and implementation.
- Focus on increased virtual/video/group activity and implement plans to reduce 100% past target follow-ups.

**Diagnostics**

- Continue insourcing of additional endoscopy capacity.

- Royal Gwent Hospital endoscopy unit opened November 2023, with the purpose to sustain services and reduce backlog of those waiting, future reports will see impact of this investment
- Radiology continue to prioritise clinically urgent cases and maternity ultrasound

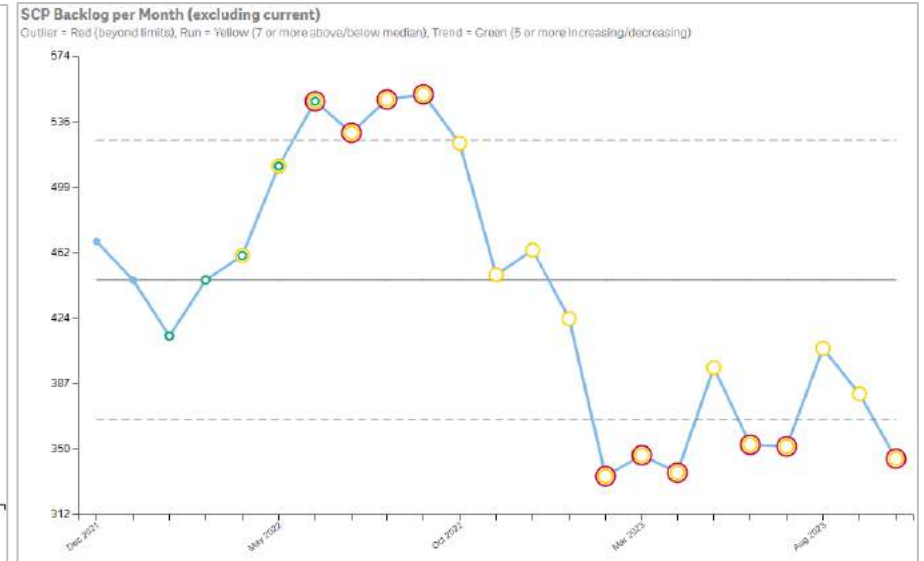
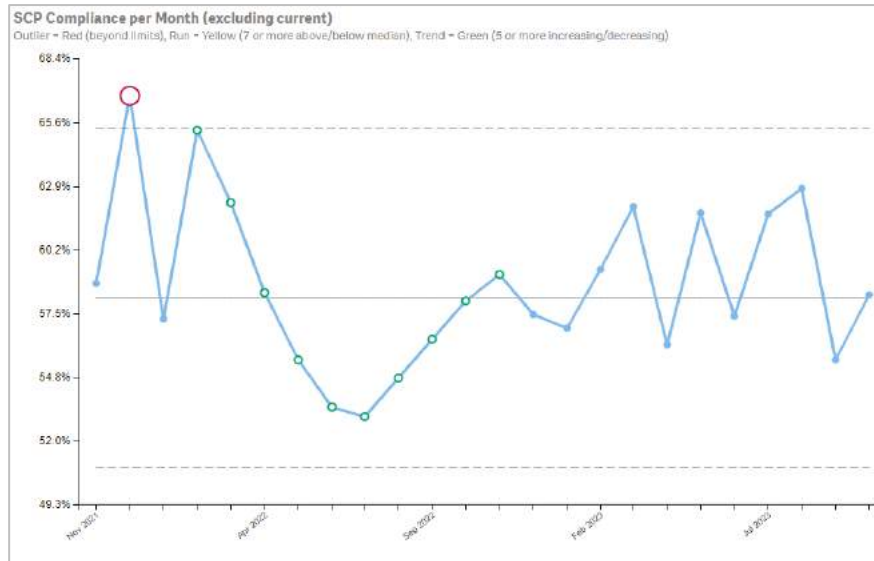
***Therapy***

- Launch of Dietetics Irritable Bowel Syndrome (IBS) 'See On Symptom' (SOS) Pathway and Dietetics Paediatric Chronic conditions 'Patient Initiated Follow-up' (PIFU) pathway.
- Adult Weight Management Service SOS & PIFU process launched.
- Ongoing work to develop SOS /PIFU pathways in Podiatry and Orthotics.

Performance

SCP Cancer Compliance per Month

Backlog of cancer patients waiting over 62 days



Analysis

Compliance against the 62-day target for definitive cancer treatment has increased from 51.6% (Mar 23) to 58.4% at the end of October 2023. This is behind the performance ambition set in the IMTP. Significant increases in demand relating to suspected cancer referrals have continued to exceed 3,500 referrals per month compared to pre-covid levels of 2,500.

Whilst SCP compliance is improving, this increased demand is continuing to have an impact on performance creating capacity challenges throughout the pathway for services provided by the Health Board and those provided at tertiary centres. Additionally, the number of SCP treatments undertaken has increased by 12% over the last 12 months and is continuing to increase month by month (October 23 = 406 SCP treatments compared to October 22 = 362 SCP treatments).

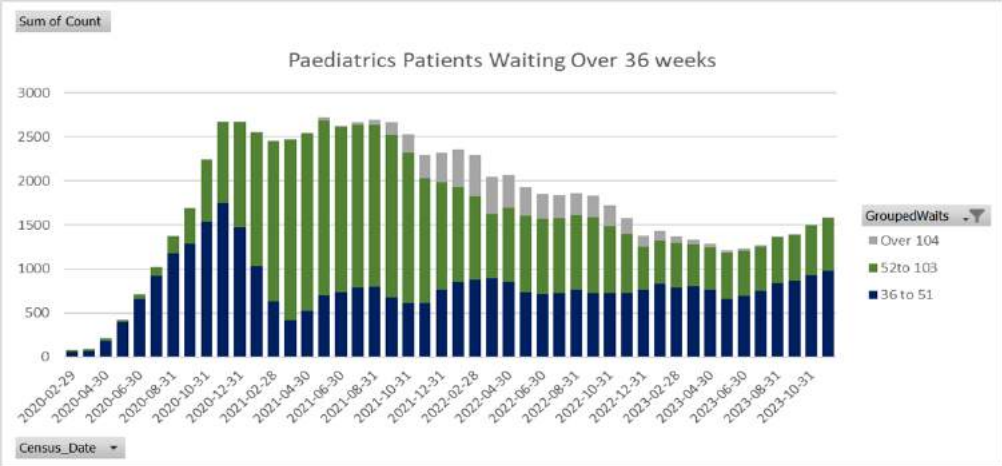
Actions

- Optimal pathway work to reduce volume of breaching patients through reviewing capacity scheduled with specialities, with a particular focus on Urology, Gynaecology, Head & Neck and Lower GI.
- Close working with Radiology regarding Accelerated Imaging and Pathology regarding turnaround times.
- Continued rollout of Did Not Attend (DNA) reduction pilot schemes – Navigator now recruited and in post within Gynaecology and Upper GI, with plans to establish within Lung by December 2023.
- Joint working with tertiary centres on shared pathways

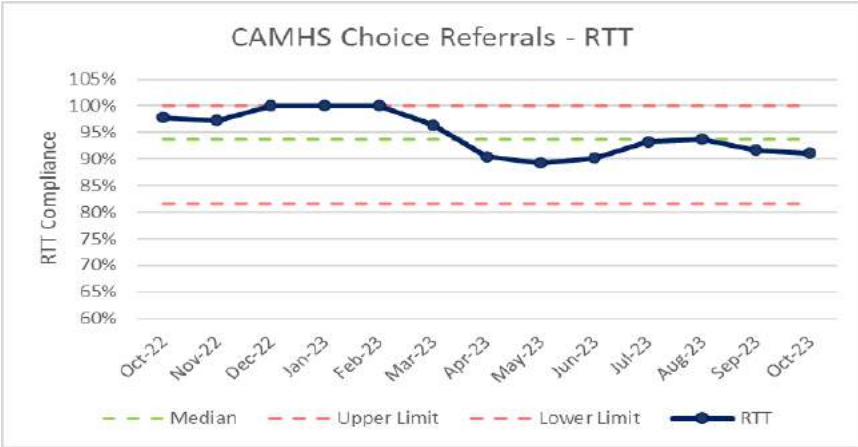
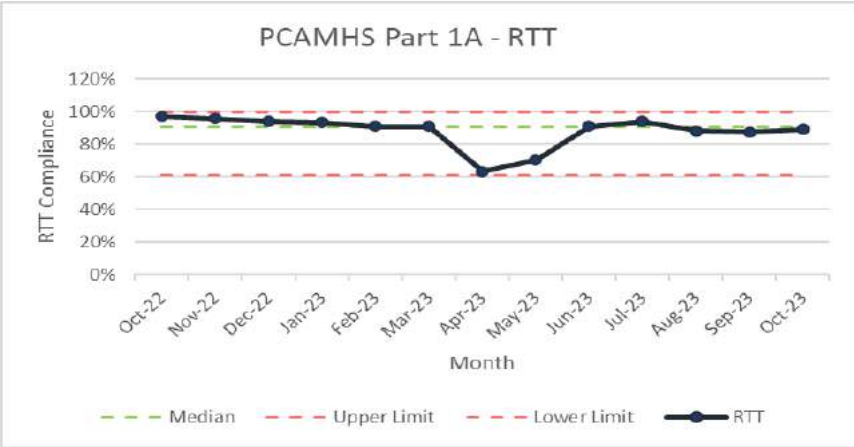


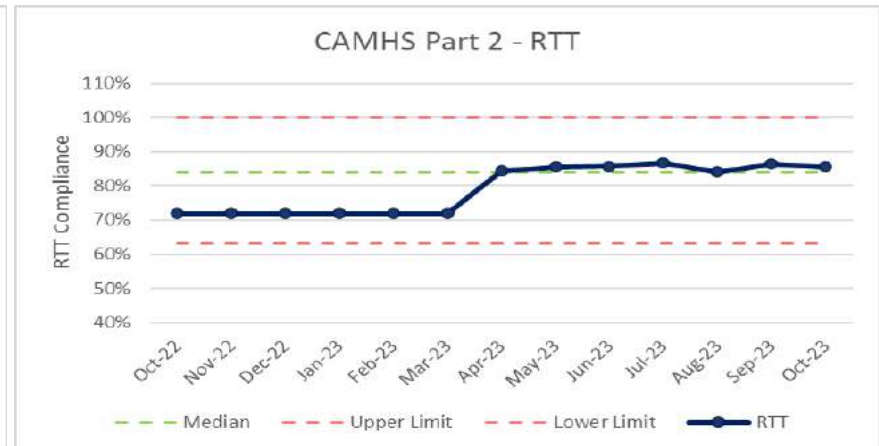
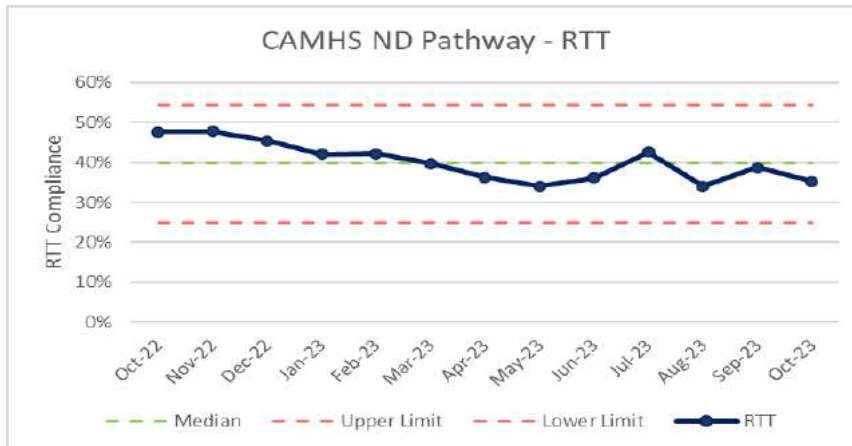
Performance

Children's Waiting Times



Children & Adolescent Mental Health Services





**Analysis**

**Children’s Waiting Times**

- The number of children on the Health Board’s waiting lists who have been waiting over 36 weeks increased during the pandemic and peaked during the summer of 2021. As of September 2023, there were 251 children waiting over 52 weeks for a new outpatient appointment. There are a number of contributing factors to the waiting list including nurse capacity, bed capacity, Anaesthetics support and theatre availability.

**Children & Adolescent Mental Health Services**

- PCAMHS Mental Health Measure Part 1a&b – RTT compliant since June 2023 and remains stable (Oct 23 = 89% compliance). Part 1b remains unachieved (Oct 23 = 0% compliance). Despite workforce constraints, the waiting list is reducing. At June 23, 640 young people were waiting which has now reduced to 396 in (Oct 2023). Workforce issues have impacted upon forecasted recovery position to 80% RTT target from April 24 to May 24, however this position may improve with the continued waiting list validation exercise.
- CHOICE – RTT compliance has remained stable over the last 18 months and continued to remain above target at 91.11% (Oct 23).
- CAMHS Part 2 – RTT compliance since June 2023, with the reported Oct 23 position at 85.5%, giving assurance that young people have updated care and treatment plans.
- ND Pathway – RTT compliance remains unachieved (35.23% Oct 23). The reporting on the neuro-developmental (ND) pathway has been separated into 0-5 years and 5-18 years to reflect the differing demands and assessment processes. As of October 23, 450 0-5 year olds and 271 5-18 year olds are on the waiting list. There are on average 220 new referrals a months which is a 300% increase since Covid-19.

**Actions**

**Children’s Waiting Times**

- There continues to be focused efforts to reduce paediatric waiting times and consequently, intensive plans have been developed to reduce and maintain the waiting time for first outpatient appointments across all specialities.

- 
- The Health Board has been working alongside the Welsh Health Specialties Services Committee (WHSSC), who are undertaking a deep dive into a range of paediatric sub-specialities to develop options with a focus on addressing increased waiting lists, in particular those waiting over 2 years.
  - Plans in place to increase Anaesthetics support to assist with recovery.

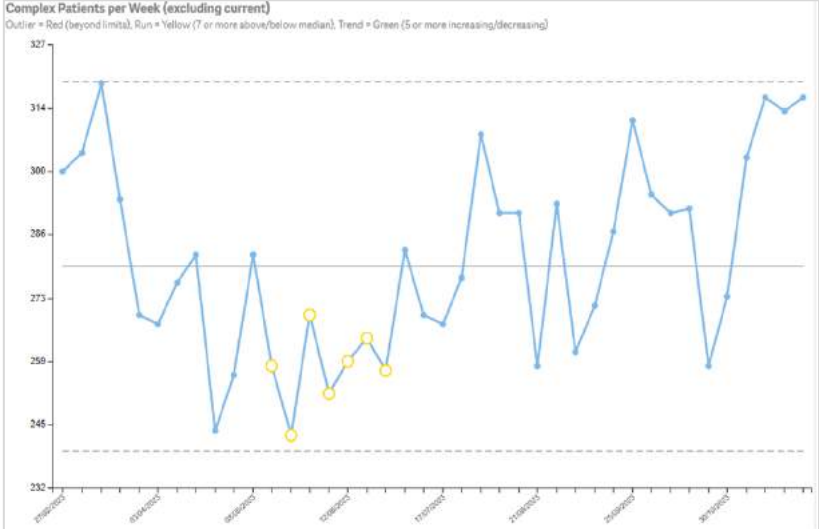
***Children & Adolescent Mental Health Services***

- Weekly performance meetings with CAPA Leads highlight capacity issues/unmet demand to be addressed.
- Vacancies due to be filled Nov/Dec 2023, with additional capacity from the CAMHS BOOST Team in March 2023.
- Waiting list validation exercise continuing and forecasted to end in December where the waiting list position will be reviewed.
- SBAR devised setting out the planning for a new pathway to incorporate a multi-disciplinary team involving speech and language therapy.
- Portsmouth profiling tool due to be implemented in Feb 24 and review of a needs-led/ support pathway for children and young people. Co-production work with parents continues with a new cohort and they will help to review the new domains of the model.
- ALNCO sessions have taken place this term to maintain close links with Education.

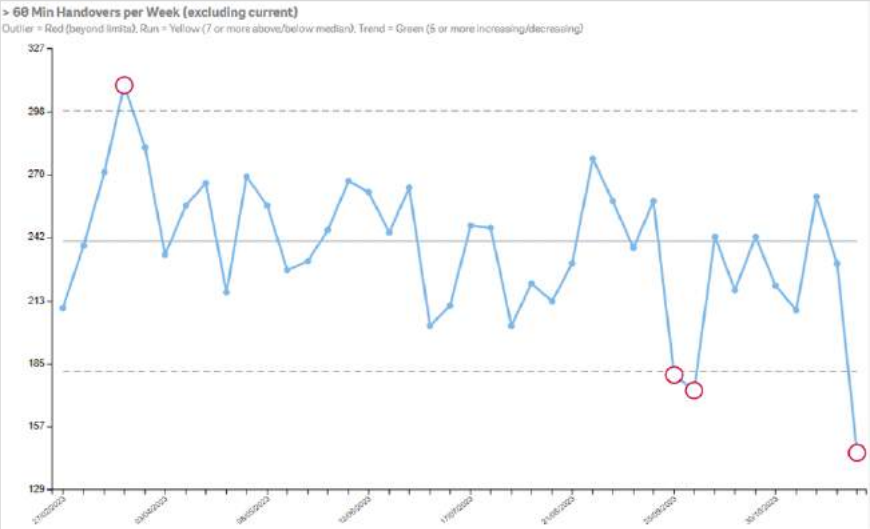
# Urgent Care System

## Performance

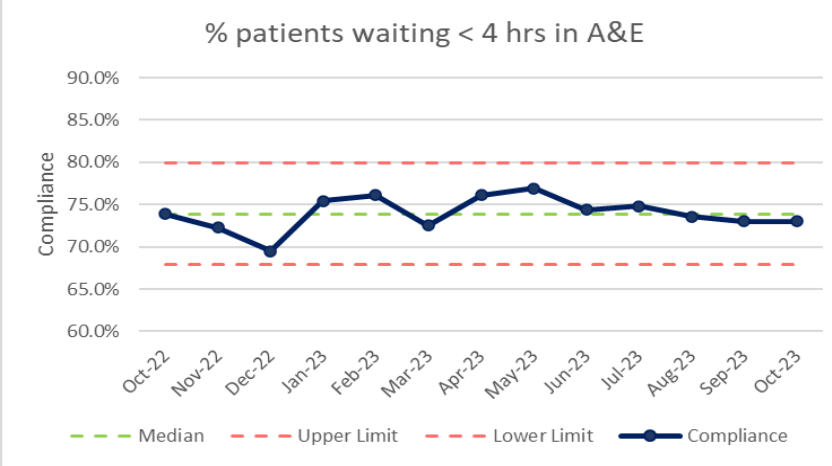
**Patients on the Complex list (unvalidated)**



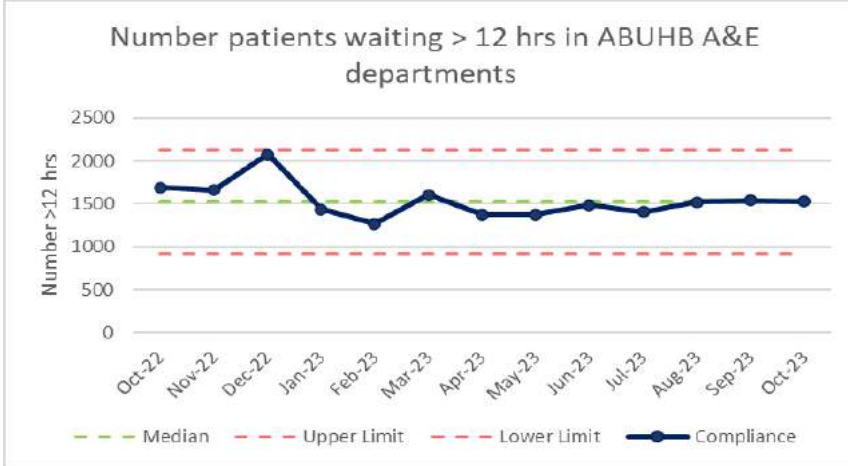
**Ambulance Handovers >1 hour**



**Patients waiting <4hrs in A&E**

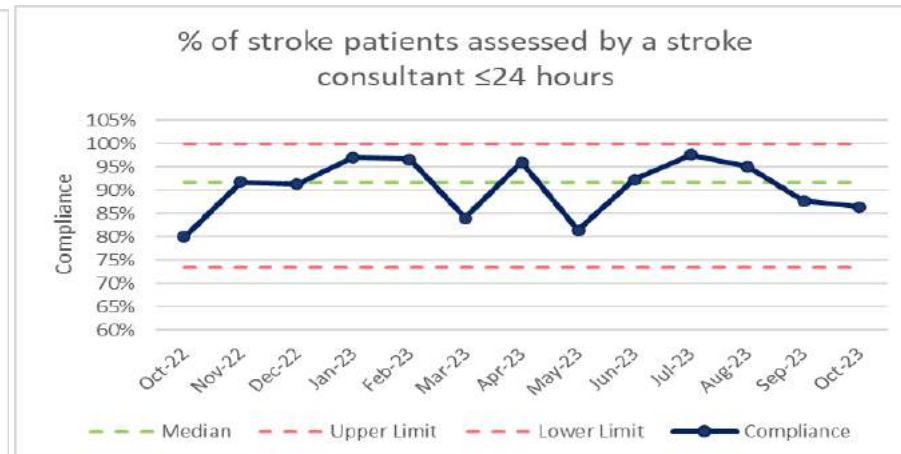
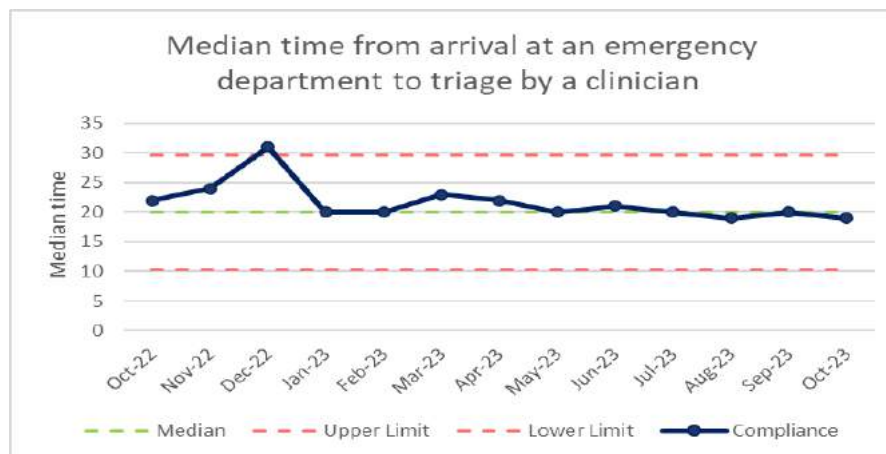


**Patients waiting >12hrs in A&E**



### Time from arrival to triage by a clinician

### Stroke patients assessed <24 hours



### Analysis

#### Number of patients on complex list

- The number of patients on the complex list has increased from the Mar 23 baseline of 275 to 316 (Nov 23). The complex list in Community sites has reduced from levels seen in 2022 of roughly 200 patients to around 170 since January 2023. Since then, it's varied between 150-190 each week. Within acute sites, the number of DTOCs typically ranges around 80-130, however this has increase to around 130 in recent weeks.

#### Ambulance

- During November, a total of 997 patients waiting over 60 minutes to be transferred to the Emergency Department from an Ambulance. Whilst this remains high as a result of poor flow through the system, there has been a concerted effort to decrease the number of delayed ambulance handovers and as such this has reduced significantly from 1,497 reported in March 23.

#### Emergency Departments

- During November there have been on average 493 daily attendances to the Emergency Department or a Minor Injury Unit and the pressure on the urgent care system has resulted in patients staying in hospital for longer.
- Despite the extreme pressures upon the urgent care system, the performance measures of patients waiting less than 4 hours in ED has been maintained at 73% in October 23 and remains above the all-Wales average of 69%. The most recent national performance data reports that whilst the 95% target for 4 hour ED waits has not been met, the Health Board's performance is the second highest in Wales.
- Patients waiting over 12 hours in Emergency Departments was reported at 1,528 in October 23, which is a decrease against the baseline of 1,606 (March 23) and has achieved and surpassed the national target of 1,689.

#### Stroke

- In October 2023, the Health Boards position of the percentage of patients assessed by a stroke consultant within 24 hours has also been maintained at 86.4%, surpassing the national target of 85%.
- The measure of the percentage of stroke patients receiving the required minutes for speech and language therapy was 37.6% in October 2023, compared to 27.6% the previous month.

---

**Actions*****Complex List***

- Further work on validation of data
- Ongoing implementation of the Education programme, with roll out at NHH/YYF/Community hospitals.
- Review of RGH discharge pilot/NHH pull model.
- Delivery of patient safety events at RGH, YYF and St Woolos, front door and step down.
- Scale and spread of Hospital 2 Home, facilitating early discharge.
- Identify new high-risk patients in hospital and enhance their discharge process.

***Ambulance & Emergency Departments***

- Expansion of PRU until 2024 with WAST and business case is in development.
- Procurement of e-Triage solution and focus on long lead time aspect (relating to technical integration with Welsh Patient Administration System (WPAS)).
- Agree mechanism to be used (i.e. CWS watchlist) and risk management approach for a pilot of a new ED referral process.
- Work collaboratively with Trauma & Orthopaedics for referral improvement within the ED.
- Continue safety flow process to sustain ambulance handover improvement and move towards 2 hours with a focus on wait to be seen time.
- Pilot mode of Acute Frailty Nurse at front door
- Revision of escalation framework to support improved handover of patients with long wits on Ambulances
- Rapid development and implementation of Non injurious fallers and head injury pathways to support conveyance away from GUH

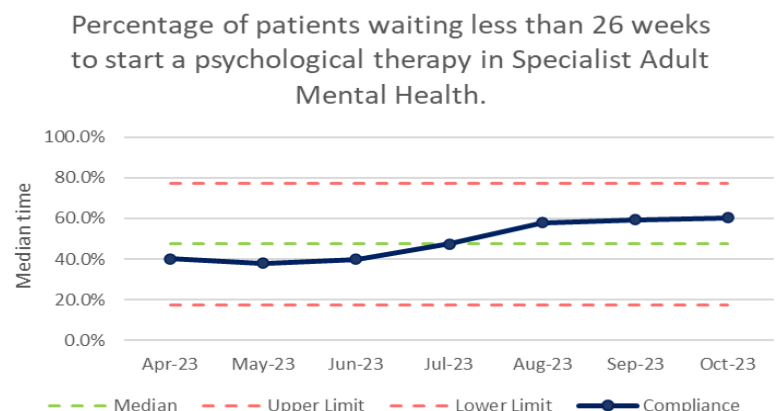
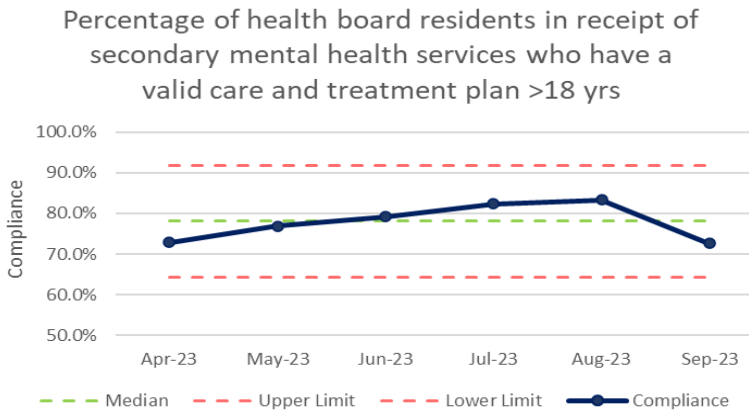
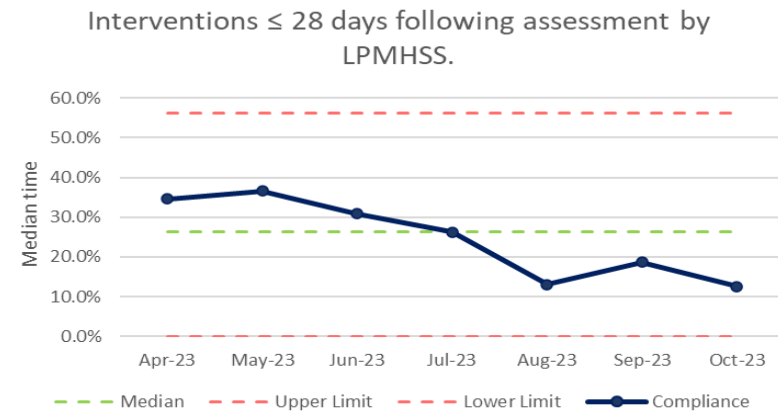
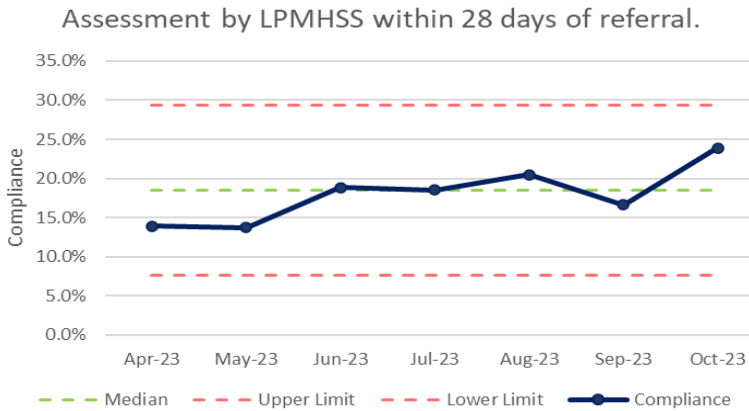
***Stroke***

- Funding confirmed for 5 WTE CNS posts and posts have been filled on a substantive basis and expected to see improvements in metrics from December 2023.
- Embedding the National Stroke Model in ABUHB through the consolidation of the rehabilitation service, concentrating resources to provide a more robust service.
- Recruitment to GIRFT Project manager role.



# Mental Health

## Performance



## Analysis

### Part 1 measures against Assessment

- Performance at the end of October remains significantly below the target of 80% for both assessment and interventions.
- Mental Health assessment within 28 days of referral performs at 23.9% an improvement on the previous month which was 16.6%
- Interventions less than 28 days following assessment at 12.6% has declined from previous month at 18.7%.

### Part 2 measures against Care and Treatment plan

- Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (18 years and over) is 73% below the target of 90%.

### Psychological Therapy within 26 weeks

- Maintained increased performance of above 57% since August reaching highest levels of performance in October at 60%

---

**Actions***Part 1 measures against Assessment*

- There is a 90-day improvement plan in place with targeted actions to address part 1 performance. This report is monitored through the Executive committee due to the escalation status as outlined in the organisations performance and accountability framework.

*Part 2 measures against Care and Treatment plan*

- Embedding of mental health services in Neighbourhood care networks continues in piloted areas with a view to expand across all boroughs.

*Psychological Therapy within 26 weeks*

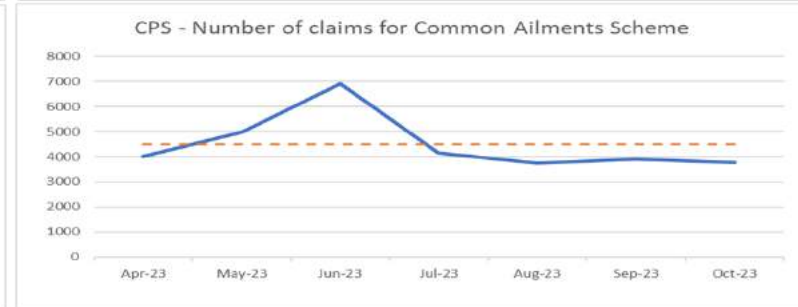
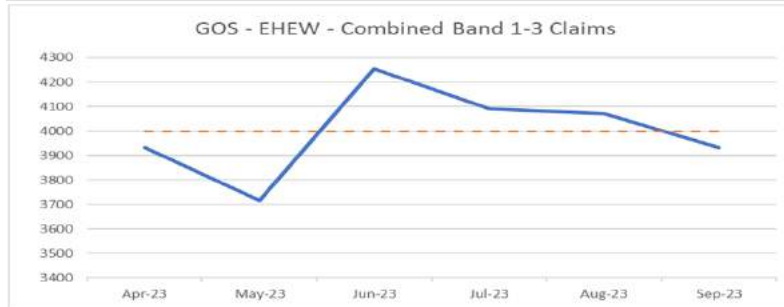
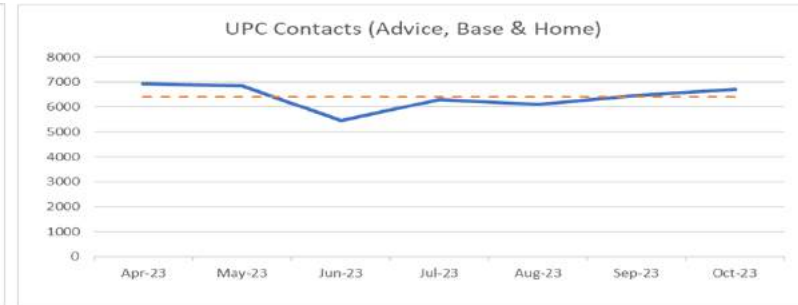
- Continue to implement plans to maximise available clinical space to deliver psychological therapy pathway improvements and provide care closer to home.



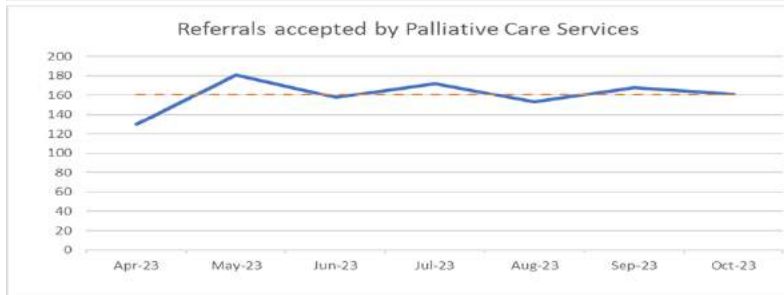
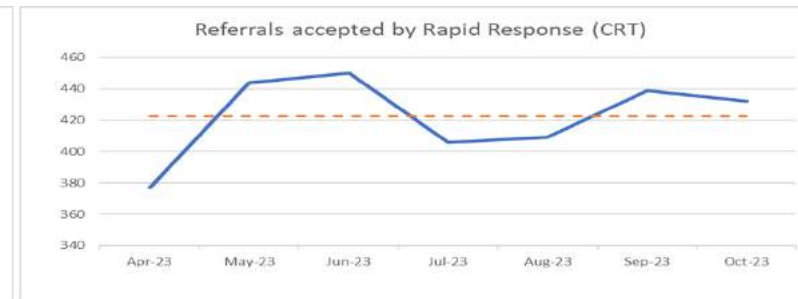
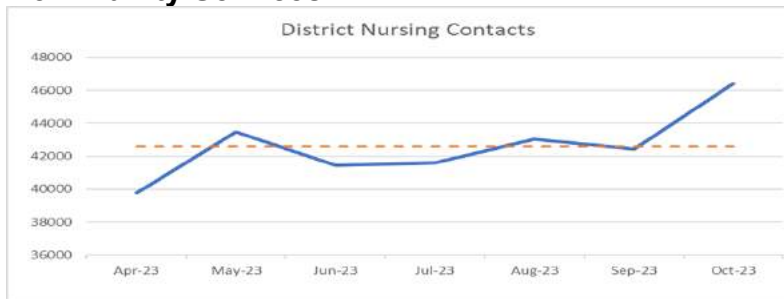
# Primary Care

## Performance

### Primary Care Services



### Community Services



## Analysis

### **Primary Care Services**

- Activity across General Medical Services (GMS) has increased to its highest point in the year in October with 370,608 appointments seen.
- The trend in urgent primary care (UPC) contacts across advice, appointments on site and home visits has been consistent since July with 6697 in October.
- Activity in General Optometry Services (GOS) for Eye Health Examinations Wales (EHEW) has decreased slightly since July reporting 4091 for July, 4071 for August and 3932 for September.
- Community Pharmacy Services (CPS) continue to deliver a consistent number of claims under the commons ailments scheme since April with claims ranging between 3700 and 4150 with the exception of May which had 4979 and June which achieved 6900.

### **Community Services**

- District Nursing contacts reached their highest during October at 46407 this was highest than the same point last year, 44268 in October 22.
- Referrals in Palliative Care Services were 161 in October a very slight decrease on the previous month which were 168.
- Rapid Response referrals have been above 400 a month since May with 432 in October.

## Actions

### **Primary Care Services**

- Work will continue to showcase the varied roles in GP Practices through video profiles to increase public confidence to see a variety of professionals when booking appointments.
- Expansion of Multidisciplinary Team (MDT) roles within Urgent Primary Care, including Advance Practice Paramedics, Clinical Pharmacists and extended scope nurse practitioners to reduce reliance on sessional medical workforce
- Finalise appointment to all Optometry Professional Collaborative Leads and implement local collaborative processes aligned to Neighbourhood Care Network Development Programme.
- Pharmacies continue to advertise the common ailments scheme to increase the number of referrals.

### **Community Services**

- District Nursing are working towards achieving the National Community Nursing Specification to ensure capacity on Saturday and Sunday daytime is at a minimum of 60% of the usual weekday capacity
- Continued collaborative approach to advanced care planning programme working with primary care, secondary care, care homes and voluntary sectors, driven by the End of Life Care delivery plan to raise awareness.
- Redesign referral pathways and single point of access to define access routes for Community Resource Teams (CRTs), Community Services and Secondary Care, aligning resources to streamline processes for GPs



# Six Goals for Urgent & Emergency Care

12<sup>th</sup> December 2023



GIG  
CYMRU  
NHS  
WALES

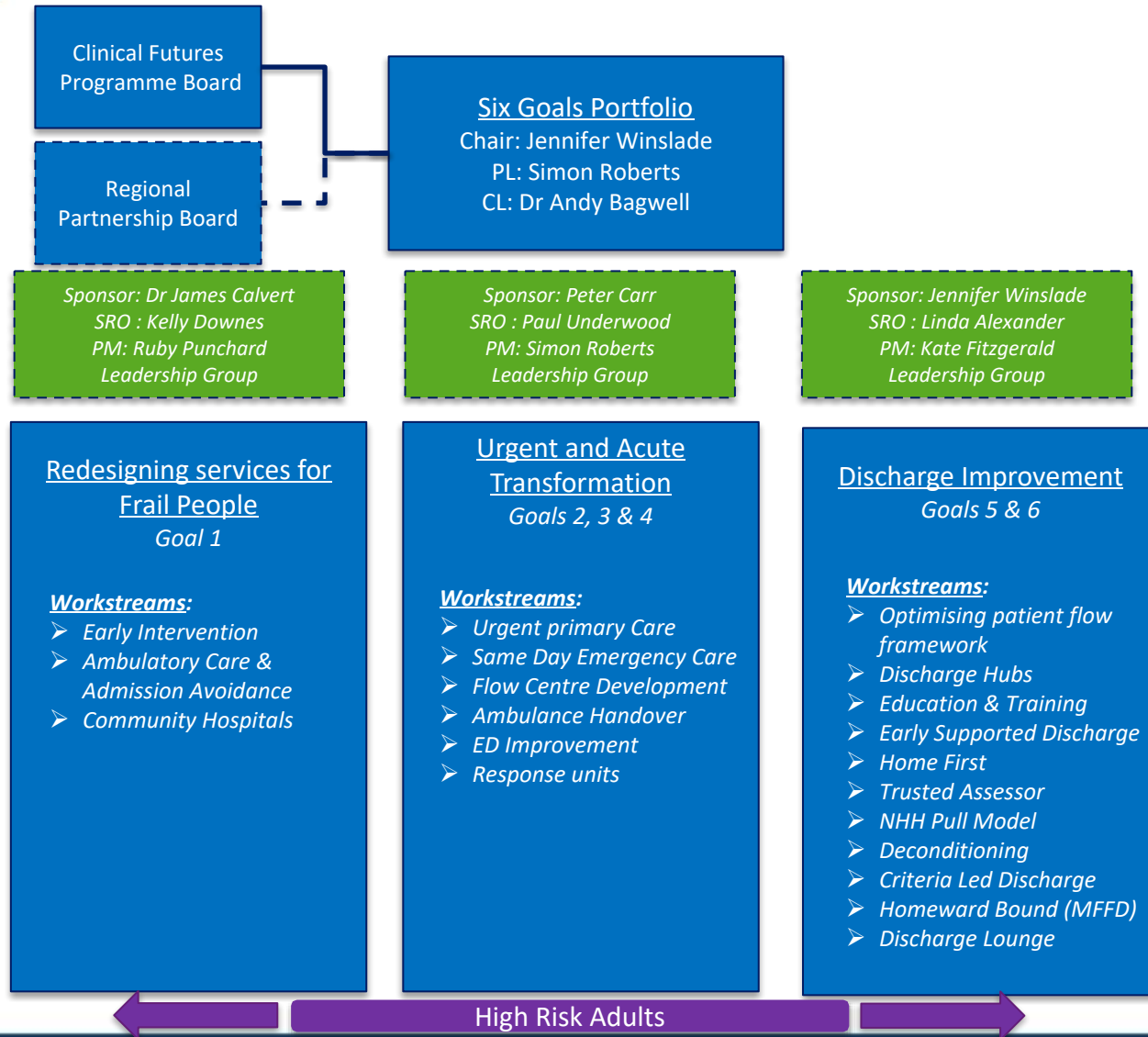
Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board

Dyfodol Clinigol  
Clinical Futures





# Six Goals Programme Structure



## Programme Governance

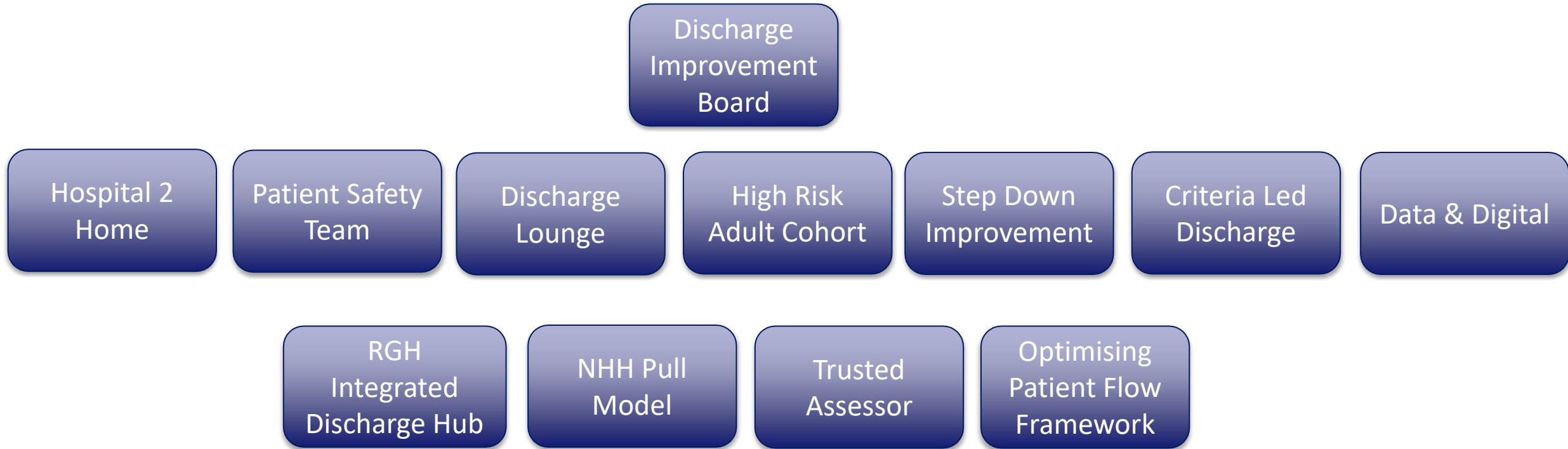
- Clinical leadership throughout the Programme
- Reporting to the Executive Clinical Futures Programme Board
- Monthly Six Goals Board Meeting
- Whole system attendance including Local Authorities, WAST, NHS Executive
- Programme Leadership Steering group
- Workstream delivery groups in place led by the SROs
- Evidence based and PDCA approach





# Goals 5 & 6

## Discharge Improvement



# Patient Safety Team



| Lead         | Linda Alexander, Deputy Director of Nursing   |
|--------------|---|
| Aim          | <ul style="list-style-type: none"> <li>To rapidly improve the timely discharge of patients essentially delivering a step change in performance, safety and patient experience, working with the five local authorities and community partners</li> </ul>  |
| Delivery     | <ul style="list-style-type: none"> <li>Lead through a triumvirate approach supported by the Clinical Futures Team</li> <li>Number of Patient Safety Events delivered at various sites, GUH/RGH/YYF/SWH/County</li> <li>Event in NHH on 13<sup>th</sup> December and RGH on 20<sup>th</sup> December</li> <li>Delivered through a multi-disciplinary approach</li> <li>Good engagement and support from local authority colleagues</li> <li>Measured activity, service improvement, patient stories</li> </ul> |
| Findings     | <ul style="list-style-type: none"> <li>Parallel discharge process – plan discharge prior to patient being medically fit</li> <li>Flow issues from GUH – SD patients</li> <li>Listening to family wants/needs instead of patient</li> <li>Lack of awareness of community services and how to access them</li> <li>End of life patients, no discussions, remaining on wards for some time</li> </ul>  |
| Forward Plan | <ul style="list-style-type: none"> <li>Series of event across acute/community sites until end of January 2024</li> <li>Draft Discharge Improvement Plan to capture actions, progress monitor via Discharge Improvement Board</li> <li>Continue to monitor and evaluate impact, plan approach ahead of next Winter</li> </ul>  |



# Hospital 2 Home



| Lead             | Donna Wetter, Interim Divisional Nurse, Complex Care   |
|------------------|--|
| Aim              | <ul style="list-style-type: none"> <li>To facilitate earlier discharge for patients identified as clinically optimised and ready for transfer to an alternative care setting/home</li> <li>To allow the person to be further assessed and/or supported in their own home</li> </ul>  |
| Delivery         | <ul style="list-style-type: none"> <li>Funding agreed via Regional Partnership Board, recruited 4.5WTE HCSWs</li> <li>Recruiting a further 6.3WTE HCSWs, funded by Regional Partnership Board</li> <li>Incorporated twilight shifts into rosters to meet demand</li> <li>Adapted x2 existing peripatetic runs, covering both North and South</li> <li>Bespoke referral and assessment forms created</li> </ul> |
| Findings         | <ul style="list-style-type: none"> <li>Pilot commenced in June 2023, open across all localities</li> <li>25 patients accessed the pathway,</li> <li>Average of 25.9 days spent on pathway, reduction in hospital bed days</li> <li>Further deconditioning prevented – work ongoing to articulate exact benefit</li> </ul>  |
| Patient Feedback | <p>I was in hospital for 8 weeks and I felt like I was using a bed for other people who needed it more. I was <b>so happy to be offered the opportunity to come home</b> and to be cared for by the H2H team. <b>Everyone I met was so lovely</b>, caring and kind. If it wasn't for you I'd probably still be in hospital. <b>Coming home has made me so much happier. A big thankyou!</b></p>                |



# Discharge Lounge



| Lead       | Natalie Skyrme, Head of Nursing Urgent Care  |
|------------|--|
| Purpose    | <ul style="list-style-type: none"> <li>To improve the function and performance of the GUH, RGH &amp; NHH Discharge/Transfer Lounges</li> <li>Reviewing and proposing changes to the GUH, RGH &amp; NHH staffing models, as well as the locations and processes within RGH &amp; NHH Lounges</li> </ul>   |
| Delivery   | <ul style="list-style-type: none"> <li>Review of best practice including visit to Taunton &amp; Somerset NHS Trust</li> <li>Review of current model/scoping future model - workforce, estates, transport and pharmacy</li> <li>SBAR approved by Executive Team – November 2023</li> </ul>  |
| Next steps | <ul style="list-style-type: none"> <li>Recruit the required substantive workforce</li> <li>Re-location of the RGH Lounge to D6W</li> <li>Completion of capital works at NHH</li> <li>Realignment of WAST resources to facilitate earlier discharges</li> <li>Pharmacy alignment</li> <li>Recruitment B7 nurse to strengthen leadership across all sites</li> </ul> |
| Timescales | <ul style="list-style-type: none"> <li>Modelling and communication – January 2024</li> <li>Recruitment, relocation and capital works - February - April 2024</li> <li>Realignment of WAST/Pharmacy, recruitment of B7 - June - August 2024</li> </ul>  |





# Step Down Improvement Project



|                   |   |
|-------------------|---|
| <b>Lead</b>       | <b>Natalie Skyrme, Head of Nursing Urgent Care</b>  |
| <b>Aim</b>        | To implement the learning derived from Patient Safety Team events relating to step down and/or discharge principles and processes, via a multi-disciplinary approach  |
| <b>Objectives</b> | <ul style="list-style-type: none"> <li>• Reviewing the purpose, format and content of the step down SBAR</li> <li>• Reviewing the step down tracker usage</li> <li>• Improving staff awareness of the pathways and services available to support step downs and/or discharges</li> <li>• Implement nurse led step downs/discharges</li> </ul> |
| <b>Membership</b> | <ul style="list-style-type: none"> <li>• Urgent Care/Operations</li> <li>• Medicine (Nursing)</li> <li>• Scheduled Care (Nursing)</li> <li>• Family &amp; Therapies (Nursing &amp; Therapies)</li> <li>• Communications</li> <li>• Informatics</li> <li>• Clinical Futures</li> </ul>   |
| <b>Timescales</b> | <ul style="list-style-type: none"> <li>• Workshop week commencing 18<sup>th</sup> December 2023</li> <li>• Work programme to be confirmed with delivery timescales for 2024</li> </ul>  |



# High Risk Adult Cohort



| Lead       | Linda Alexander, Deputy Director of Nursing   |
|------------|---|
| Aim        | <ul style="list-style-type: none"> <li>• Test of concept, identifying new high-risk patients across acute hospital site, focus on expedite discharge, cohort of patients who experience long stays</li> <li>• Criteria for HRAC - over 50 years, 14 day in-patient stay in the last 3 years</li> <li>• Aligned to wider Six Goals HRAC Programme</li> </ul> |
| Delivery   | <ul style="list-style-type: none"> <li>• Discharge view developed to track HRAC patients, flagging at day 10</li> <li>• Concept and discharge viewer shared with Assistant Medical Director, Clinical Site Lead at RGH, Senior Nurse, Medicine</li> <li>• Agree to test concept on D4E at RGH</li> </ul>  |
| Next steps | <ul style="list-style-type: none"> <li>• Initial meeting with Clinical Site Lead/Senior Nurse, visit to D4E, 18<sup>th</sup> December 2023</li> <li>• Test concept, operational process to be scoped</li> <li>• Aligned to existing processes, integrated with Board Round/MDTs</li> </ul>  |
| Timescales | <ul style="list-style-type: none"> <li>• Test concept on D4E - Jan/Feb 2024</li> <li>• Feedback at Discharge Improvement Board - February 2024</li> <li>• Monitor/evaluate, test and develop across further wards and sites - March/April 2024</li> <li>• Aim to implement as BAU – May onwards</li> </ul>  |



# Goals 5 & 6 - Risks/Issues



- Increasing number of patients who are medically optimised for discharge remain in acute hospital beds
- Discharge delays - increased risk of patients deconditioning in hospital, further risk of infection/falls, causing patient harm
- Wider System impact, improving safety and quality
- Progression of Trusted Assessor Model, operating in YYF for Stroke patients only
- No. of patients delaying in the system i.e. awaiting social worker allocation/assessment escalation to local authority
- Different working practice/referral methods across local authorities, navigation of the system, themes picked up through the Patient Safety Team events
- Culture/working practices, takes time to change



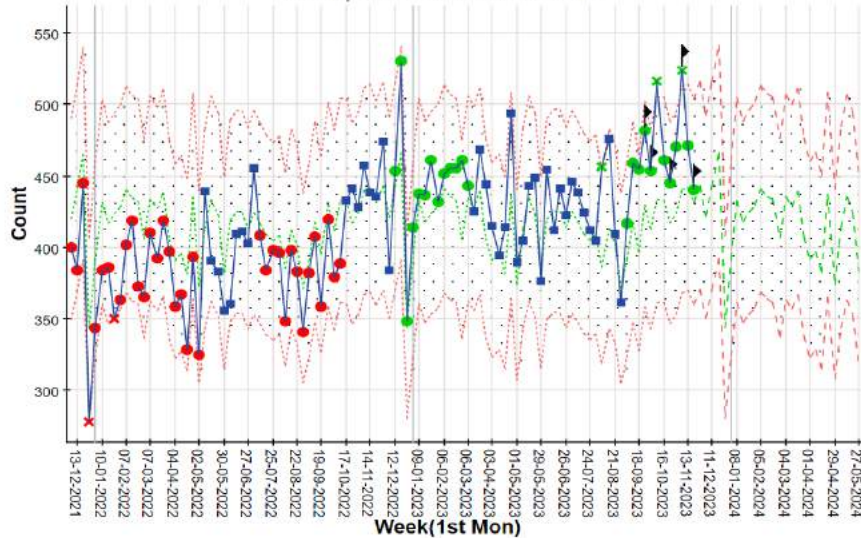


# Evidence Base - Discharge Data



## Emergency Medicine: Provider Spell Discharges (Overnight)

Data Updated: 2023-12-04 06:01:12



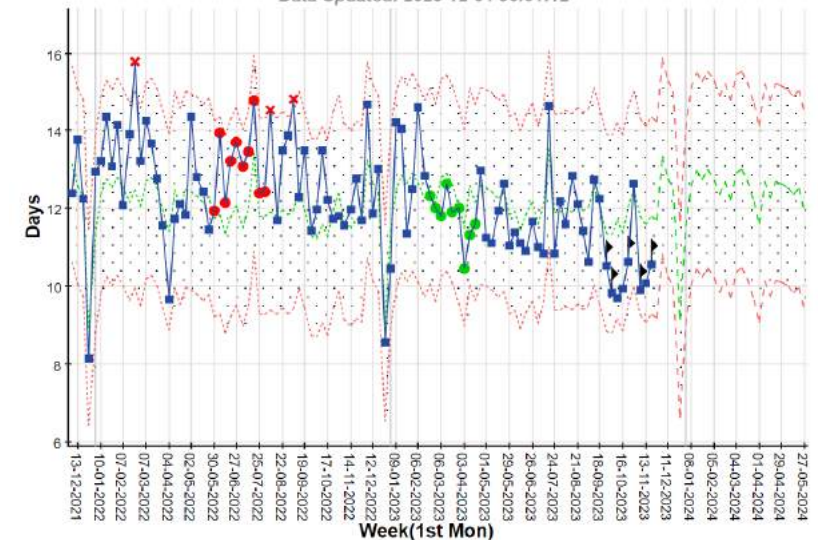
For patients admitted under Emergency Medicine, length of stay on discharge shows a significant improvement on the first 6 weeks where Patient Safety Events have been conducted (flags)

Average length of stay has been around 11-14 days since September 2022, February and March 2023 were slightly improved for a period

On the weeks with PSE, average length of stay has been around 10-11 days. This improvement is seen across all three eLGHs, including NHH where PSE hasn't yet occurred. Community sites have much more variable length of stay, so it is too soon to tell if there has been consistent improvement

## Emergency Medicine: Provider Spell Length of Stay (Overnight)

Data Updated: 2023-12-04 06:01:12



Inpatient Ward, assessment units Discharges of emergency Patients from all sites, excluding any RPs

Prior to September, weekly numbers were typically ranging from 390-470 discharges to patient's residence/care home

Since 4<sup>th</sup> September, the number discharged each week has been 450-510

With two weeks since September peaking to around 520 discharges

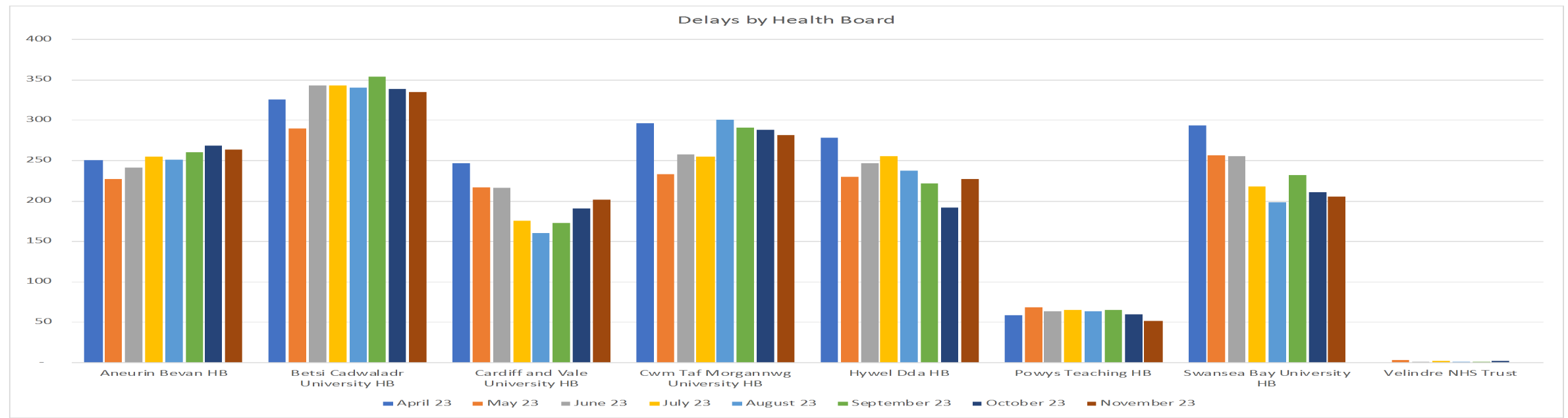


# Pathways of Care Delays (POCD)

## Pathway of Care Delays By Health Board



| Health Board                    | April 23     |               | May 23       |               | June 23      |               | July 23      |               | August 23    |               | September 23 |               | October 23   |               | November 23  |               |
|---------------------------------|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|
|                                 | Delays       | Days Delayed  | Delays       | Days Delayed  | Delays       | Days Delayed  | Delays       | Days Delayed  | Delays       | Days Delayed  | Delays       | Days Delayed  | Delays       | Days Delayed  | Delays       | Days Delayed  |
| Aneurin Bevan HB                | 250          | 5,058         | 227          | 4,116         | 241          | 4,920         | 255          | 4,731         | 251          | 4,939         | 260          | 5,663         | 268          | 5,451         | 264          | 5,357         |
| Betsi Cadwaladr University HB   | 326          | 6,802         | 290          | 5,265         | 343          | 7,998         | 343          | 5,945         | 340          | 6,076         | 354          | 6,441         | 339          | 6,387         | 335          | 6,620         |
| Cardiff and Vale University HB  | 247          | 6,937         | 217          | 4,952         | 216          | 5,954         | 176          | 4,198         | 160          | 3,424         | 173          | 4,190         | 191          | 3,941         | 202          | 4,352         |
| Cwm Taf Morgannwg University HB | 296          | 8,310         | 233          | 5,266         | 258          | 5,628         | 255          | 4,858         | 301          | 5,985         | 291          | 7,304         | 288          | 6,037         | 282          | 6,298         |
| Hywel Dda HB                    | 278          | 7,267         | 230          | 5,451         | 247          | 6,056         | 256          | 5,289         | 238          | 5,261         | 222          | 5,304         | 192          | 4,263         | 227          | 4,578         |
| Powys Teaching HB               | 59           | 1,083         | 69           | 1,322         | 63           | 1,194         | 65           | 1,380         | 63           | 1,354         | 65           | 1,518         | 60           | 1,187         | 52           | 1,184         |
| Swansea Bay University HB       | 294          | 7,541         | 257          | 6,423         | 256          | 6,561         | 218          | 4,388         | 198          | 4,193         | 232          | 5,793         | 211          | 4,981         | 205          | 4,478         |
| Velindre NHS Trust              | -            | -             | 3            | 27            | 1            | 5             | 2            | 13            | 1            | 7             | 1            | 5             | 2            | 43            | -            | -             |
| <b>All Wales</b>                | <b>1,750</b> | <b>42,998</b> | <b>1,526</b> | <b>32,822</b> | <b>1,625</b> | <b>38,316</b> | <b>1,570</b> | <b>30,802</b> | <b>1,552</b> | <b>31,239</b> | <b>1,598</b> | <b>36,218</b> | <b>1,551</b> | <b>32,290</b> | <b>1,567</b> | <b>32,867</b> |





# Admissions with LoS >21 days - Percentage

Number of people admitted as an emergency who remain in an acute or community hospital over 21 days since admission.

[Back to home](#)

[Clear all filters](#)



GIG  
CYMRU  
NHS  
WALES

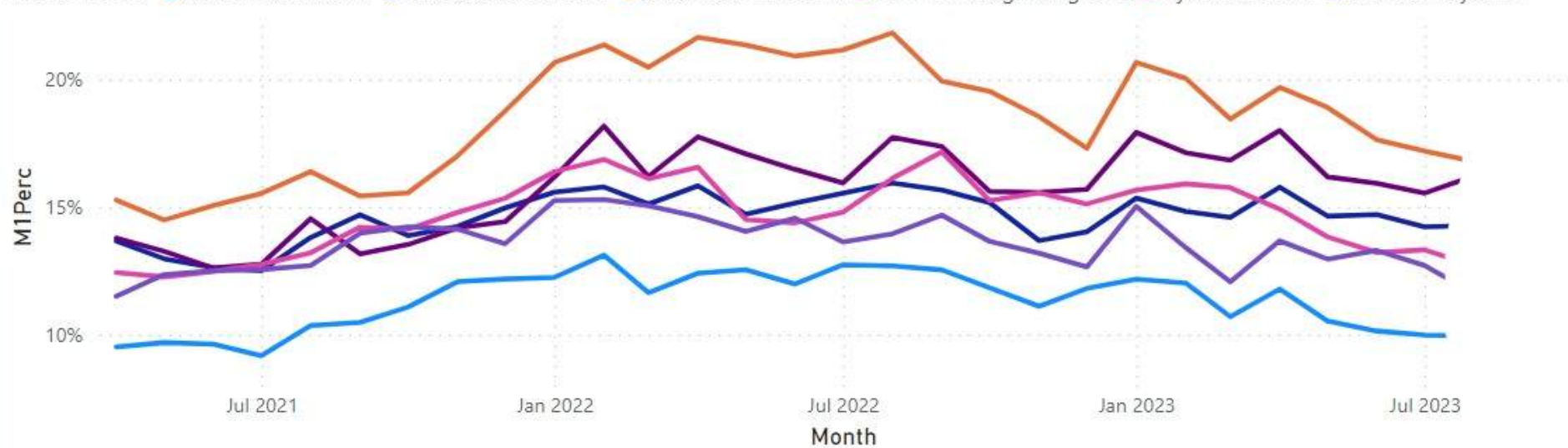
Delivery Unit  
Uned Gyflawni

| Month             | Aneurin Bevan UHB | Betsi Cadwaladr UHB | Cardiff and Vale UHB | Cwm Taf Morgannwg UHB | Hywel Dda UHB | Swansea Bay UHB | Total        |
|-------------------|-------------------|---------------------|----------------------|-----------------------|---------------|-----------------|--------------|
| 01 October 2023   | 8.2%              | 11.3%               | 13.0%                | 14.2%                 | 10.1%         | 9.8%            | <b>11.1%</b> |
| 01 September 2023 | 9.7%              | 13.8%               | 15.8%                | 15.2%                 | 12.4%         | 11.2%           | <b>13.0%</b> |
| 01 August 2023    | 9.9%              | 14.3%               | 16.8%                | 16.2%                 | 12.7%         | 11.6%           | <b>13.5%</b> |
| 01 July 2023      | 10.0%             | 14.2%               | 17.2%                | 15.5%                 | 13.3%         | 12.7%           | <b>13.6%</b> |
| 01 June 2023      | 10.1%             | 14.7%               | 17.6%                | 15.9%                 | 13.2%         | 13.3%           | <b>14.0%</b> |
| 01 May 2023       | 10.5%             | 14.6%               | 18.9%                | 16.2%                 | 13.8%         | 13.0%           | <b>14.3%</b> |
| 01 April 2023     | 11.8%             | 15.8%               | 19.7%                | 18.0%                 | 14.9%         | 13.7%           | <b>15.4%</b> |
| 01 March 2023     | 10.7%             | 14.6%               | 18.4%                | 16.8%                 | 15.8%         | 12.1%           | <b>14.5%</b> |
| <b>Total</b>      | <b>11.1%</b>      | <b>14.5%</b>        | <b>18.2%</b>         | <b>15.6%</b>          | <b>14.4%</b>  | <b>13.3%</b>    | <b>14.3%</b> |

**Please note:** There is a lag in the data of 1 to 2 months before it is fully reflective (~5% in the latest month and ~2% in the month prior).

## M1Perc by Month and Health Board

Health Board ● Aneurin Bevan UHB ● Betsi Cadwaladr UHB ● Cardiff and Vale UHB ● Cwm Taf Morgannwg UHB ● Hywel Dda UHB ● Swansea Bay UHB



[Change to Volume View](#)

Health Board

- Aneurin Bevan UHB
- Betsi Cadwaladr UHB
- Cardiff and Vale UHB
- Cwm Taf Morgannwg UHB
- Hywel Dda UHB
- Powys Teaching THB
- Swansea Bay UHB
- Velindre NHS Trust

# Percentage bed days with LoS >21 days

Percentage of total emergency bed days accrued by people with a length of stay over 21 days.

[Back to home](#)

[Clear all filters](#)



GIG  
CYMRU  
NHS  
WALES

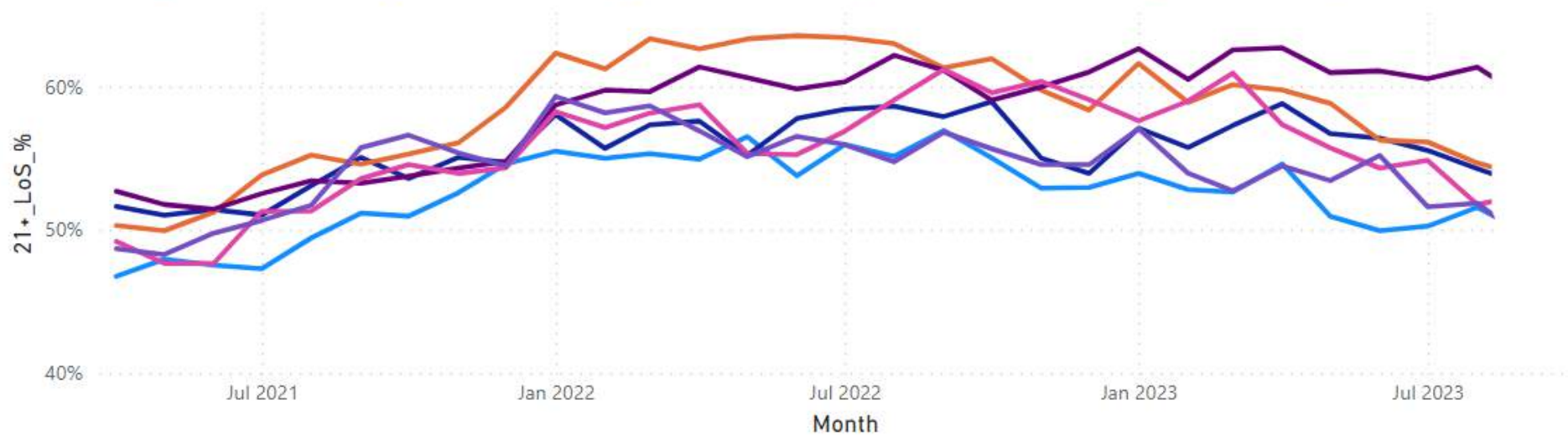
Delivery Unit  
Uned **Gyflwyni**

| Month             | Aneurin Bevan UHB | Betsi Cadwaladr UHB | Cardiff and Vale UHB | Cwm Taf Morgannwg UHB | Hywel Dda UHB | Swansea Bay UHB | Total        |
|-------------------|-------------------|---------------------|----------------------|-----------------------|---------------|-----------------|--------------|
| 01 October 2023   | 43.3%             | 47.1%               | 47.5%                | 59.5%                 | 44.6%         | 44.9%           | <b>48.5%</b> |
| 01 September 2023 | 49.8%             | 53.1%               | 53.7%                | 59.1%                 | 52.4%         | 49.3%           | <b>53.3%</b> |
| 01 August 2023    | 51.6%             | 54.3%               | 54.7%                | 61.3%                 | 51.8%         | 51.9%           | <b>54.7%</b> |
| 01 July 2023      | 50.2%             | 55.5%               | 56.1%                | 60.5%                 | 54.8%         | 51.6%           | <b>55.2%</b> |
| 01 June 2023      | 49.9%             | 56.4%               | 56.3%                | 61.1%                 | 54.3%         | 55.2%           | <b>55.8%</b> |
| 01 May 2023       | 50.9%             | 56.7%               | 58.8%                | 61.0%                 | 55.7%         | 53.4%           | <b>56.4%</b> |
| 01 April 2023     | 54.6%             | 58.8%               | 59.7%                | 62.7%                 | 57.3%         | 54.4%           | <b>58.2%</b> |
| 01 March 2023     | 52.6%             | 57.3%               | 60.1%                | 62.5%                 | 60.9%         | 52.7%           | <b>57.8%</b> |
| <b>Total</b>      | <b>52.3%</b>      | <b>55.4%</b>        | <b>58.1%</b>         | <b>58.7%</b>          | <b>55.3%</b>  | <b>54.1%</b>    | <b>55.7%</b> |

**Please note:** There is a lag in the data of 1 to 2 months before it is fully reflective (~5% in the latest month and ~2% in the month prior).

## 21+\_LoS\_% by Month and Health Board

Health Board ● Aneurin Bevan UHB ● Betsi Cadwaladr UHB ● Cardiff and Vale UHB ● Cwm Taf Morgannwg UHB ● Hywel Dda UHB ● Swansea Bay UHB



Powys and Velindre are included for completeness. Please press **Ctrl** + select the other health boards to view the benchmarked picture without these.

### Health Board

- Aneurin Bevan UHB
- Betsi Cadwaladr UHB
- Cardiff and Vale UHB
- Cwm Taf Morgannwg UHB
- Hywel Dda UHB
- Powys Teaching THB
- Swansea Bay UHB
- Velindre NHS Trust



|  |  |
|--|--|
| <b>DYDDIAD Y CYFARFOD:<br/>DATE OF MEETING:</b>      | 21 December 2023   |
| <b>CYFARFOD O:<br/>MEETING OF:</b>                   | Finance and Performance Committee                              |
| <b>TEITL YR ADRODDIAD:<br/>TITLE OF REPORT:</b>      | Stroke Improvement Plan  |
| <b>CYFARWYDDWR<br/>ARWEINIOL:<br/>LEAD DIRECTOR:</b> | Peter Carr, Executive Director of Therapies and Health Science |
| <b>SWYDDOG ADRODD:<br/>REPORTING OFFICER:</b>        | Rhys Monk, Directorate Manager for Stroke                      |

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

Er Sicrwydd/For Assurance

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

This paper is being brought to the committee to provide assurance on the progress of the Stroke Service Action Plan in response to the GIRFT (Getting It Right First Time) report commissioned in 2022. The report also references other reviews that have been undertaken since 2021, the 2021 Therapy Review and the 2023 HIW all-Wales Patient Flow Review and acts as an overarching ABUHB Stroke Improvement Plan.

**Cefndir / Background**

Over the past 12 months, the health board's stroke services have seen many opportunities, experienced significant challenges, and delivered substantial developments.

In 2022, the Medicine Division commissioned the GIRFT national team to undertake an assessment of its Stroke services which culminated in 20 recommendations (appendix a. GIRFT Report).





During the past year, there has been momentous change and upheaval that has highlighted the fragility of the service; a retirement of the Nevill Hall Consultant, difficulty recruiting into both Consultant and AHP (Allied Health Professional) roles, several key CNS (Clinical Nurse Specialist) taking maternity leave and well as immense pressure on an already stretched and stressed workforce.

The service is currently undergoing an urgent service change to consolidate rehabilitation services on one site, based at YYF (Ysbyty Ystrad Fawr) to concentrate its remaining resource. However, despite these challenges, progress has been made on the GIRFT recommendations.

In addition to the GIRFT Report, there have been other reviews and assessments of the Stroke service; The 2021 Therapy Review (appendix b.) and 2023 HIW (Healthcare Inspectorate Wales) Patient Flow Review (appendix c.). The ABUHB management response to the 2023 HIW review was submitted as required (appendix e.).

To ensure that ABUHB (Aneurin Bevan University Health Board) has a consistent improvement plan, care has been taken to integrate these three reviews into one wide ranging improvement plan.



## Asesiad / Assessment

The final report from the GIRFT team was received in September 2022 and is attached as Appendix a. The report includes a total of 20 short- and medium-term recommendations, from which the key priorities are seen to be as follows:

- Provide supernumerary specialist stroke nurse presence at GUH (Grange University Hospital) on a 24/7 basis to ensure ownership and direction of the stroke patient pathway
- Enhance pre-hospital notification arrangements to ensure elimination of avoidable delays at the front door
- Increase thrombolysis rates to be consistently within agreed national norms
- Raise organisational priority for patients gaining access to the acute stroke unit within four hours
- Widen range of workforce options / competence to ensure 24/7 ability to perform swallow assessments
- Review rehabilitation / early supported discharge pathway, with emphasis on seven-day access to therapies, (this being considered likely to involve utilising fewer rehabilitation sites in the Health Board)
- Ensure robust arrangements for patient review six months post-discharge
- Support development of clinical leadership for the service

A complete update of the status of each recommendation is referenced in the attached document: (appendix d. GIRFT Action Tracker)

To summarise the contents of the referenced appendices, of the 20 recommendations, five of these have been completed and are now within specified ranges for deliverables. These are:

| Action  | Measurement                         |
|---|-------------------------------------|
| <b>Action 1:</b> Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP (Sentinel Stroke National Audit Program) data for clinical assurance.                     | SSNAP Rating: A (90%+) <sup>□</sup> |
| <b>Action 3:</b> Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB (Aneurin Bevan University Health Board) to embed the Optimal Stroke Imaging pathway. The use of first line MRI (Magnetic Resonance Imaging) for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. | SSNAP Rating: A (90%+) <sup>□</sup> |
| <b>Action 6:</b> Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.  | 17.00% <sup>1</sup>                 |
| <b>Action 17:</b> Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.   | 96.40% <sup>2</sup>                 |
| <b>Action 18:</b> Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.   | 97.00% <sup>3</sup>                 |

<sup>1</sup> Data referenced: SSNAP Quarterly Report April - Jun '23

<sup>2</sup> Data referenced: SSNAP Quarterly Report April - Jun '23

<sup>3</sup> Data referenced: [Dashboard and Observations \(sharepoint.com\)](#)



Further to these recommendations, there are an additional 10 that are ongoing. These nine recommendations are noted in table a. below grouped into two categories, those actions that are improving well under current arrangements, and those that require additional support.

**Table a. Ongoing implementation, improving under current arrangements**

| Action   | Progress  |
|--|---|
| <b>Action 5:</b> Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging should help to release bed capacity and increase access.  | This metric is currently 75% compliant, and with planned developments to the rehabilitation pathway this metric is projected to increase due to the Stroke Teams having more influence over patient movement between HASU and YYF Rehabilitation wards.   |
| <b>Action 7:</b> Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.  | Funding has been confirmed for 5 WTE (Whole Time Equivalent) CNS posts and posts have been filled on a substantive basis, despite challenges due to substantial amounts of maternity leave this situation is expected to improve starting from November 2023 as staff return.   |
| <b>Action 8:</b> Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.   | Engagement sessions have been undertaken with ED teams and training is being cascaded starting from December 2023. The metric is currently 47% compliant and expected to increase as more staff can carry out this assessment.  |
| <b>Action 11:</b> Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways. | <p>The CNR Service includes a Living Well after Stroke Service which offers self-referral to all people living in ABUHB with stroke and their families.</p> <ul style="list-style-type: none"> <li>➤ Initial Assessment</li> <li>➤ Low level emotional support</li> <li>➤ A personalised Co-produced Stroke Recovery Plan</li> <li>➤ Professional referrals including communication, counselling, exercise programmes and social prescribing</li> <li>➤ Advice on practical matters including navigating the social care and benefits system</li> <li>➤ Advice on preventing the reoccurrence of stroke</li> <li>➤ Support to carers needs such as their own health and wellbeing, access to peer support</li> <li>➤ Regular informal reviews</li> <li>➤ Access to a range of bespoke stroke recovery specific groups including Fatigue management, understanding my stroke, Acceptance and Commitment, Communication Groups, walking groups, Neuro@NERS gym-based exercise groups</li> <li>➤ Participants are encouraged to form informal support networks and we have several examples of this becoming self-sustaining for longer term support</li> </ul> <p>We are supporting people to become peer mentors and have commenced in reach to the YYF Site of 2 people with lived experience of stroke</p> |
| <b>Action 12:</b> Embed the National Stroke Service Model in ABUHB   | This model will naturally be implemented as the service seeks to consolidate its rehabilitation service into one  |



|  |  |
|--|--|
|  | site, concentrating resources to provide a more robust service.  |
| <b>Action 15:</b> Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach. | There is a psychology service in ABUHB which provides 3 in reach sessions per week to the Stroke Rehab Wards [ 1 per ward] This is delivered by 3 Clinical Psychologists an Assistant Psychologist and a Trainee psychologist. People are supported during their hospital stay and followed up by the psychology team once they are at home for intervention and support on a 1:1 basis or where appropriate through a range of psycho-educational group interventions. The psychology team run regular consultations with the inpatient and community therapists to support them in managing people with cognitive and emotional issues after stroke. |
| <b>Action 16:</b> ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.   | This data is being captured in the WNCR (Welsh Nursing Care Record) and is regularly monitored. A Dashboard needs to be created from this data to be provided to ward to allow the nursing teams to allow them to report by exception.   |

**Table b. ongoing implementation, requires additional intervention**

| Action  | Progress   |
|---|--|
| <b>Action 4:</b> ABUHB to develop a strategy to improve direct access to the stroke unit within 4 hours of presentation.  | This metric is consistently rated E by SSNAP reports and will require executive support to ringfence HASU (Hyper Acute Stroke Unit) and Stroke Rehabilitation beds to preserve patient flow through ED (Emergency Department) to HASU through to Rehabilitation wards.   |
| <b>Action 13:</b> Ensure 7-day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.   | The latest guidance has moved away from the 45 minutes of Therapy and now suggests 3 hours of combined motor recovery rehabilitation per day. This will not just be delivered by Therapists but will have an overall contribution from all ward staff on a ward with an enabling rehabilitation ethos.   |
| <b>Action 14:</b> The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT (Speech and Language Therapy), embracing a capability framework of competency [Stroke Educational Framework <a href="https://stroke-education.org.uk/">https://stroke-education.org.uk/</a> ]. | The current Therapies commissioned staffing for stroke across all professions is 51% below minimum National Standards. Therefore, delivery of a 5-day service is extremely challenging and without significant financial investment 7-day service provision remains unachievable. A Therapies Staffing review was undertaken in 2021 but there has been no change in the commissioned stroke staffing since that review. |

There are then five final recommendations that are awaiting completion of other actions before they can commence. These are:

| Action   | Reason that action is not started                               |
|--|---|
| <b>Action 2:</b> Commission an ESD (Early Support Discharge) pathway process flow map, it is only after full mapping of a needs based ESD (Early Support Discharge) pathway or Integrated Community Stroke | Awaiting completion of Rehabilitation reconfiguration Nov 2023. |



|   |   |
|---|---|
| <p>Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.</p>  |   |
| <p><b>Action 9:</b> ABUHB to put a cohort of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.</p>  | <p>Awaiting confirmation/identification of suitable and appropriate session.</p>  |
| <p><b>Action 10:</b> Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support</p>  | <p>Awaiting completion of Rehabilitation reconfiguration Nov 2023.</p> <p>Currently CNRS (Community Neurological Rehabilitation Service) offers up to 12 weeks of specialised stroke rehab in the early Supported stroke discharge pathway to people with mild /moderate physical and communication impairment</p> <p>After the 12 weeks people are supported to access specialised Neurophysiotherapy outpatient services AND/OR access the Neuro@NERS exercise rehab programme which has stroke specialised support workers and a Neurophysiotherapy from CNRS (Community Neurological Rehabilitation Service) attending sessions to provide expert support and exercise modification</p> <p>After the 12 weeks anyone with ongoing complex communication needs is supported with integrating their communication impairment via the Living Well after stroke service</p> <p>The psychology service supports people in the longer term where clinically indicated</p> |
| <p><b>Action 19:</b> Ensure this evidence-based bundle of care (nurse and therapist &lt;24hrs, all relevant therapists &lt;72 hrs, rehab goals agreed &lt; 5days) is more consistently delivered. Improve documentation of MDT (Multi-Disciplinary Team) goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5-day rota.</p> | <p>Awaiting completion of Rehabilitation reconfiguration Nov 2023.</p> <p>A 5-day service provision will be unchanged without significant financial investment to be able to increase to a 7-day service which will continue to impact on the ability to achieve some of the goals around seeing patients within 72 hours. Ward reconfiguration and the colocation of rehabilitation services to a single site will be a priority, once complete standardising the approach for MDT (Multi-Disciplinary Team) goal setting etc will be part of ongoing pathway reconfiguration work.</p>  |
| <p><b>Action 20:</b> Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.</p>   | <p>Action has been on hold until appointment of full CNS team. Reviews are expected to begin when the team has been restructured starting from Q4 2023/24.</p>  |

This summary clearly shows that work is still ongoing to implement all the GIRFT recommendations, with the upcoming reconfiguration plans playing a significant part in facilitating progress with the final six recommendations. Progress updates





continue to be a standing agenda item for the Stroke Service Delivery Group, chaired by the Executive Director of Therapies and Health Science.

The attached charts (appendix f.) taken from the NHSDU Stroke Resources page which measures various KPIs (key performance indicators) and provides context across Wales show definitive improvements in many of the key metrics that indicate safe and effective Stroke care. Recognising that whilst there is still some way to go until the health board improves all metrics, considerable progress has been made.

Appendix a.  
**GIRFT Report.**



RNOH\_GIRFT\_ABUH  
B Stroke Report\_Fin:

Appendix b.  
**2021 Therapy Review**



Review%20of%20Th  
erapy%20Stroke%20

Appendix c.  
**2023 HIW Patient Flow Review**



31082023 - Patient  
flow - Final brandec

Appendix d.  
**GIRFT Action Log.**

Appendix e.  
**HIW Patient Flow Review – ABUHB response**

Appendix f.  
**NHSDU Stroke Resources Summary for ABUHB (Sept. 22 to Aug. 23).**





## Argymhelliad / Recommendation

The Committee is asked to

- Note the assurance from this paper that progress and focus is still very much on the GIRFT recommendations, and the additional recommendations from the recent HIW all-Wales review, and that actions that have been taken to implement specific recommendations have shown improvements in many key performance indicators, indicative of good Stroke care across the pathway.

### Amcanion: (rhaid cwblhau) Objectives: (must be completed)

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:  
Datix Risk Register Reference and Score:

Safon(au) Gofal ac Iechyd:  
Health and Care Standard(s):

- Safe Care
- 3.1 Safe and Clinically Effective Care  
Choose an item.  
Choose an item.



|   |   |
|---|---|
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br><a href="#">Link to IMTP</a>  | Adults in Gwent live healthily and age well   |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP  | Experience Quality and Safety   |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br><a href="#">Strategic Equality Objectives 2020-24</a> | Improve patient experience by ensuring services are sensitive to the needs of all and prioritise areas where evidence shows take up of services is lower or outcomes are worse<br><br>Choose an item.<br>Choose an item.<br>Choose an item. |

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

| <b>Effaith: (rhaid cwblhau)<br/>Impact: (must be completed)</b>  |   |
|--|---|
|  | <b>Is EIA Required and included with this paper<br/>No does not meet requirements</b>   |
| <b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b>   | An EQIA (Equality Impact Assessment) is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change.<br>If you require advice on whether an EQIA is required contact <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a> |
| <b>Deddf Llesiant Cenedlaethau'r Dyfodol – 5 ffordd o weithio Well Being of Future Generations Act – 5 ways of working</b> | Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs<br>Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives  |





<https://futuregenerations.wales/about-us/future-generations-act/>

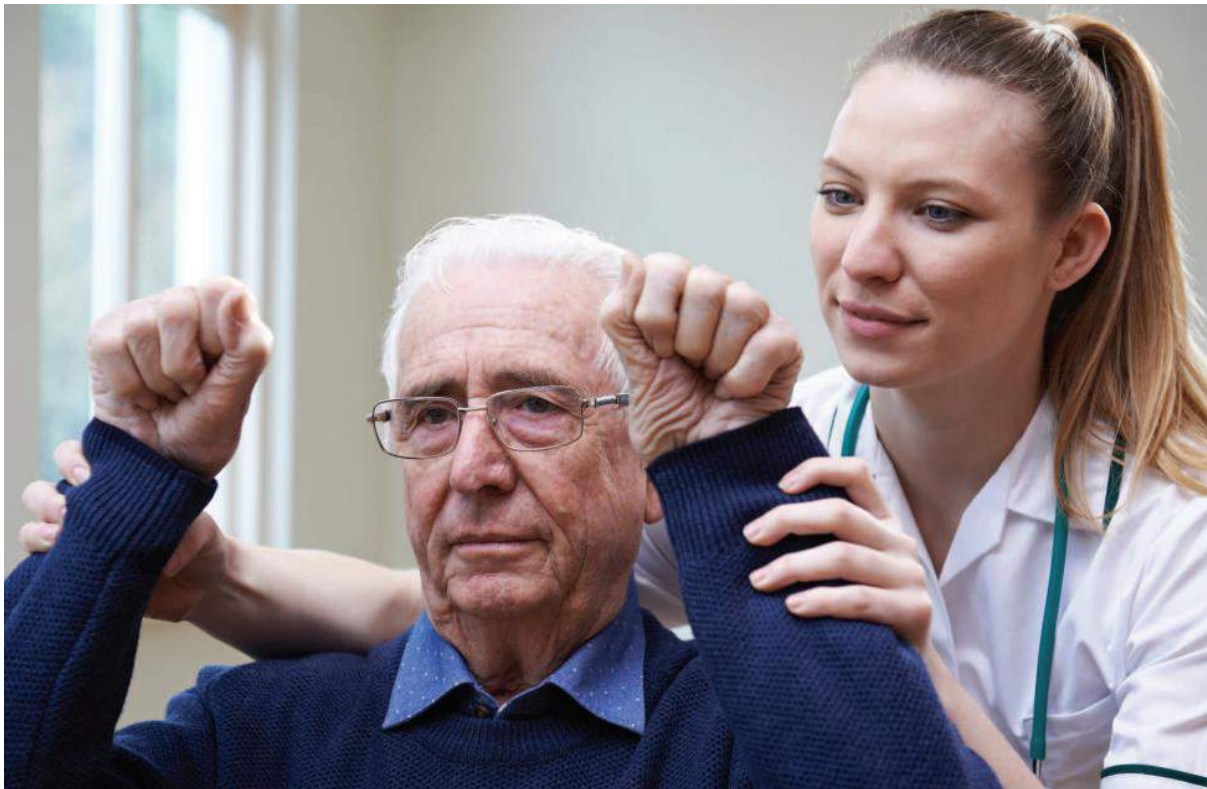


# GETTING IT RIGHT FIRST TIME

## Stroke Medicine Review Report

### Aneurin Bevan University Health Board

### September 2022



*This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT), in collaboration with the Wales Planned Care Board team. It aims to identify improvements in stroke services at ABUHB to help them ensure best outcomes for patients, by reducing unwarranted variation and maximising the use of existing resources and assets.*

Written by:

**Dr David Hargroves** Consultant Stroke Physician, East Kent Hospitals University Foundation Trust (EKHUFT), Clinical lead for Stroke, EKHUFT & South East (Wessex, BOB, Kent, Surrey and Sussex) for NHSE/I, National Speciality Adviser for the National Stroke Programme for NHSE, National Clinical Lead for Stroke (GIRFT) for NHSE/I and;

**Dr Deb Lowe**, Consultant Stroke Physician & Geriatrician Wirral University Teaching Hospital, National Clinical Director for Stroke Medicine – NHSE&I, Senior Clinical Advisor for Stroke Medicine – NHSI GIRFT Programme

## Table of Contents

|  |    |
|--|----|
| <b>1. Introduction</b> .....   | 4  |
| <b>2. Background</b> .....   | 4  |
| <b>3. Aneurin Bevan University Health Board</b> .....  | 5  |
| <b>3.1. ABUHB and Its People</b> .....   | 6  |
| <b>4. Service Overview</b> .....   | 6  |
| <b>4.1. Nevill Hall Hospital</b> .....   | 9  |
| <b>4.2. Ysbyty Ystrad Fawr</b> .....   | 11 |
| <b>4.3. Royal Gwent Hospital</b> .....   | 12 |
| <b>4.4. The Grange University Hospital</b> .....   | 14 |
| <b>5. SSNAP Data Performance Metrics: Findings and Recommendations</b> .....                             | 15 |
| <b>5.1 Stroke Activity and Performance</b> .....   | 16 |
| <b>5.2 SSNAP Patient-Centred Data (routinely admitting teams)</b> .....                                  | 16 |
| <b>5.3 Admission to record start</b> .....   | 17 |
| <b>5.4 Delay (days) between clock start and date of starting electronic SSNAP record</b> .....           | 17 |
| <b>5.5 Patents discharged with ESD or CRT</b> .....  | 18 |
| <b>6. Hyper-Acute Stroke Pathway SSNAP Performance Metrics</b> .....                                     | 19 |
| <b>6.1 Percentage of patients scanned within 1 hour of clock start</b> .....                             | 19 |
| <b>6.2 Clock start to stroke time</b> .....  | 20 |
| <b>6.3 Stay on stroke unit</b> .....   | 20 |
| <b>6.4 Thrombolysis rate (all stroke)</b> .....  | 21 |
| <b>6.5 Clock start to thrombolysis</b> .....   | 22 |
| <b>6.6 Median time between clock start and being assessed by stroke nurse</b> .....                      | 22 |
| <b>6.7 Specialist consultant assessment - % assessed by stroke consultant within 14hrs</b> <sup>23</sup> |    |
| <b>6.8 Specialist consultant assessment – Time between clock start and being assessed</b> .....          | 23 |
| <b>6.9 Swallow screen within 4 hours</b> .....   | 24 |
| <b>6.10 Swallow Screen within 72hrs of clock start</b> .....   | 24 |
| <b>6.11 Antibiotics for newly acquired pneumonia</b> .....   | 25 |

|  |    |
|--|----|
| <b>7. MDT Working</b> .....  | 25 |
| <b>7.1 Applicability and minutes of OT</b> .....                         | 27 |
| <b>7.2 Clock start to OT assessment time</b> .....                       | 27 |
| <b>7.3 Applicability and minutes of physiotherapy</b> .....              | 28 |
| <b>7.4 Clock start to physiotherapy assessment time</b> .....            | 28 |
| <b>7.5 Applicability and minutes of SALT</b> .....                       | 29 |
| <b>7.6 Clock start to SALT assessment time</b> .....                     | 29 |
| <b>7.7 Applicability and minutes per day of psychology</b> .....         | 30 |
| <b>7.9 Nutrition screening and seen by dietician at discharge</b> .....  | 32 |
| <b>7.10 Mood and cognition screening by discharge</b> .....              | 32 |
| <b>7.10 Nursing therapy and rehab goals</b> .....                        | 33 |
| <b>7.10 Joint health and social care plan by discharge</b> .....         | 34 |
| <b>7.11 Discharged with a named contact</b> .....                        | 34 |
| <b>7.12 Patients applicable for a 6-month assessment</b> .....           | 34 |
| <b>7.13 Applicable patients receiving 6-month assessments</b> .....      | 35 |
| <b>8. Secondary prevention</b> .....                                     | 36 |
| <b>8.1 If in atrial fibrillation, discharged on anticoagulants</b> ..... | 36 |
| <b>9. Summary of Recommendations</b> .....                               | 36 |

## 1. Introduction

Getting It Right First Time (GIRFT) is a national programme designed to improve patient care, by reducing unwarranted variations in clinical practice. GIRFT helps identify clinical outliers and best practice amongst providers, highlights changes that will improve patient care and outcomes and delivers efficiencies (such as the reduction of unnecessary procedures) and cost savings.

Working to the principle that a patient should expect to receive equally timely and effective investigations, treatment and outcomes wherever care is delivered, irrespective of who delivers that care, GIRFT aims to identify approaches from across the NHS that improve outcomes and patient experience.

The ambition of the programme in Aneurin Bevan UHB is to identify examples of innovative, high quality and efficient service delivery as well as identifying areas of unwarranted variation in clinical practice and/or divergence from the best evidence-based care. RNOH/GIRFT worked closely with the National Clinical Lead for Stroke in Wales, Dr Shakeel Ahmad, to ensure that this project is aligned with the Wales Stroke Strategy.

## 2. Background

The GIRFT Projects Directorate at the Royal National Orthopaedic Hospital (RNOH/GIRFT) was approached by the Aneurin Bevan University Health Board (ABUHB), to conduct a review of their Stroke services using the GIRFT methodology, with the aim to support the Health Board with effective delivery, structure and performance of their stroke services.

This Programme of work is split into three phrases:

- 1) RNOH/GIRFT delivered a summit meeting on Thursday 27<sup>th</sup> January 2022 to provide colleagues from ABUHB with an overview of the GIRFT Programme and the GIRFT stroke workstream in England and to explain the principles and approach of the stroke programme planned for ABUHB.
- 2) The RNOH/GIRFT team visited all four stroke units in ABUHB on 11<sup>th</sup> May 2022; Nevill Hall Hospital (NHH), Ysbyty Ystrad Fawr (YYF), Royal Gwent Hospital (RGH) and The Grange University Hospital (GUH). A deep dive review and feedback meeting was conducted at GUH with key stroke staff attending either in person or joining virtually from the other three sites that had been visited earlier in the day.
- 3) Once this report has been delivered and the recommended actions made clear, the GIRFT Stroke Clinical Leads will hold a series of virtual monthly implementation support meetings. The purpose of these meetings will be to support and challenge the ABUHB clinical, operational and analytical teams to implement the recommendations from this report and to leave a legacy of sustainable quality improvement.

This document captures the key findings and recommendations arising from the visit to ABUHB by Dr David Hargroves and Deb Lowe on the 11<sup>th</sup>, May 2022. We are extremely grateful to all those who attended our visit and gave such open and honest feedback.

This report is a companion document to the Health Board Provider Level SSNAP Datapack. Many of the process markers of performance used in the GIRFT stroke analysis come from The Sentinel Stroke National Audit Programme (SSNAP). This is a major national healthcare quality improvement programme based formerly at the Royal College of Physicians (RCP) in

London, now housed within the School of Population Health and Environmental Studies at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is a single source of stroke data in England, Wales, and Northern Ireland. It measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards, including the 2016 National Clinical Guideline for Stroke.

### **3. Aneurin Bevan University Health Board**

The Aneurin Bevan University Health Board (ABUHB), which was established on the 1st October 2009, covers the areas of Blaenau Gwent, Caerphilly, Monmouthshire, Newport, Torfaen and South Powys and services a population of 600,000 and has approximately 850 stroke admissions per year. It employs over 14,000 staff, two thirds of whom are involved in direct patient care. There are more than 250 consultants in a total of over 1000 hospital and general practice doctors, 6,000 nurses, midwives, allied professionals and community workers.

ABUHB has a new specialist and critical care centre, the Grange University Hospital (GUH), which opened in November 2020, has 560 beds and features a 24-hour Acute Assessment Unit, Emergency Department and Helicopter Pad. It provides a 24/7 Emergency Service for patients that need specialist and critical care. Upon opening, GUH became the only Hyper Acute Stroke Unit in ABUHB, taking over this role from the Royal Gwent Hospital (RGH), based in Newport. RGH is one of three enhanced Local General Hospitals operating in ABUHB, the others being Nevill Hall Hospital (NHH), in Abergavenny, and Ysbyty Ystrad Fawr (YYF) in Ystrad Mynach. Each of the Local General Hospitals provides therapy and rehab services for stroke patients. Most patients are admitted via the Flow Centre to GUH for their acute phase of care. Any self-presenters at the ELGHs or patients who have had a stroke whilst on an ELGH site are assessed and depending on clinical presentation are almost always "drilled and shipped" to GUH.

There are also Community Hospitals and facilities which were not included in this review but may care for some patients once they have completed their stroke pathway and awaiting discharge as a step-down facility. These are:

- 1) St Woolos Hospital (Newport) 'Ruperra' ward and formally dedicated to Stroke Rehabilitation. However, when GUH opened this ward moved to the ELGH and is now a community ward.
- 2) County Hospital (Pontypool) this hospital receives patients who normally reside in Torfaen, from both the Royal Gwent and Neville Hall Hospitals for rehabilitation after stroke,
- 3) , provide some community based inpatient stroke rehabilitation services.
- 4) Monnow Vale, (Monmouth) provides community based inpatient rehabilitation, not specifically for stroke patients
- 5) Ysbyty Aneurin Bevan (Ebbw Vale) provides community based inpatient rehabilitation, not specifically for stroke patients
- 6) County Hospital (Pontypool) community based inpatient rehabilitation, not specifically for stroke patients



### 3.1. ABUHB and Its People

The strength of a National Health Service is in its people. The power of an organisation is so often in the loyalty, dedication, shared purpose and clear vision of its staff to deliver the best care they can and to always put the patient at the centre of everything they do. We were impressed by the culture and leadership at all the hospitals, which became evident within a few minutes of meeting the multi-disciplinary teams.

We also witnessed frustration and fatigue; to be expected at the end of a two-year pandemic, but this ran deeper and relates to a longer duration than the pandemic as it was clear that many felt unable to influence change within their organisation, yet still were willing and able to speak up and express their desire to drive the necessary changes forward.

We were told that the workforce challenges throughout NHS Wales are significant across medical, nursing and therapy teams, but are particularly marked in some of the ABUHB hospitals. [BASP-Stroke-Medicine-Workforce-Requirements-Report](#) and the <https://www.hee.nhs.uk/our-work/hee-star> are useful benchmarking tools which the ABUHB stroke team may wish to use to address these workforce challenges.

There is good evidence for working within networks and we were very pleased to hear that the Welsh Stroke Strategy looks to support the development of stroke networks across Wales, to share knowledge, information, facilitate inter-organisational collaboration and learning and manage change. This will require excellent leadership, and we were impressed to see so many natural leaders across the professions whose skills need to be harnessed to support delivery of high-quality care.

### 4. Service Overview

The following Service Overview was provided by ABUHB prior to the meeting and discussed during the deep dive session. Additional information was gathered in the pre-visit virtual meeting and in the meetings with staff on the day.

| SERVICE OVERVIEW – Aneurin Bevan University Health Board |   |  |  |   |
|--|---|--|--|---|
| 1  | <b>Population served</b>                              | Total Number: 600,000 in ABUHB   |  |   |
| 2  | <b>Hospital beds in total in individual hospitals</b> | Where based and Total Number: 1217<br>RGH 218            NHH 212<br>YYF 227            GUH 560   |  |   |
| 3  | <b>Stroke beds</b>                                    | Number of beds<br>Stroke Rehab RGH 24<br>Stroke Rehab NHH 22<br>Stroke Rehab YYF 15<br>Hyper Acute Stroke<br>GUH 12+ 3 general<br>medicine | Base and No. of<br>Hasu=1 HASU<br>GUH HASU 12<br>beds specifically<br>for HASU the ward<br>is 15 bedded with<br>the additional 3<br>beds used for GM<br>patients |   |
| 4  | <b>Stroke Consultants</b>                             | Number per site<br>RGH- 1 Consultant<br>NHH – 1 consultant<br>YYF – 1 consultant<br>GUH – 4 consultants                                    | Number On-Cal<br>8<br><br>Stroke-only  | Further detail: i.e. 5/7 or<br>7/7 service<br>1:8 |



|   |                             |   |  |  |
|---|-----------------------------|---|--|--|
|   |                             | Total DCC's:45,   | Consultants on-call:   |  |
| 5 | <b>Stroke Nurses</b>        | WTE Number<br>4   | Hours of Cover<br>7am -5pm   | Plans in discussion for 12 hour cover when vacancies filled and staff trained. |
| 6 | <b>Stroke Ward Staffing</b> | Registered Nurses:<br>3 day<br>3 night<br>Health Care support:<br>3 day<br>3 night<br>Nursing Bands:<br>Band 6 x2<br>Band 5<br>Band 3<br>Band 2 | Therapists:<br><br>SLT 0.7WTE<br>dedicated SLT for HASU<br><br>1WTE SLTA FOR HASU<br>(No other sites have stroke specific staff. Only able to provide 4 day dysphagia cover.<br><br>Occupational Therapists:<br>GUH 0.8WTE<br>BAND 7, 0.6<br>BAND 6<br>RGH= 1 WTE<br>BAND 7, 1WTE<br>BAND 6, 1WTE<br>B5, 1WTE BAND4<br>1 WTE B3<br>NHH: 0.8 WTE<br>BAND 6, 1WTE<br>BAND 5, 0.8 WTE<br>BAND 4<br>YYF: 1WTE BAND 6, 1WTE BAND5<br>1WTE BAND 3<br>AND 0.8 WTE<br>BAND 8A<br>FLOATING<br><br>Physiotherapist:<br><br>GUH 2 WTE<br>YYF 2.5 WTE<br>RGH 3.6WTE<br>NHH 3.3 WTE | Extra Detail:<br>1 ward manager, supernumerary to numbers by day (M-F)         |
| 7 | <b>Psychology</b>           | 1 WTE Psychologist for Stroke<br>1 WTE Assistant  |  | Based in Community Neuro rehab service but in reach to wards and               |

|     |   |   |  |  |
|-----|---|---|--|--|
|     |   | psychologist for Stroke<br>1 WTE Consultant<br>psychologist for Stroke<br>and Neurological<br>conditions  |  | provide life after stroke<br>psychology service<br>through 1:1 interventions<br>and group based<br>psychoeducational<br>modules  |
| 8   | <b>ESD and<br/>community<br/>stroke rehab<br/>Service</b>               | 5 days<br>Cover 0800-1700   | Speech Therapy<br>1.2 WTE<br>OT 3.2 WTE<br>Physio 2.8 WTE<br>Dietitian 0.4 WTE<br>Therapy Assistant<br>Practitioner: 5.6<br>WTE<br>Life after Stroke<br>Wellbeing<br>practitioners: 1.8<br>WTE | Extra detail: 1 physio is<br>also Team Lead so has<br>0.3 WTE dedicated to<br>managerial role.<br><br>All patients can access<br>the service based<br>Niwrostiwt Neuro<br>Recovery College which<br>delivers education on<br>common stroke issues<br>and opportunities for<br>personal recovery. |
| 9   | <b>6/52 and 6/12<br/>Review Process</b>                                 | 6 weeks follow up consultants<br>6/12 is completed by CNS   |  |  |
| 10  | <b>Stroke imaging</b>   | Access to CTA: hours / per day 24 hours a day<br>Access to CTP: hours / per day 0 Hours a day<br>Access to AI: Y/N Not available But funding been approved the<br>Welsh Government recently<br><b>Access to MRI first line for acute stroke and TIA patients?:</b><br><b>There are no dedicated slots for stroke and TIA but this is</b><br><b>available daily.</b><br><b>Current waiting for TIA imaging. MRI two weeks, CT one week,</b><br><b>Carotid doppler one week.</b><br><b>Inpatient CT 10 min to 1 hour, MRI 2 to 24 hours (same day 60%,</b><br><b>next day 40 %), MRI Scans requested after 3 pm mostly done</b><br><b>next day.</b><br>Modality used for carotid imaging? Carotid Doppler |  |  |
| 11. | <b>Relationship with<br/>IAT Centre &amp;<br/>Hours of<br/>Service:</b> | Please describe: Bristol South meads 8am to 6 Pm 7 days a week  |  |  |

Most of this report focuses on the performance and data we have for ABUHB's hyper-acute stroke service, as the GIRFT methodology relies heavily on the use of data to drive improvement. This, however, is only one part of the complex pathway of stroke care within this hospital group. It was important to the visiting team to understand the flow, the facilities, and the people within the three surrounding stroke units to enable a rounded discussion at the deep dive meeting held at GUH and to support the development of strategic and quality improvement recommendations.

#### 4.1. Nevill Hall Hospital



*The NHH Rehab Team*

Nevill Hall Hospital (NHH) in Abergavenny has 213 inpatient beds and a wide range of services including a 24/7 nurse led minor injuries unit and a medical assessment unit.

The stroke ward at NHH had 28 beds when we visited, 24 beds were funded and 21 of these were stroke beds; the remaining were general care of the elderly beds. The team informed us that on average, 20% of the beds were occupied by acute stroke admissions; these patients don't get entered in to SSNAP as this hospital is not classed as a routinely admitting stroke unit. The model in ABUHB is that all patients should come through the Flow Centre for admission at the GUH not ELGHs. There is access to thrombolysis 24/7 and a 'drip and ship' model is employed with some but not all patients moving to The Grange for their hyper-acute stroke care. The length of stay was reported to be 42 days. As the ward is mixed, this figure also included patients classed as "General Medicine and Care of the Elderly".

There are two medical consultants that support the unit, one substantive and one locum consultant that is going through the Certificate of Eligibility for Specialist Registration (CESR) route. The medical lead at this ward is very clearly a highly valued member of the team and there was a positive inclusive culture felt on the ward. The ward has two foundation doctors and one CMT doctor during the week. There had been two experienced Clinical Nurse Specialists supporting the ward on a pro-rata basis that had moved to the Grange when the HASU was centralised in 2021. These posts have not been backfilled on the ELGH sites. We were pleased to hear that ABUHB had recruited two new Nurse Consultants in other areas so there could be scope to develop similar roles in Stroke

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was a very high level of neuro-rehabilitation expertise within the group of senior therapists that we were able to meet. Of note there was only 0.6 WTE dysphagia trained Speech and Language Therapy provision. At the time of the review, it was reported that there was no psychology support but in theory there is usually 4 hours

per week of support for inpatients. The role of rehabilitation assistants was recognised and their ability to support 7 day working with the correct supervision was supported.

Access to Early Supported Discharge (ESD) and Community Rehabilitation Teams (CRT) was variable. There was usually at least a 1 week wait to access 'ESD' and there was no enablement/domiciliary care included within the commissioned service. The ESD responds to received referrals within 1 day of discharge Monday – Friday. Contact is via telephone triage – if same day assessment is indicated, it is available (staffing challenges may sometimes affect this). If same day assessment is not indicated, we target the right profession to complete the assessment – this approach is based on the Malcolmess Care Aims intended outcomes framework and aims to get the right person out to assess at the right time. This allows stroke survivors to settle at home and explore their new functional status so that when we assess they are able to identify hopes and goals in a more meaningful way than they can on the first day home from hospital when they are often very tired and just needing time. The pathway was commissioned for 3 months, but this could be extended based on patient need. If a patient was discharged to a nursing home, there appeared to be less access to specialist stroke rehabilitation. The ESD team works with people for up to 3 months (average 8 weeks). If ongoing support is required, this is arranged through outpatient physio/SLT services. The clinical psychology team support over a longer time frame up to and over one year.

Social work support is locality based and can be variable with significant delays for packages of care. It is not unusual to wait 4 weeks for a larger package of care and even longer delays for nursing home placements.

There had previously been a commissioned Stroke Association Family and Carer support worker service across ABUHB, but this service had been decommissioned. Following the end of the commissioned stroke association service, Life-After Stroke support is provided through 2 Life after Stroke wellbeing practitioners who are embedded in the Community Neuro Rehab Service. The recently appointed 2 practitioners will support anyone who has had a stroke in the past year and provides face to face, telephone and virtual support as appropriate. The service sends a letter and leaflet contact for people to request support. The service will also in reach to the stroke units if in reach support is requested by the ward staff.

The estates at Nevill Hall were sub-optimal for delivery of effective rehabilitation. There was inadequate therapy space and no quiet space for speech and cognitive assessments. Toilet facilities were mixed sex, and you could not enable patients requiring a hoist for transfer to use the bathrooms. Some of the environmental constraints within this ward could be addressed by returning the ward to 24 funded beds and utilising the released space to address the above concerns.



## 4.2. Ysbyty Ystrad Fawr



*The YYF Rehab Team*

Ysbyty Ystrad Fawr (YYF) in Hengoed has 164 inpatient beds and has a Minor Injuries Unit, medical assessment unit included within its services. It has 30 rehabilitation beds, 15 of which are usually occupied by stroke patients. It was reported that the length of stay is approximately 42 days on this ward. At times the stroke ward may be occupied with more General Medical or Care of the Elderly patients so the length of stay will be affected by this. It was also reported that it was unusual for acute stroke patients to present to this hospital and only a handful of patients had been transferred to The Grange by 'drip and ship'. This is because all patients are managed through the flow centre and directed to the GUH. Stroke patients are referred from the HASU at GUH into this unit for rehabilitation. This makes flow management and discharge planning difficult, as the ward works with multiple locality social work teams and different commissioned community CRT services and one ESD team. There seemed to be a lack of a commissioned pathway for complex neurological rehabilitation.

There is a single-handed consultant who is job planned to deliver 6 PAs to support the service and there has been a Stroke Consultant vacancy at this site for almost 5 years. There are additional ward rounds by a Care of the Elderly Consultant but when the Stroke Consultant is away, there is usually only one ward round per week. Junior doctor support can be variable but on average there are 5 junior doctors including F2's, GPVTS and two registrars. There was an excellent culture of training and education within the unit and supported places to attend the Welsh Stroke Conference each year. There was good support from ward-based pharmacists for safe prescribing.

There was excellent nursing leadership, as with all the hospitals we visited, but there are significant nursing recruitment challenges at YYF with a 50% nursing vacancy rate despite attempts at international recruitment. Band 4 nurses had recently been appointed using band 5 funding.

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1.2 WTE SLT for the entire hospital; of this, only 0.6 WTE is dysphagia trained SLT. The remaining 0.6 WTE is for communication only. At the time of the review, it was reported that there was no psychology support but in theory there is usually support for inpatients from an in-reach on referral model. There is a very limited spasticity service offered at this hospital with ad hoc support available. The senior physiotherapist was also being trained to administer Botox therapy which is to be commended.

There is good social work support and a discharge coordinator role but still major delays in accessing packages of care and nursing home places.

Follow up post discharge is delivered at 6 weeks by the Stroke Consultant, but there is no routine 6 month follow up.

The ward was made up entirely of single rooms. Whilst this has some advantages for privacy and infection control, there is evidence that stroke patients in the rehabilitation phase get a lot of benefit from the socialisation of communal bay accommodation and therapy spaces. The toilet facilities could not accommodate patients that needed to be hoisted. The rehabilitation therapy space was not based on the rehabilitation ward and was not exclusively reserved for the rehabilitation ward.

### 4.3. Royal Gwent Hospital



*The RGH Rehab Team*

Royal Gwent Hospital in Newport has approximately 370 inpatient beds and again a 24/7 Minor Injuries Unit and Medical Assessment Unit amongst its services. There are 24 stroke rehabilitation beds, and these are usually exclusively occupied by stroke patients with the occasional complex neurological rehabilitation patient. The average length of stay is

approximately 44 days. There are some self-presenting stroke patients making up around 10-15% of all admissions; these patients are rarely moved to The Grange.

The Medical Consultant cover is currently being provided by a Consultant from The Grange who carries out a twice weekly ward round. The ward is also supported with daily specialty doctor cover; this is clearly not a sustainable model and new consultant appointments were being explored to support the medical workforce. There are 4 junior doctors that support this ward, one foundation doctor and three middle grade speciality doctors.

There were significant challenges across nursing recruitment with 5 RN vacancies and 4 CSW vacancies at the time of our visit. It was clear to see that there was strong nursing leadership as this unit has previously been a nurse led rehabilitation unit, but frustration was expressed with the ongoing recruitment difficulties. There was a good working relationship between the therapy and nursing teams with key interventions to support nursing workload.

There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. Once again there was limited dysphagia trained Speech and Language Therapy provision with only 1 WTE band 6 SLT for the entire hospital. There was a reported delay of 3-4 weeks for PEG insertion. There is psychology support from an in-reach on referral model.

There were similar challenges to NHH and YYF with access to ESD and CRT, with a perception of a delay in availability onto ESD. NHH ESD responds to received referrals via a telephone call the day after discharge from hospital. Assessment is undertaken on the same day when required. Delays in packages of care, which sit within Social Services / Community Resource Team (CRT) is still a concern and may delay access. Only patients that were fit for transfer could be discharged for home therapy, with only one patient able to do so. Neuro-rehabilitation out-patient services were only available for Physiotherapy.

There are significant delays to access packages of care and nursing home placements. Stroke patients are moved to other ward areas to support flow due to discharge delays if they are no longer receiving active rehabilitation. It was reported that on average 15% of patients were medically optimised for discharge.

There were two large therapy areas on the ward but no quiet room for speech and cognitive assessments. There was one bathroom accessible for hoist transfer patients. Group rehabilitation was offered, and Occupational Therapists had changed working patterns recently to support morning Personal Activities of Daily Living (PADL) assessment and to support the nursing staff.



#### 4.4. The Grange University Hospital



*The GUH Rehab Team*

As described earlier, this new hospital has 560 beds and provides all Specialist and Critical Care services for Gwent. It is also a major Trauma Centre for the region as well as being ABUHB's Acute Stroke Centre. It has 15 stroke beds, 12 of which are funded Hyper-Acute Stroke Unit beds, with an average length of stay of 6 days. It is difficult to meet the 4 hour target for admission as beds are not ring-fenced and frustration was expressed about the inability to manage their own beds.

There are 7 side rooms, two bays with 4 monitored beds in each and one therapy room on the ward (which at times of high demand in the hospital overnight was being used as a General Medical patient bed, although this has now been removed from the site escalation plans)

There are 4 stroke consultants that support the acute stroke pathway. There are 6 Neurologists that are employed by this Health Board and are based at the Royal Gwent Hospital, but only one works within the stroke team. A total of 8 consultants support the on-call rota from the four ABUHB hospitals. There is remote PACS radiology access to support remote review of brain scans

There were reported to be excellent nursing levels and no issues with recruitment. There is access to 5-day therapy services for Physiotherapy, Occupational Therapy and Speech and Language Therapy. There was 0.8 WTE SLT in post but 1.4WTE funded Speech and Language Therapy. There was no dietician support for the stroke unit with psychology support being offered as an in-reach service to the ELGH rehab site.

The acute care pathway was reviewed during our discussions with the team, and we had the opportunity to 'walk' the stroke pathway from A&E to radiology and up to the ward. Pre-alerts do occur directly to the stroke nurses but there is often limited information, which does not

enable pre-registration. Stroke Specialist Nurses are available Monday to Friday, 8am to 5pm and outside these times the Medical Registrar supports acute stroke assessments in A&E. An A&E sister commented during the visit, that she couldn't understand why the stroke review team would visit the resuscitation /high intensity A&E area as "stroke patients should never be assessed here". This was concerning, as acute stroke patients are some of the most acutely unstable patients in the emergency department. We accept that this may have been the opinion of an individual, but parity of esteem for stroke patients and support for the stroke team in A&E is essential to a successful stroke pathway.

Following initial review, suspected stroke patients go directly to CT +/- CT Angiogram. This pathway is less streamlined out of hours. Artificial Intelligence decision support software is not used, nor is Computed Tomography Perfusion (CTP), to support recanalization referrals and decisions. Thrombolysis is given in A&E. MRI is available 0730 to 2000 7 days a week for investigating minor strokes and stroke mimics and CT provision is available 24/7.

Thrombectomy services are delivered at Bristol South Mead Neuroscience Centre, 8am to 6pm, 7-days a week. There are good relationships between the referring hospital and the Neuroscience centre, although Thrombectomy rates remain well below a potential target of 8-10% of all stroke patients.

There are no specific TIA and Minor Stroke out-patient clinics delivered at GUH as the model for GUH does not include an outpatient footprint. These are all provided by the three other hospitals. Patients wait between 5 and 6 days to be seen and there is no provision for 'one stop assessment'. There is no access to first line MRI imaging, as per NICE guidelines, and patients often wait up to a week for brain and carotid imaging. Vascular surgery centralised in SE Wales on 18<sup>th</sup> July 2022 and is performed at the Regional Vascular Unit at the University Hospital of Wales in Cardiff. Intracerebral Haemorrhage Patients requiring Neurosurgical Intervention are also managed here.

## **5. SSNAP Data Performance Metrics: Findings and Recommendations**

The recommendations that we have made in the report have been based upon the data accessible to us at the time of the visit to ABUHB and within the SSNAP published annual portfolio reports. It is also based on information from Trust Executives, Clinical Leads and Operations Managers on the pre-visit meeting and at the site visits. These are not exhaustive but are key areas that if focused on will reduce unwarranted variation and improve delivery of services along the stroke pathway.

During the deep dive visit on 11<sup>th</sup> May 2022, RNOH/GIRFT presented performance data for SSNAP registered routinely admitting stroke services in Wales, benchmarked against all stroke units in Wales and against the English national average. GUH is represented as the single routinely admitting stroke service in ABUHB; however, it is recognised that there are patients directly admitted to ELGHs and may not transfer to GUH (and therefore not included in SSNAP data). This included data from the most recent published SSNAP data available for the period October 2021-December 2021. Although this represents only a short period in time, having reviewed annual data in preparation for this visit, the Clinical Leads are confident that this quarterly data is representative of the performance out with this timeframe, and that recommendations are all relevant for future quality improvement.

## 5.1 Stroke Activity and Performance

Figure 1

| Routinely Admitting Team             | Admissions (Oct 21 - Dec 21) | SSNAP level | SSNAP score | Case ascertainment band | Audit compliance band | Combined Total Key Indicator level |
|--------------------------------------|------------------------------|-------------|-------------|-------------------------|-----------------------|------------------------------------|
| Grange University Hospital           | 186                          | D           | 48.4        | A                       | B                     | D                                  |
| Glan Clwyd District General Hospital | 95                           | D           | 59          | A                       | A                     | D                                  |
| Maelor Hospital                      | 92                           | D           | 42.5        | C                       | A                     | D                                  |
| Ysbyty Gwynedd                       | 88                           | D           | 44          | A                       | A                     | D                                  |
| University Hospital of Wales         | 178                          | C           | 64          | A                       | A                     | C                                  |
| Prince Charles Hospital              | 135                          | C           | 65          | A                       | A                     | C                                  |
| Princess Of Wales Hospital           | 70                           | D           | 45.6        | B                       | A                     | D                                  |
| Bronglais Hospital                   | 28                           | B           | 71.7        | A                       | A                     | B                                  |
| Prince Philip Hospital               | 40                           | B           | 72          | A                       | A                     | B                                  |
| West Wales General                   | 44                           | C           | 63.2        | B                       | B                     | B                                  |
| Withybush General Hospital           | 45                           | A           | 81.7        | A                       | B                     | A                                  |
| Morrison Hospital                    | 153                          | D           | 59          | A                       | A                     | D                                  |

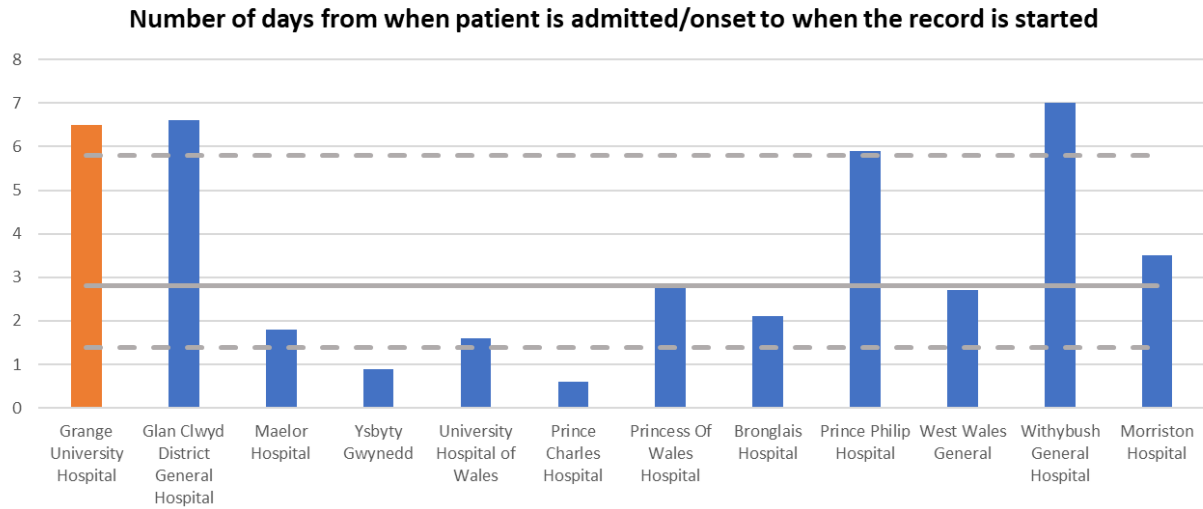
## 5.2 SSNAP Patient-Centred Data (routinely admitting teams)

Figure 2

| Routinely admitting teams            | Patient Centred Data |    |       |           |    |    |      |     |           |            |       |
|--------------------------------------|----------------------|----|-------|-----------|----|----|------|-----|-----------|------------|-------|
|                                      | Scan                 | SU | Throm | Spec Asst | OT | PT | SALT | MDT | Std Disch | Disch Proc | PC KI |
| Grange University Hospital           | A                    | E  | D     | D         | B  | B  | D    | E   | D         | C          | D     |
| Glan Clwyd District General Hospital | B                    | E  | D     | D         | C  | C  | B    | C   | A         | C          | C     |
| Maelor Hospital                      | B                    | E  | B     | D         | D  | D  | D    | B   | C         | D          | D     |
| Ysbyty Gwynedd                       | C                    | E  | E     | D         | E  | D  | D    | C   | A         | D          | D     |
| University Hospital of Wales         | B                    | E  | E     | E         | B  | A  | C    | B   | B         | A          | C     |
| Prince Charles Hospital              | A                    | E  | C     | E         | A  | B  | C    | D   | B         | B          | C     |
| Princess Of Wales Hospital           | B                    | E  | C     | E         | C  | D  | E    | E   | A         | C          | D     |
| Bronglais Hospital                   | A                    | C  | B     | B         | C  | B  | C    | C   | A         | E          | B     |
| Prince Philip Hospital               | A                    | D  | E     | A         | C  | B  | B    | B   | A         | C          | B     |
| West Wales General                   | A                    | E  | C     | B         | C  | B  | C    | B   | A         | C          | B     |
| Withybush General Hospital           | A                    | B  | B     | A         | B  | A  | C    | B   | B         | A          | A     |
| Morrison Hospital                    | C                    | E  | D     | B         | C  | B  | C    | D   | B         | C          | D     |

### 5.3 Admission to record start

Figure 3



Grey lines show the median and interquartile range of sites in England

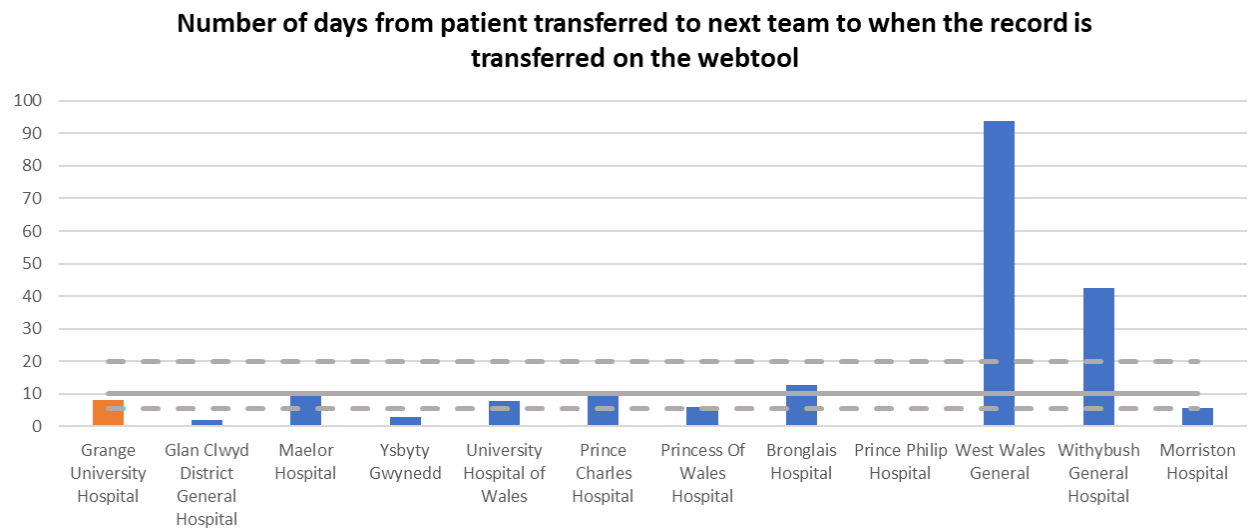
Team-centred results at team level for Audit Compliance measure C5.1

Source: SSNAP Oct 2021-Dec 2021

**Number of days from when patient is admitted/onset to when the record is started – 6.5 days**

### 5.4 Delay (days) between clock start and date of starting electronic SSNAP record

Figure 4



Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Audit Compliance measure C4.4

Source: SSNAP Oct 2021-Dec 2021

**Number of days from patient transferred to next team to when the record is transferred on the webtool – 7.9 days**

Analysis from the most recent SSNAP process markers (fig 1 and 2) at the time of this review demonstrated:

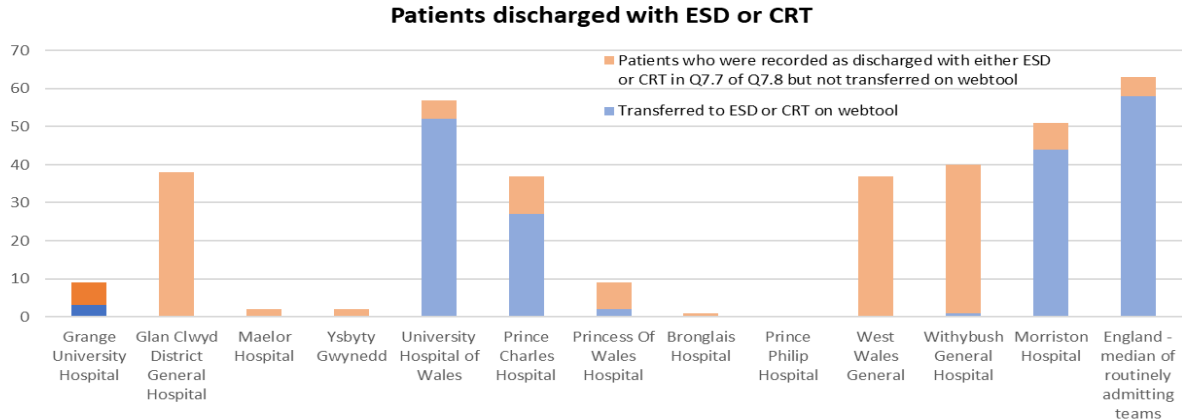
- A good level of case ascertainment band
- Excellent data submission for time to first scan
- There is significant opportunity for improvement in the timely access to the stroke beds at GUH with specialist assessments (particularly SLT) and access to mechanical thrombectomy
- Improvement is required in audit compliance, with significant delays of 6.5 days from admission to records starting respectively (fig 3)
- MDT working and discharge processes are lacking in the SSNAP record

SSNAP collects data on the whole care pathway from initial arrival at hospital, through all inpatient settings, across ESD and community rehabilitation and up to a six-month follow-up appointment. Use of SSNAP is an imperative to drive quality improvement. Recognising that the overall aim of SSNAP (fig 4) is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients is vitally important. SSNAP operates through manual provider level data entry. Acknowledging that SSNAP is only as good as the data submitted is paramount; all efforts should be made to ensure data is entered as accurately possible

**Recommendation 1: Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.**

## 5.5 Patents discharged with ESD or CRT

Figure 5



Team-centred results at team level for Audit Compliance measure C4.6

Source: SSNAP Oct 2021-Dec 2021

### **Total number of patients discharged with ESD or CRT: 9x patients**

- **Transferred to ESD or CRT on webtool – 3x patients**
- **Patients who were recorded as discharged with either ESD or CRT in Q7.7 of Q7.8 but not transferred on webtool – 6x patients**

Local intelligence suggests the number of patients supported with ESD during this timeframe was 31 referrals accepted from GUH during Q3 of 2021 (total number of referrals received from all sites including Cardiff and England was 85).



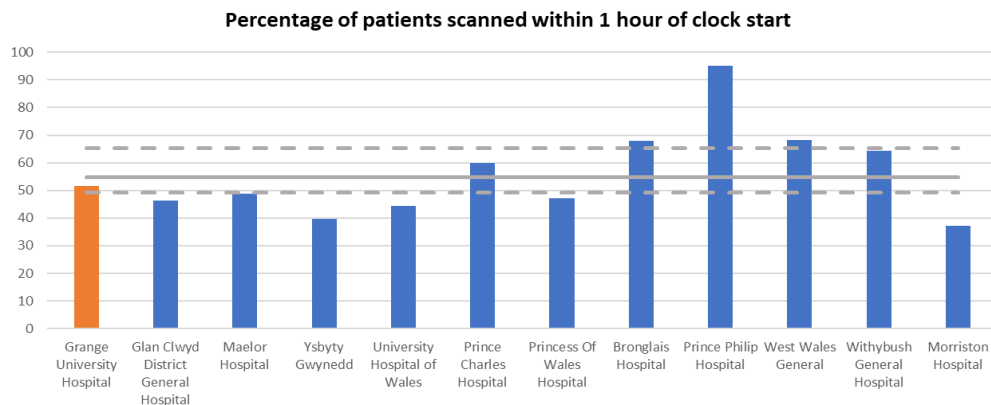
There was wide variation in the access to ESD as recorded on SSNAP. At GUH, the rate of patients discharged with ESD or CRT is significantly lower than the England median. Continued rehab may be delivered at ELGH sites.

**Recommendation 2: Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM [stroke-integrated-community-service-february-2022.pdf](https://www.england.nhs.uk/stroke-integrated-community-service-february-2022.pdf) (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.**

## 6. Hyper-Acute Stroke Pathway SSNAP Performance Metrics

### 6.1 Percentage of patients scanned within 1 hour of clock start

Figure 6



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 1.1A

Source: SSNAP Oct 2021-Dec 2021

#### Percentage of patients scanned within 1 hour of clock start – 51.6%

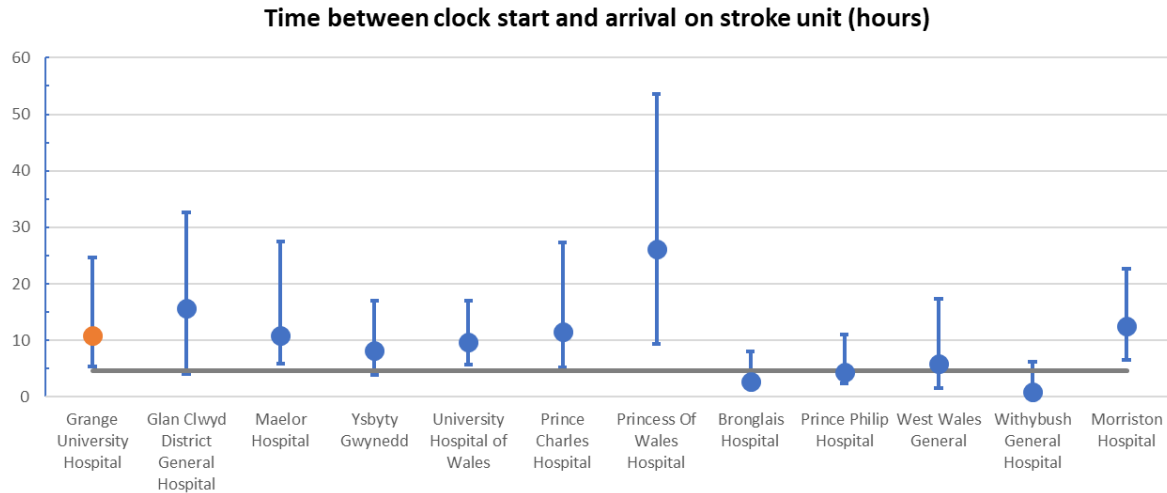
GUH's percentage of patients scanned within 1 hour of clock start was slightly lower than the national average.

Pre-hospital identification of suspected stroke patients could reduce delays to scanning and delivery of emergency treatment and stroke unit admission.

**Recommendation 3: Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 [National-stroke-service-model-integrated-stroke-delivery-networks](#).**

## 6.2 Clock start to stroke time

Figure 7



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient centred results at team level for Key Indicator 2.2A

Source: SSNAP Oct 2021-Dec 2021

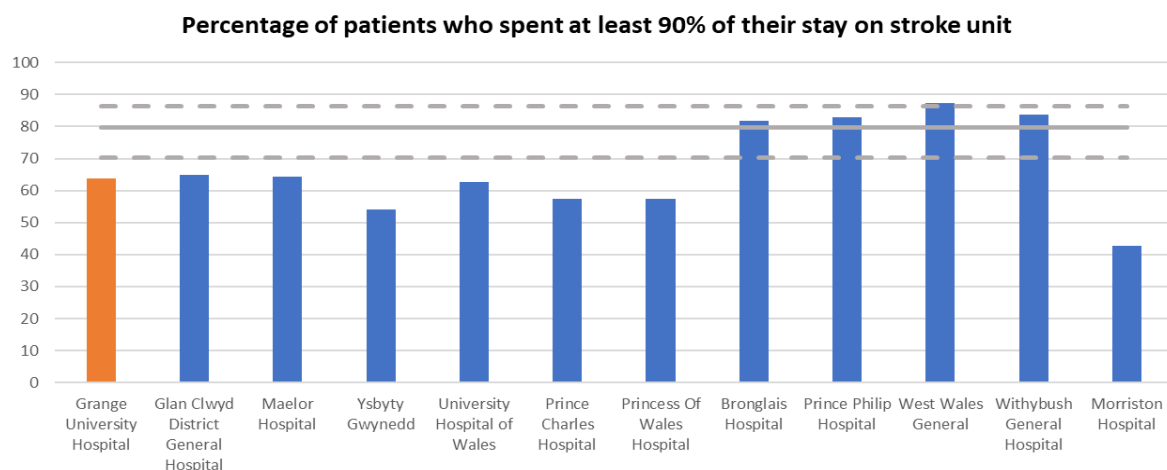
### **Time between clock start and arrival on stroke unit (hours) – 10.85**

Timely admission to a Stroke Unit is considered a vital aspect of hyper acute care. GUH rates are on a par with the Welsh average, but are however, below the England average rates. There is inadequate bed capacity at GUH to enable all stroke patients to have an admission within 4 hours of presentation to hospital and enable equitable access to evidence-based stroke unit care for all.

**Recommendation 4: ABUHB to develop a strategy to improve direct access to the stroke unit within 4 hours of presentation.**

## 6.3 Stay on stroke unit

Figure 8



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 2.3A

Source: SSNAP Oct 2021-Dec 2021

### **Percentage of patients who spent at least 90% of their stay on stroke unit – 63.9%**

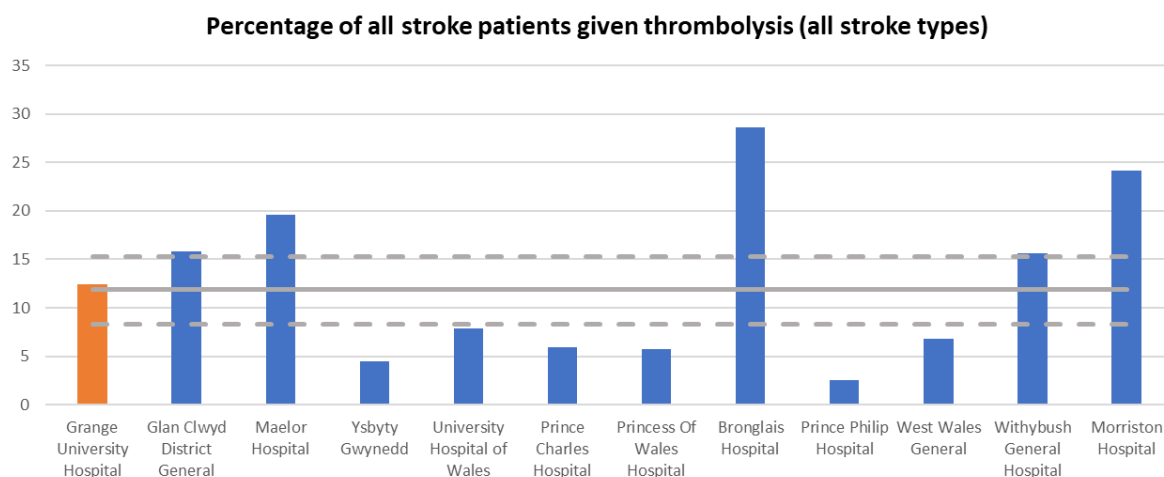


The GUH rates for accommodating patients for 90% of their in-patient stay on a stroke unit is lower than the England median. Patients that spend greater than 90% of their time on a stroke unit have fewer severe complications compared to those spending less than 90% of their inpatient stay on stroke units. The RGH reported moving stroke patients to other wards when they were medically optimised, to release beds. This will also have a positive impact on the 90% stay target.

**Recommendation 5: Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging (see fig 7 and 8) should help to release bed capacity and increase access.**

## 6.4 Thrombolysis rate (all stroke)

Figure 9



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 3.1A

Source: SSNAP Oct 2021-Dec 2021

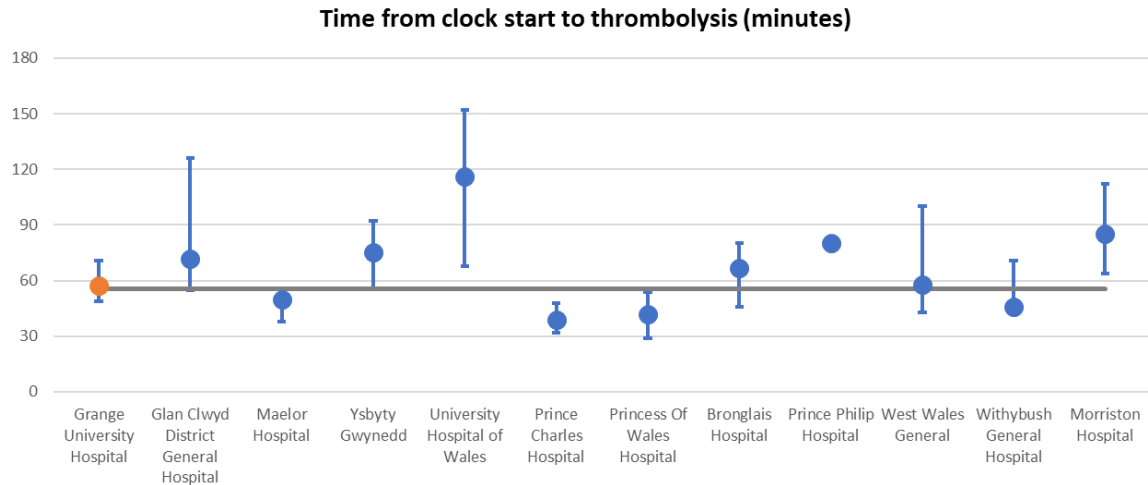
### **Thrombolysis rate – 12.4%**

The thrombolysis rates are slightly above the England national average of 12%.

**Recommendation 6: Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.**

## 6.5 Clock start to thrombolysis

Figure 10



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 3.5A

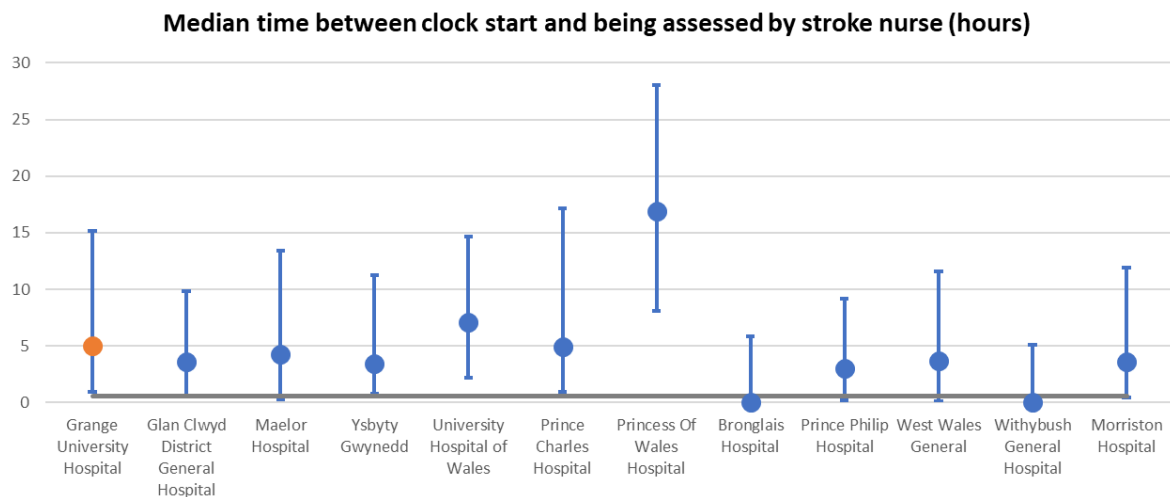
Source: SSNAP Oct 2021-Dec 2021

### **Time from clock start to thrombolysis (minutes) – 57mins**

The GUH is providing timely access to thrombolysis from admission. Rates are in line with the median of sites in England. Aiming for a target closer to 30 minutes is gold standard and is being achieved in many highly performing stroke units in England, aided mostly by pre-registration of patients, immediate review by the stroke team and going straight to CT scanning.

## 6.6 Median time between clock start and being assessed by stroke nurse

Figure 11



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.4A

Source: SSNAP Oct 2021-Dec 2021

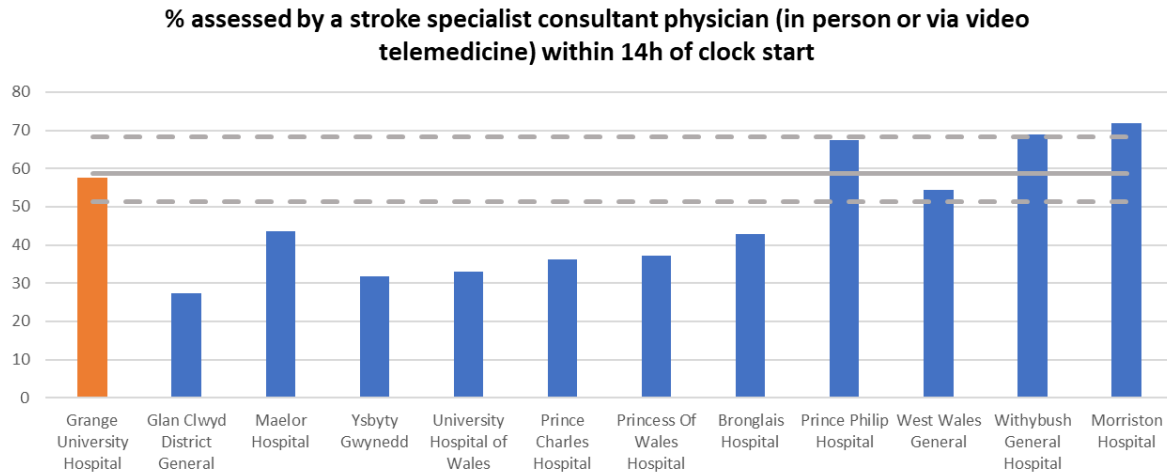
### **Median time between clock start and being assessed by stroke nurse – 4.95hr**

GUH's median time between clock start and being assessed by a stroke nurse is 4.95 hours. There is variation due to GUH's inability to deliver a Stroke Specialist Nurse Assessment out-of-hours (outside of Monday-Friday 8am to-5pm).

**Recommendation 7: Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.**

**6.7 Specialist consultant assessment - % assessed by stroke consultant within 14hrs**

Figure 12



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Item Reference G9.19

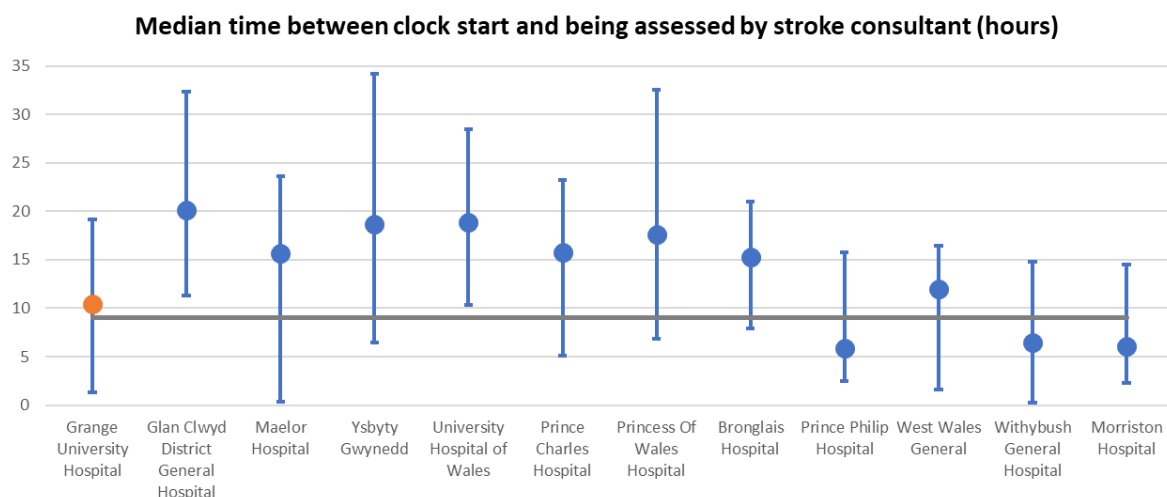
Source: SSNAP Oct 2021-Dec 2021

**% assessed by a stroke specialist consultant physician (in person or via video telemedicine) within 14h of clock start – 57.5%**

**Good practice identified:** The percentage of patients assessed by a stroke specialist consultant physician within 14hrs of clock start is in line with the English national average.

**6.8 Specialist consultant assessment – Time between clock start and being assessed**

Figure 13



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 4.2A

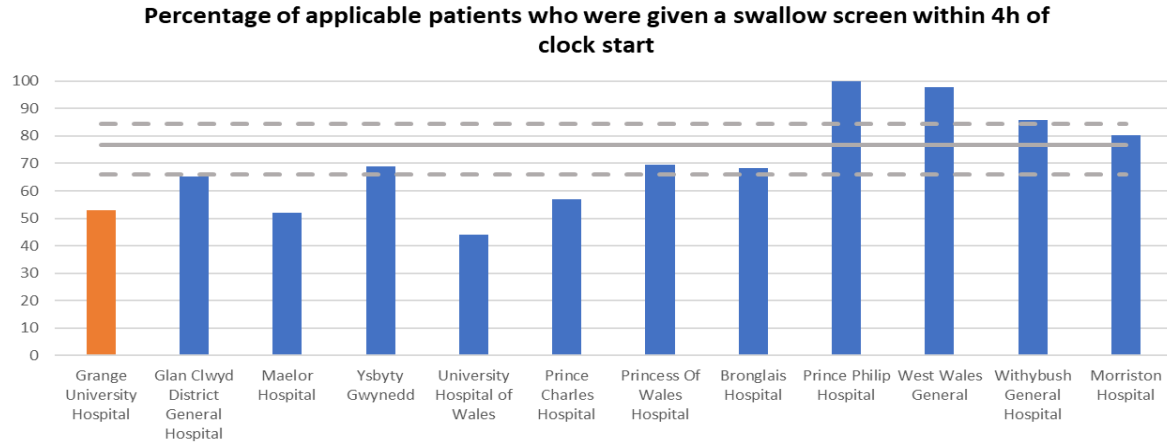
Source: SSNAP Oct 2021-Dec 2021

**Median time between clock start and being assessed by stroke consultant (hours) – 10.37hrs**

GUH are in line with the national average for the median time taken for first consultant review.

## 6.9 Swallow screen within 4 hours

Figure 14



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 4.5A

Source: SSNAP Oct 2021-Dec 2021

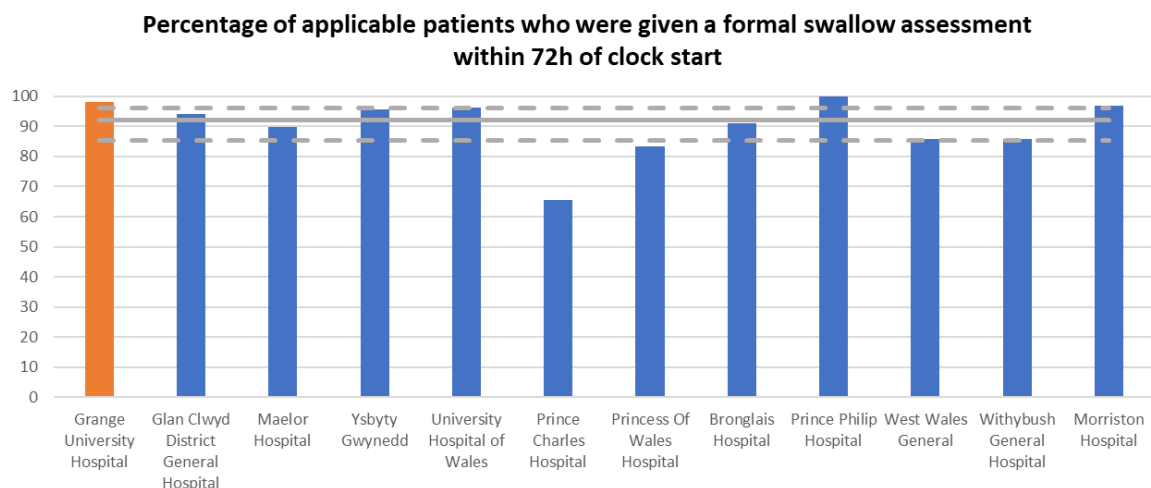
**Percentage of applicable patients who were given a swallow screen within 4hrs of clock start – 52.8%**

Only 52.8% of patients accessed a swallow screen within 4 hours, this is significantly lower than the national average.

**Recommendation 8: Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.**

## 6.10 Swallow Screen within 72hrs of clock start

Figure 15



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 4.6A

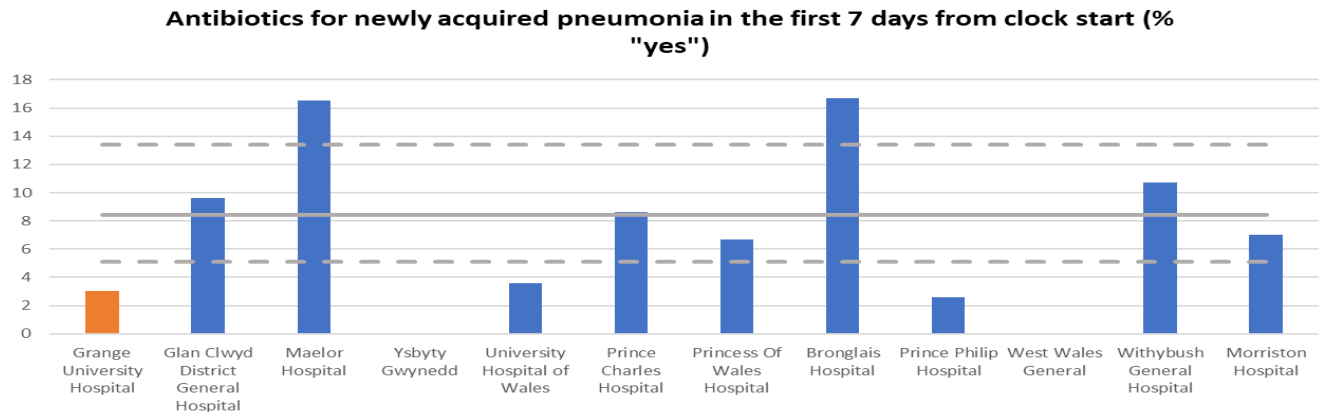
Source: SSNAP Oct 2021-Dec 2021

**Percentage of applicable patients who were given a formal swallow assessment within 72h of clock start - 98.2%**

**Good practice identified:** 98.2% of GUH's patients accessed a formal swallow assessment by a Speech and Language Therapist within 72 hours of clock start. This is in the top quartile when compared with NHS Trusts in England.

## 6.11 Antibiotics for newly acquired pneumonia

Figure 16



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Post72h Indicator J26.3

Source: SSNAP Oct 2021-Dec 2021

**Antibiotics for newly acquired pneumonia in the first 7 days from clock start – 3 cases**

**Good practice identified:** The data shows a low use of antibiotics for presumed pneumonia within the first 7 days of admission. This may be due to good processes being in place regarding swallow screening.

## 6. MDT Working

There is good evidence of early supported discharge and the delivery of therapy in people's homes.

There are, however, significant social care delays. Findings from the Stroke Association survey show that 50% of patients feel abandoned following discharge.

There is significant room for improvement in discharge processes and services i.e. social, packages of care and availability of care homes. Offering a stepdown for these patients to encourage flow across GUH and the rehab sites should be a priority. A goal should be to maximise support for patients who are most impaired and dependant following discharge.

ABUHB took part in the Welsh Leadership academy that ran last year and found the outcomes very valuable. They put a cohort of staff groups (e.g. doctors, 3<sup>rd</sup> sector, managers etc) through the programme and found that this is invaluable when it comes to team working and improving leadership and effectiveness of a service. Several staff also enrolled on the first Wales Stroke and Neuro Leadership Programme which ran into the pandemic

**Recommendation 9: ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.**

The community discharge pathway demonstrated a time based model, the current commissioned pathway is for 3 months. The Stroke Association carers support pathway has not been fully embeded in all units, with significant gaps in two thirds of the units. Currently,

patients in a residential or nursing home in this region do not have access to rehabilitation, other than ESD to people who meet the ESD criteria. People with more significant impairment requiring additional staffing to undertake effective rehab do not fit the criteria. The ESD rehab programme is time limited but there is a Neuro recovery college model which provides a range of educational modules covering fatigue management, living well with stroke, GRASP upper limb rehab, rebuilding your life after stroke, community exercise. These modules are open for people to attend and provide support for much longer than 3 months for ESD. The Life After Stroke wellbeing practitioners also support on a longer term basis as do the clinical psychology team. We also informed that there is also a pathway to which works in partnership with the DWP to support people back into employment and or voluntary roles.

The psychology team routinely provide life after stroke support. The Acquired Brain Injury (ABI) team have also stepped in to provide longer term rehab on a number of occasions. Both the ABI and psychology resources are small and we have worked hard to prioritise people who are most in need of ongoing support. The basis of our prioritisation is risk to wellbeing and ability of people who are already proximal to manage this risk.

The Niworstiwt Recovery College was developed by the ABI and psychology teams to support us in our commitment to doing the most good for the most people, whilst minimising harm and maximising autonomy. Whilst led by the ABI team the Niworstiwt is a collaboration between CNRS ABI & Stroke teams, people with lived experience of stroke and brain injury, Headway and the Stroke Association. The latter organisations contribute to the Stiwt's steering group.

**Recommendation 10: Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support:** [stroke-integrated-community-service-february-2022.pdf](https://www.england.nhs.uk/wp-content/uploads/2022/02/stroke-integrated-community-service-february-2022.pdf) ([england.nhs.uk](https://www.england.nhs.uk)).

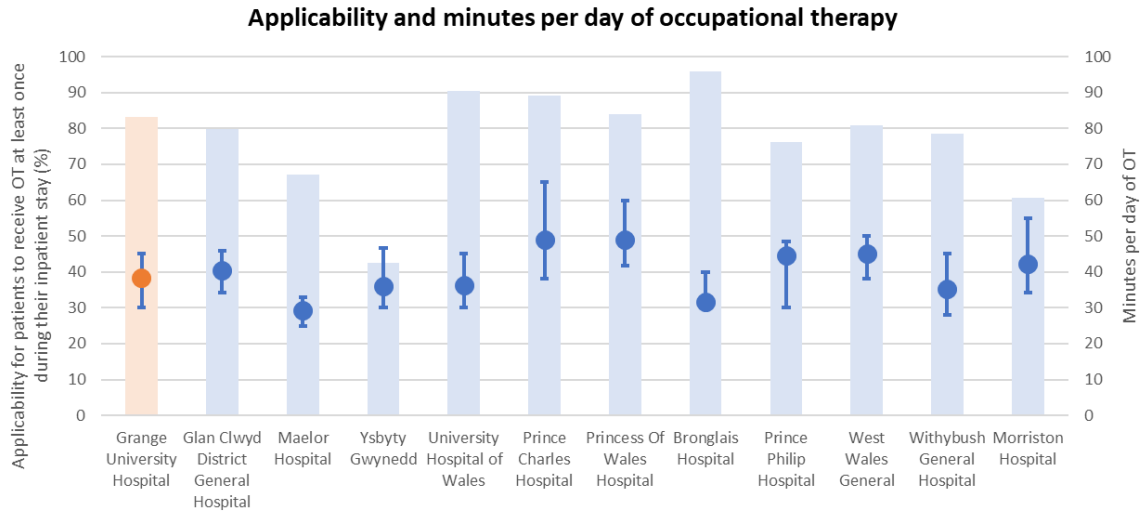
**Recommendation 11: Embed the Stroke Association Carers Support Pathway (SACS).** RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.

**Recommendation: 12: Embed the National Stroke Service Model in ABUHB**  
<https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf>



## 7.1 Applicability and minutes of OT

Figure 17



Bars show the % of patients applicable to receive physiotherapy at least once during their inpatient stay (England median is 87%). Dots show the median minutes received per day (and interquartile range)

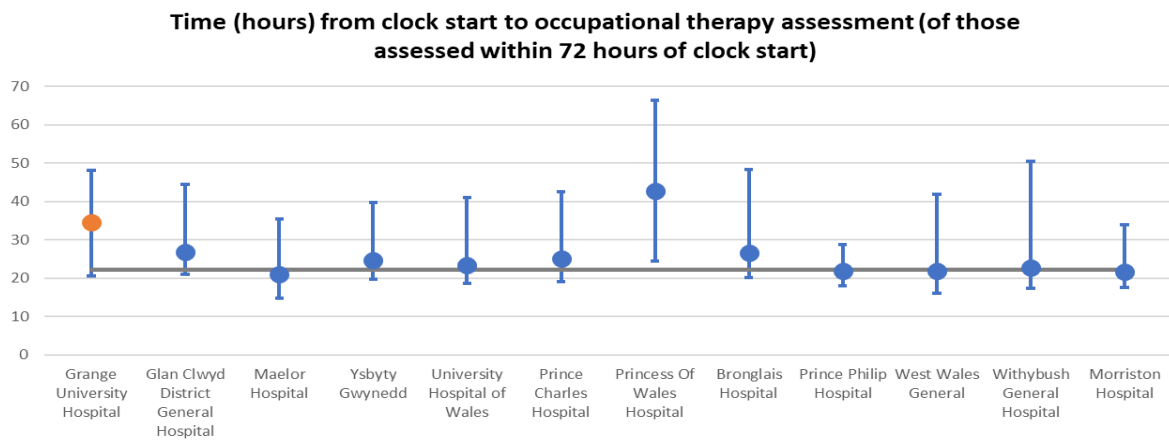
Patient-centred results at team level for Key Indicators 5.1A and 5.2A

Source: SSNAP Oct 2021-Dec 2021

**Applicability and minutes per day of OT – 38.38%, in line with Wales’s average**

## 7.2 Clock start to OT assessment time

Figure 18



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

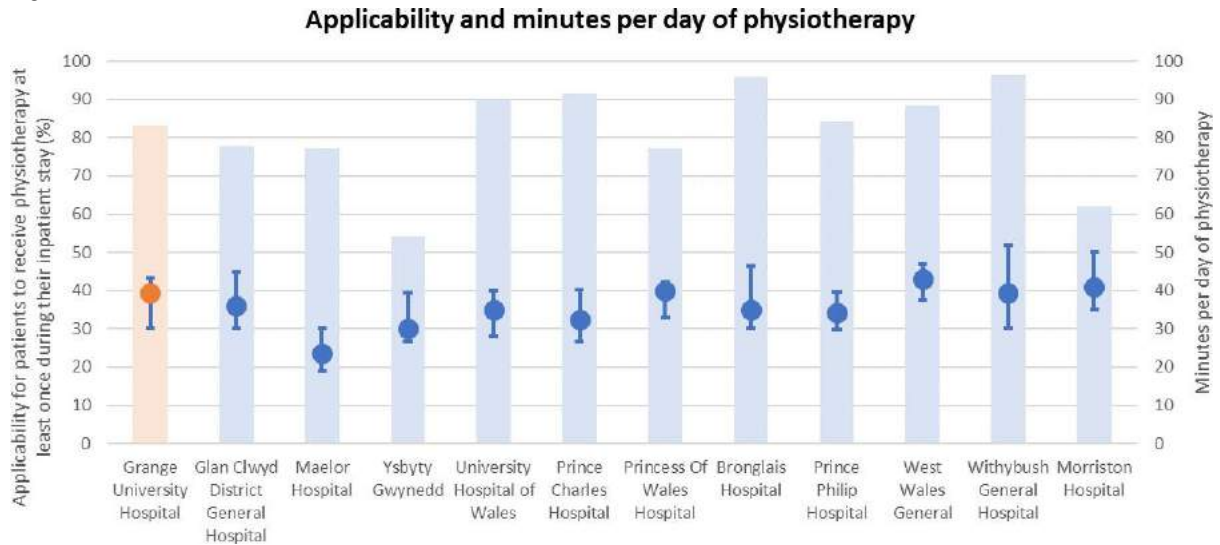
Patient-centred results at team level for Key Indicator 8.2A

Source: SSNAP Oct 2021-Dec 2021

**Time from clock start to occupational therapy assessment – 34.35 hours**

### 7.3 Applicability and minutes of physiotherapy

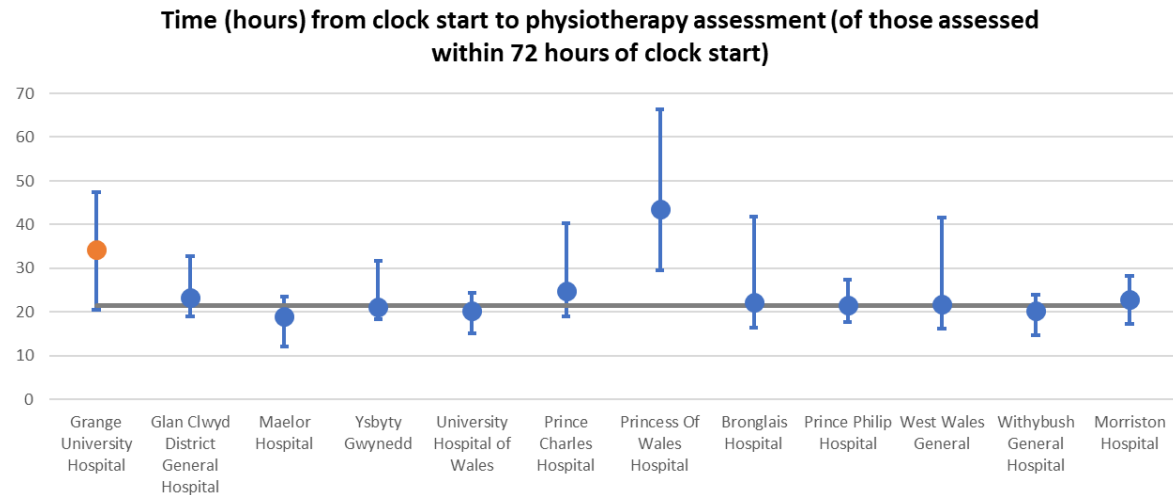
Figure 19



**Applicability and minutes per day of physiotherapy – 39.2% in line with Wales's average**

### 7.4 Clock start to physiotherapy assessment time

Figure 20



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.4A

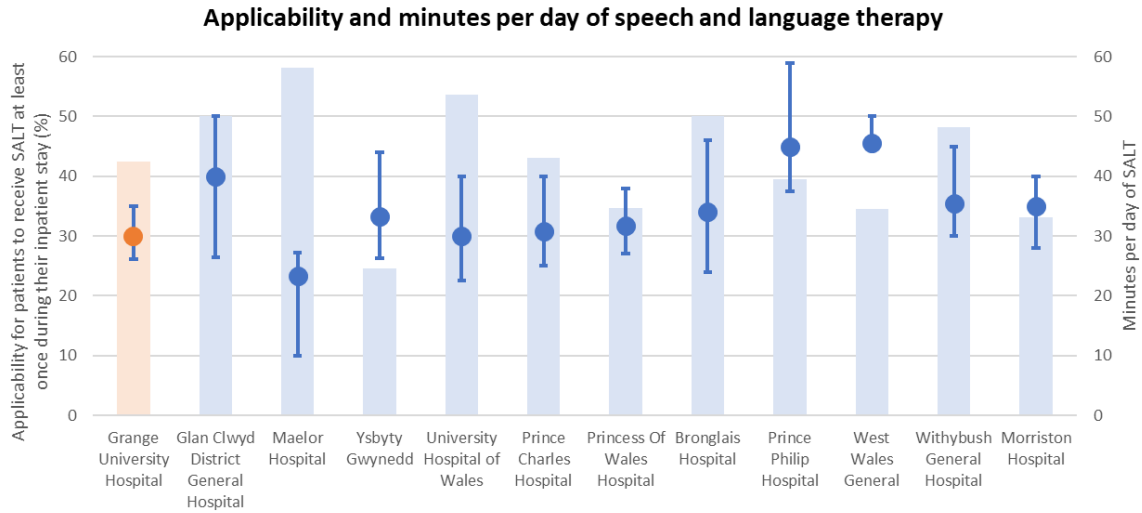
Source: SSNAP Oct 2021-Dec 2021

**Time (hours) from clock start to physiotherapy assessment (of those assessed within 72 hours of clock start) – 34.17%**

**Recommendation 13: Ensure 7 day access to physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients**

## 7.5 Applicability and minutes of SALT

Figure 21



Bars show the % of patients applicable to receive speech and language therapy at least once during their inpatient stay (England median is 54.4%). Dots show the median minutes received per day (and interquartile range)

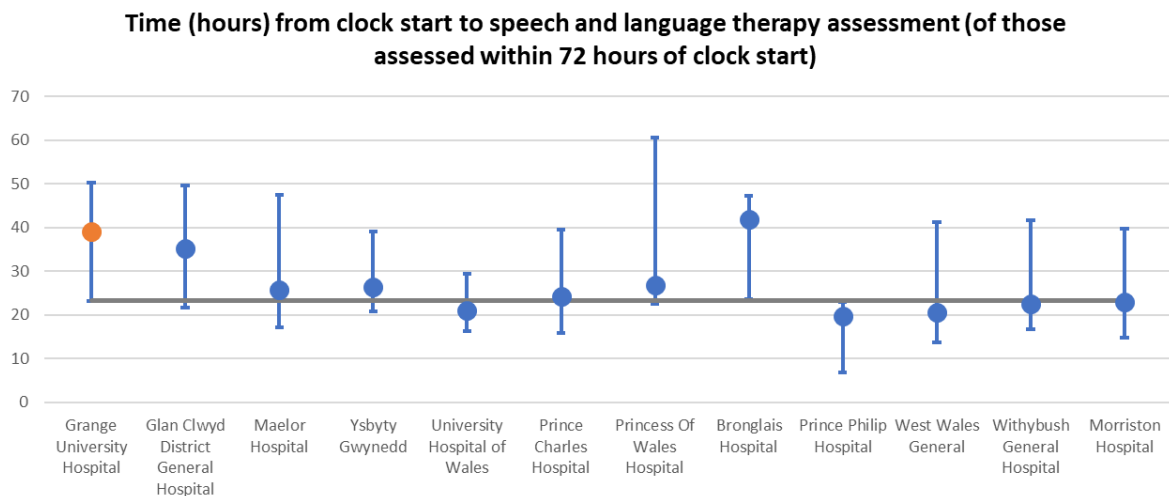
Patient-centred results at team level for Key Indicators 7.1A and 7.2A

Source: SSNAP Oct 2021-Dec 2021

**Number of minutes per day on which SALT is actually received – 30%, below Wales’s average.**

## 7.6 Clock start to SALT assessment time

Figure 22



Bars show the median by trust and interquartile range. Grey line shows the median of sites in England

Patient-centred results at team level for Key Indicator 8.6A

Source: SSNAP Oct 2021-Dec 2021

**Time (hours) from clock start to speech and language therapy (SLT) assessment (of those assessed within 72 hours of clock start) – 39.05hrs**

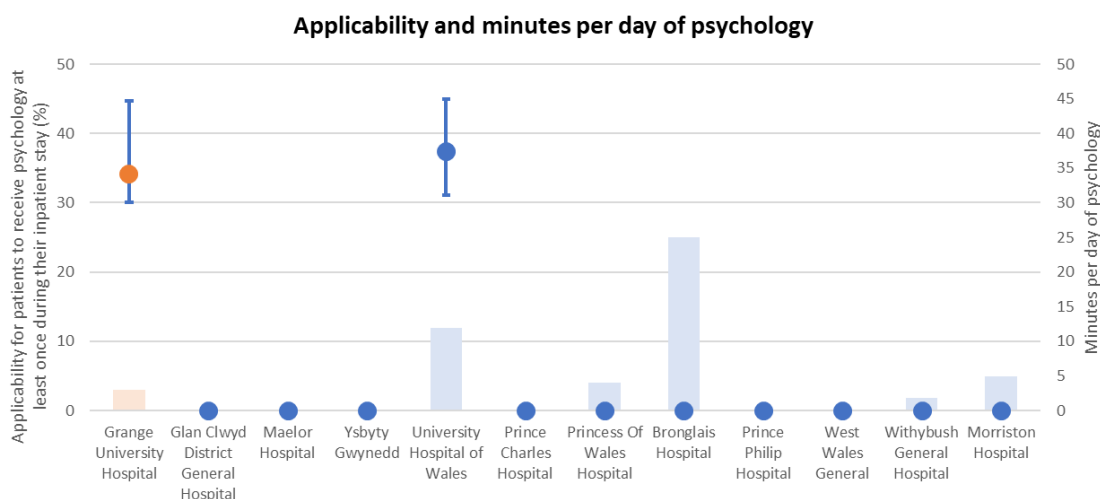
There is variation in the timely access to speech and language therapy services (see fig 21 and 22), as well as to physiotherapy and occupational therapy. The HASU currently provides a 5-day service for speech and language therapy. There are significant challenges in this pathway. The SSNAP standard is that sites should have at least two of the therapies shown available seven days a week. In most units, this is physiotherapy and occupational therapy.

**Recommendation 14: The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework <https://stroke-education.org.uk/>].**

Currently not meeting the SSNAP 5 day standards for intensity of therapy, so it is clear that a review of rehabilitation staffing is required to meet 5 days before expansion to 7 days can be considered. Expanded use of rehabilitation assistants and group therapy sessions to be considered. It may be worth exploring a virtual liaison tele-swallow service given the extreme staffing pressure within speech and language therapy.

## 7.7 Applicability and minutes per day of psychology

Figure 23



Bars show the % of patients applicable to receive psychology at least once during their inpatient stay (England median is 3.2%). Dots show the median minutes received per day (and interquartile range)

Patient-centred results at team level for Item Reference J7.3-J7.7

Source: SSNAP Oct 2021-Dec 2021

**% of the patient's days at in hospital (out of period patient requires psychology across all teams) on which it is received by the patient – 34.2%**

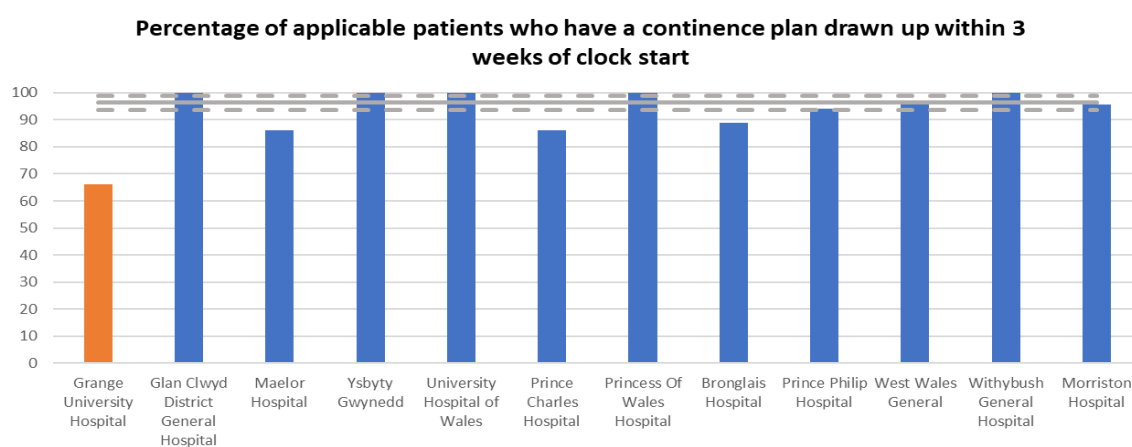
Assess to neuropsychology is variable across the region. A high proportion of patients (1 in 3) may require psychological support post-event. The current psychology model is 1 session of in reach per week for each ELGH based stroke unit. However, at the time of the GIRFT visit the psychology resource was significantly depleted by absences. We are told this has improved now, although there have not been any applicants to cover fixed term appointments, through secondments or agency staff. The psychology service provides support across the whole pathway and takes referrals from medics, primary care and healthcare professionals.

The ABUHB CNRS psychology team work across the width and along the full length of the stroke pathway. In practical terms this involves responding to requests for assistance from the HASU, the three sub-acute rehabilitation wards, the three Early Supported Discharge Teams, the ABUHB Living Well-After Stroke Service, and colleagues working in community services supporting stroke survivors. The CNRS psychology team have also been instrumental in the establishment of the Neurological Conditions Recovery College.

**Recommendation 15: Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.**

## 7.7 Continence plans

Figure 24



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 9.2A

Source: SSNAP Oct 2021-Dec 2021

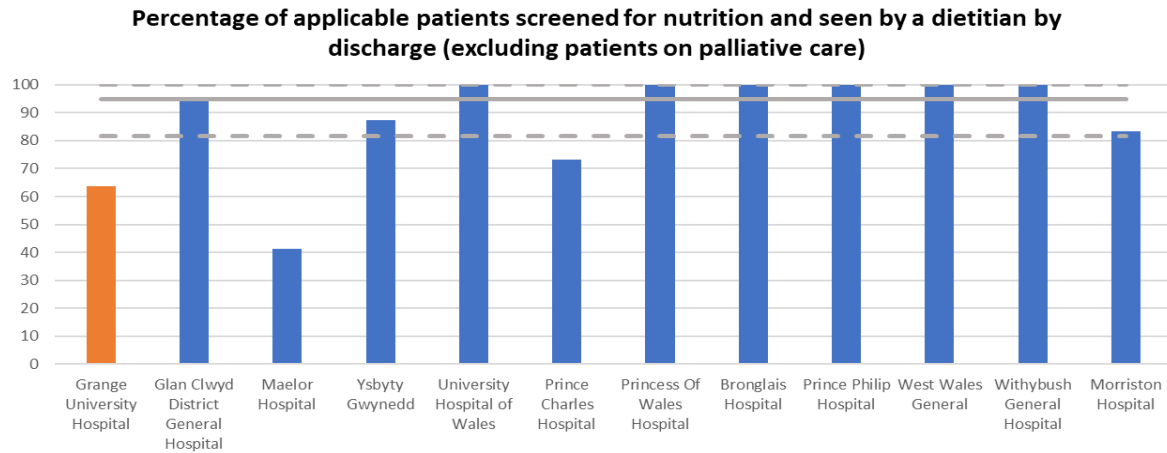
**Percentage of applicable patients who have a continence plan drawn up within 3 weeks of clock start – 66.1%**

The data showing the percentage of patients who have continence planning within 3 weeks of admission is low in comparison to the national average. This is likely to be an issue with documentation in medical notes and hence data reporting.

**Recommendation 16: ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly ‘compliance’ meeting to provide assurance.**

## 7.8 Nutrition screening and seen by dietician at discharge

Figure 25



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key indicator 9.1A

Source: SSNAP Oct 2021-Dec 2021

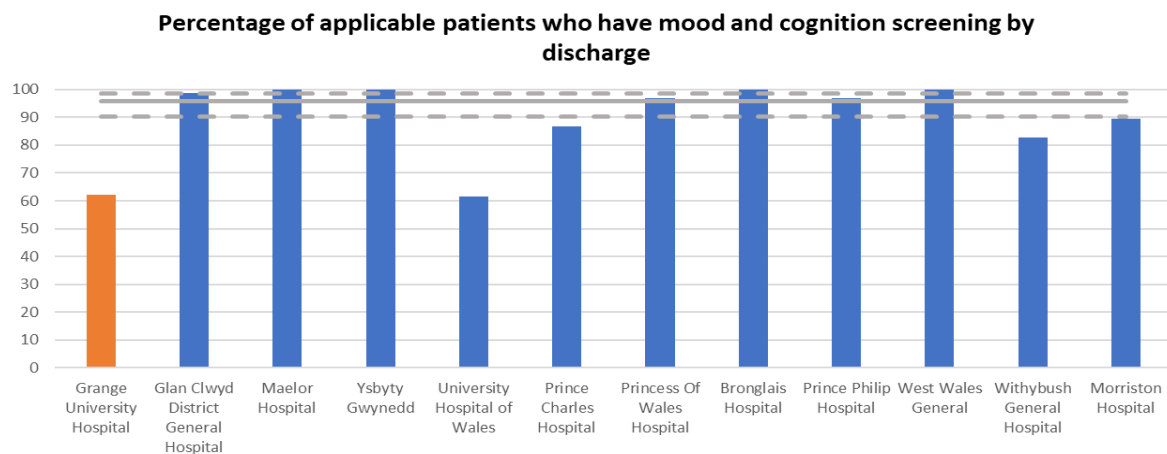
### **Percentage of applicable patients screened for nutrition and seen by a dietitian by discharge (excluding patients on palliative care) – 63.6%, below Wales average**

The data showing the percentage of patients who have been screened for nutrition and been seen by a dietitian by discharge is low in comparison to both the English and Welsh national averages. This is likely to be due to an issue with documentation and hence data reporting. We were informed that all patients assessed by ESD teams have a nutritional screen completed.

**Recommendation 17: Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly ‘compliance’ meeting put in place to provide assurance.**

## 7.9 Mood and cognition screening by discharge

Figure 26



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 9.3A

Source: SSNAP Oct 2021-Dec 2021



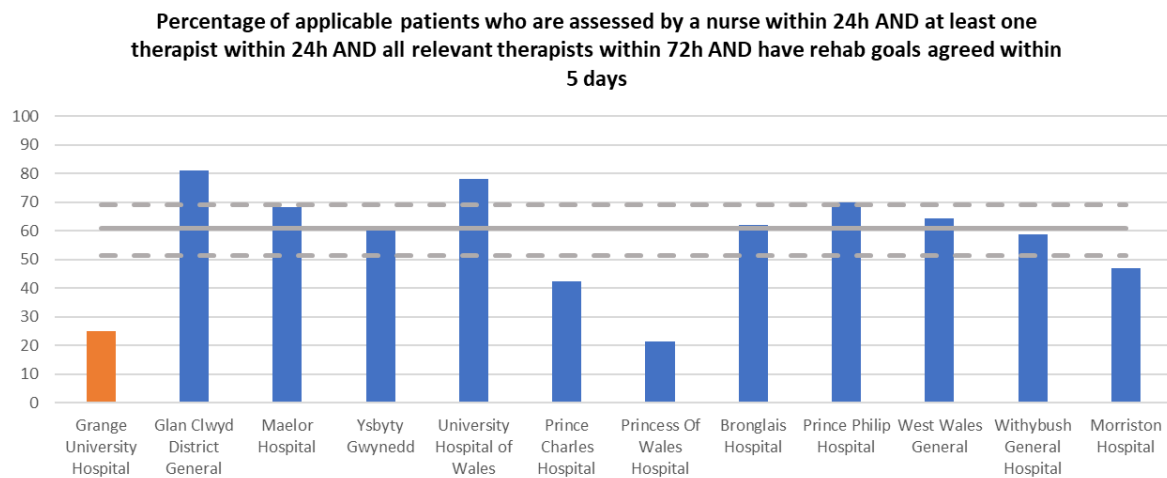
**Percentage of applicable patients who have mood and cognition screening by discharge – 62.1% which is below the Wales average.**

It was evident there is focus on mood and cognition assessment. The data showing the percentage of patients who have mood and cognition screening by discharge is low in comparison to the national average. This is likely to be an issue with documentation and hence data reporting.

**Recommendation 18: Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.**

## 7.10 Nursing therapy and rehab goals

Figure 27



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 8.8A

Source: SSNAP Oct 2021-Dec 2021

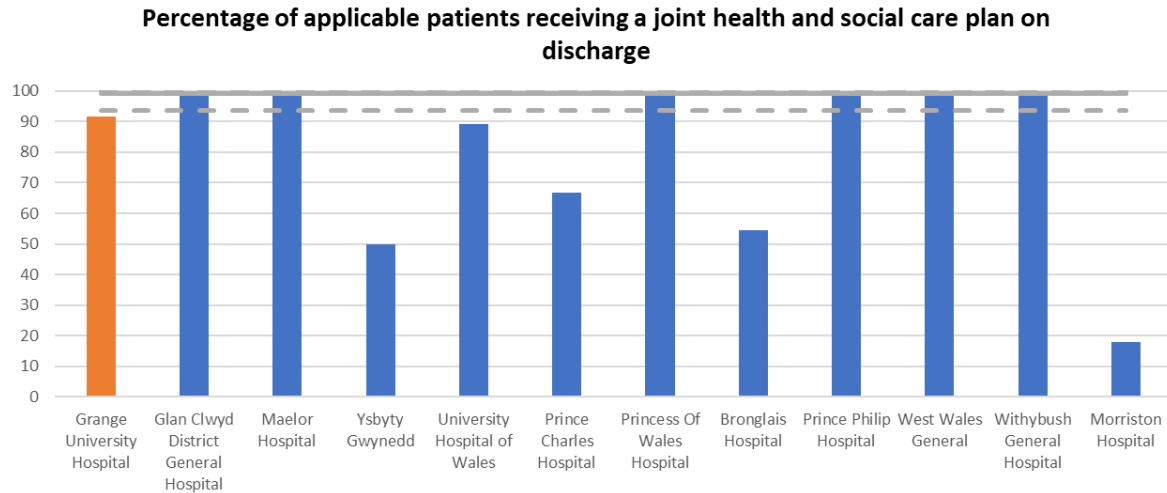
**Percentage of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days – 25%**

This performance measure (see fig 27) may be related to poor documentation, which makes it difficult for a data clerk to record that this target has been met. Although goals are often set, this may not be clearly documented following MDT discussions.

**Recommendation 19: Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.**

## 7.11 Joint health and social care plan by discharge

Figure 28



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.1A

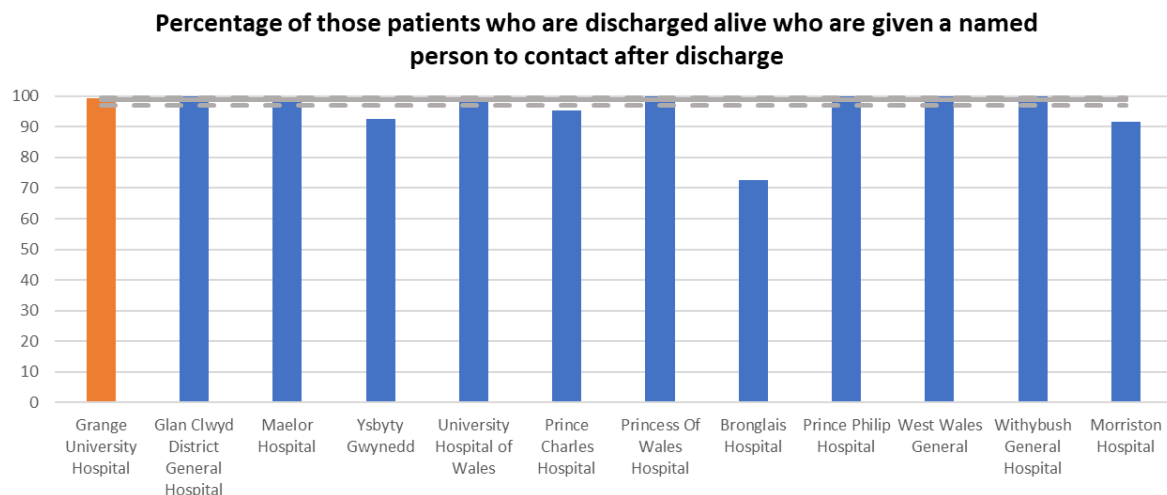
Source: SSNAP Oct 2021-Dec 2021

### **Percentage of applicable patients receiving a joint health and social care plan on discharge – 91.7%**

Joint health and social care planning by discharge is delivered and documented in over 90% of patients, this is below the English national average.

## 7.12 Discharged with a named contact

Figure 29



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.4A

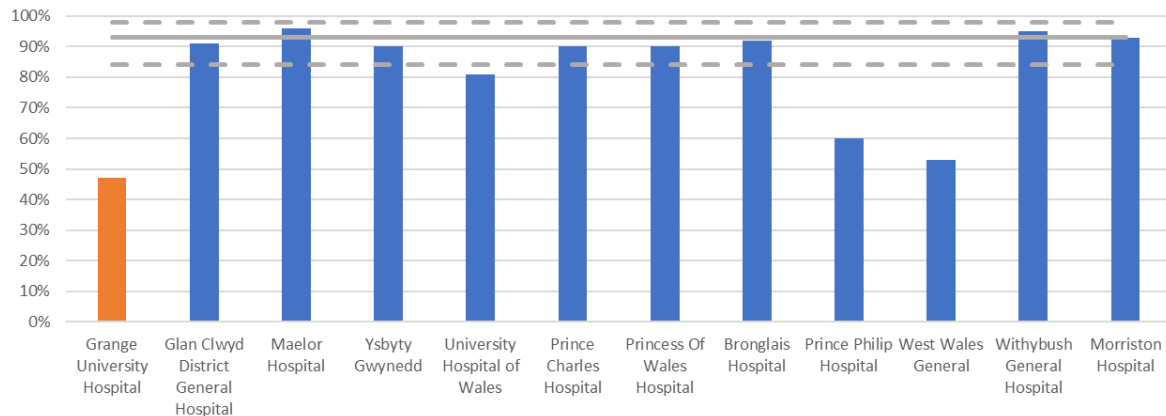
Source: SSNAP Oct 2021-Dec 2021

### **Percentage of those patients who are discharged alive who are given a named person to contact after discharge – 99.3%**

## 7.13 Patients applicable for a 6-month assessment

Figure 30

**Proportion of patients alive who are considered applicable to be assessed at 6 months**



Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Item Reference B12.3

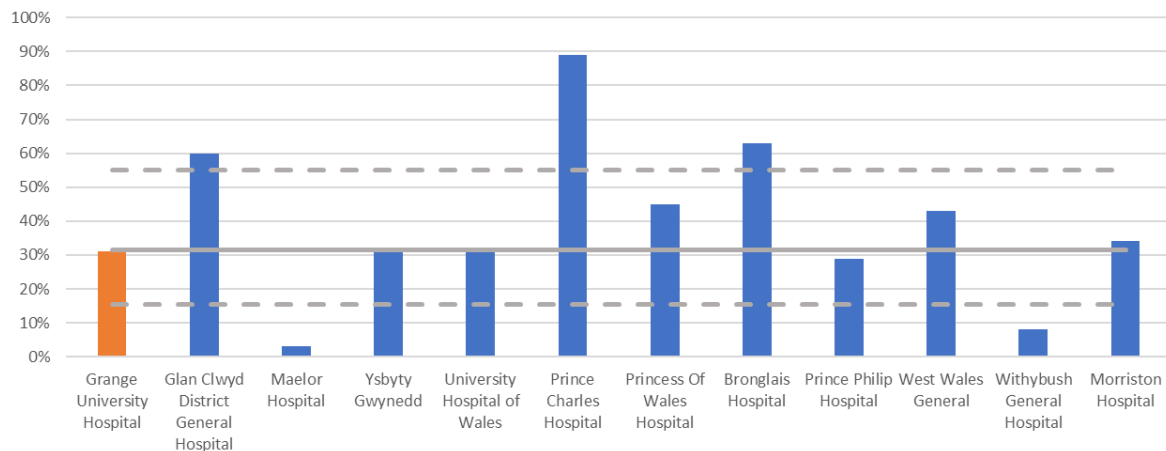
Source: SSNAP Oct 2021-Dec 2021

**Proportion of patients alive who are considered applicable to be assessed at 6 months – 47%, below Wales’s average.**

**7.14 Applicable patients receiving 6-month assessments**

Figure 31

**Proportion of applicable patients receiving 6 month assessments**



Grey lines show the median and interquartile range of sites in England

Team-centred results at team level for Item Reference B13.3

Source: SSNAP Oct 2021-Dec 2021

**Proportion of applicable patients receiving 6-month assessments – 60%**

There is unwarranted variation in the proportion of patients who receive a 6-month assessment.

Delivering an adequate review post discharge is essential to ensure that patients have completed all the necessary investigations to identify the aetiology of stroke, have had access to appropriate post discharge rehabilitation, are taking appropriate secondary prevention and are having their risk factors for recurrent stroke adequately managed. This

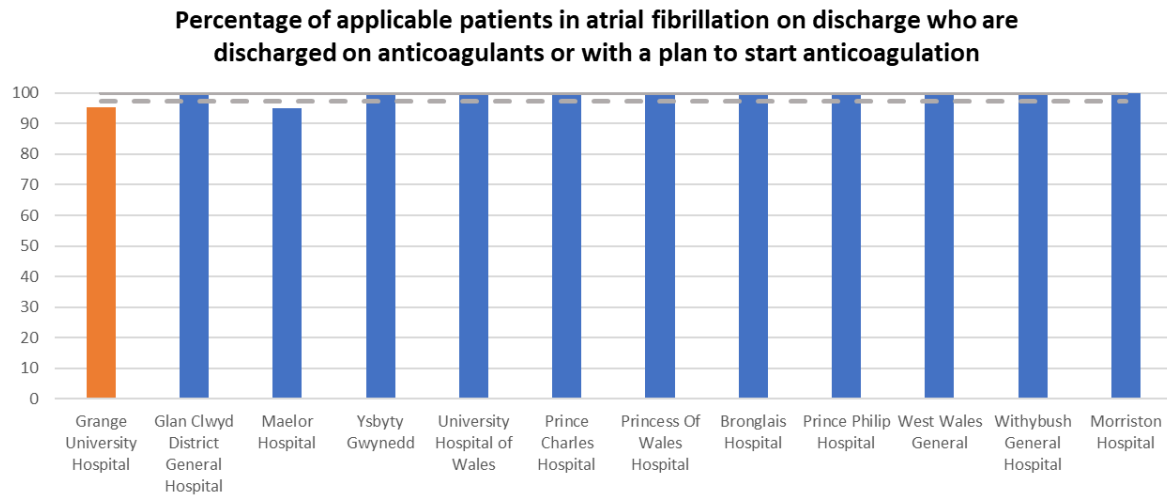
does not need to be delivered by a secondary care stroke physician and is often more effectively delivered by community stroke nurses who deliver a more holistic approach

**Recommendation 20: Standardise post discharge reviews using the GM-SAT six-month post stroke review tool.**

## 8 Secondary prevention

### 8.1 If in atrial fibrillation, discharged on anticoagulants

Figure 32



Grey lines show the median and interquartile range of sites in England

Patient-centred results at team level for Key Indicator 10.3A

Source: SSNAP Oct 2021-Dec 2021

**Percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation – 95.2%**

## 9 Summary of Recommendations

The table below summarises the recommendations made in the body of this report and is intended to serve as a useful tool for action planning.

**Table of Recommendations**

| # | Recommendation  |
|---|---|
| 1 | Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.   |
| 2 | Commission an ESD pathway process flow map. It is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM <a href="https://www.england.nhs.uk/stroke-integrated-community-service-february-2022.pdf">stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)</a> ) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.                                 |
| 3 | Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 <a href="https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf">https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf</a> . |
| 4 | ABUHB to develop a strategy to improve direct access to the stroke unit within 4 hours of presentation.   |
| 5 | Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for   |

|    |   |
|----|---|
|    | imaging should help to release bed capacity and increase access.  |
| 6  | Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.   |
| 7  | Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.  |
| 8  | Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.   |
| 9  | ABUHB to put more cohorts of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.  |
| 10 | Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: <a href="https://www.england.nhs.uk/stroke-integrated-community-service-february-2022.pdf">stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)</a> .  |
| 11 | Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.  |
| 12 | Embed the National Stroke Service Model in ABUHB <a href="https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf">https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf</a>  |
| 13 | Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.   |
| 14 | The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework <a href="https://stroke-education.org.uk/">https://stroke-education.org.uk/</a> ].   |
| 15 | Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach.  |
| 16 | ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.  |
| 17 | Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.   |
| 18 | Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.   |
| 19 | Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota. |
| 20 | Standardise post discharge reviews using the GM-SAT six-month post stroke review tool: <a href="https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/07/gm-sat-proforma.pdf">https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/07/gm-sat-proforma.pdf</a>  |

**Review of Therapies in Stroke Services**  
**Aneurin Bevan University Health Board (July 2021)**

*Authors:*

*Alice Reed, Head of Nutrition and Dietetic Services, Cwm Taf Morgannwg University Health Board*

*Madelaine Najjar, Dietetic Operational Lead – Bridgend, Cwm Taf Morgannwg University Health Board*

**Background**

In February 2017, Welsh Government published its Stroke Delivery Plan 2017-2020 (Welsh Government, 2017) to continue to improve stroke services in Wales. It provided a framework for action by Health Boards setting out expectations of stroke care which included workforce. Allied Health Professionals form an integral and part of this critical workforce in giving patients 'an excellent chance of surviving and returning to independence as quickly as possible'.

All Health Boards in Wales participate in the Sentinel Stroke National Audit programme (SSNAP) (Kings College London, 2021) which includes regular review of performance against set standards.

In a recent review by the NHS Wales Delivery Unit (Appendix A), stroke services at ABUHB were reported for targets associated with therapies as B, C, C and D to St. Woolos, Royal Gwent (RGH), Neville Hall (NHH) Hospitals and Ysbyty Ystrad Fawr (YYF) respectively. This report was against October to December 2019 performance. The report also stated there continues to be minimal change in performance overall. Several observations and subsequent recommendations were made. Many improvements have already been scoped and some initiated to date by the stroke therapy team with plans to implement others over time. This in itself will result in some efficiencies.

Whilst treatment of stroke patients remained a priority service during 2020, it was undoubtedly affected by the urgent need to address the impact of COVID19. From discussions with the therapy team staff worked flexibly over this period to support stroke patients and wider priority patients during the pandemic.

A significant impact for ABUHB was the opening of the Grange University Hospital (GUH) ahead of schedule to increase bed capacity during the pandemic. Originally, plans proposed to move HASU stroke beds to GUH. This was completed without immediate closure of stroke beds on other sites and therefore without additional stroke specialist therapy workforce. The current specialist workforce stretched to cover these additional beds.

**Purpose**

The aim of this report is to analyse the current status of specialist therapy workforce for stroke services in ABUHB against recommended standards. This includes services to patients in commissioned stroke beds as well as those receiving specialist care from the Early Supported Discharge (ESD) community service which in Aneurin Bevan University Health Board is via the Community Neuro-rehabilitation Service (CNRS).

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.



The purpose is to identify any efficiencies or gaps in therapy workforce to ensure stroke services and therefore stroke survivors are assessed and treated by an adequately staffed workforce that are skilled and competent.

The report objectives are set out as follows:

1. Mapping of existing therapy workforce for hyper-acute stay unit (HASU), acute & rehabilitation beds
2. Mapping of existing therapy workforce for ESD
3. Comparison of therapy workforce levels against clinically recommended levels in each setting
4. Identification of gaps in therapy workforce for stroke services in ABUHB
5. Identification/suggestions for efficiencies to explore to improve workforce of therapy workforce for stroke services

### **Criteria**

Professions included in this analysis include;

- Physiotherapists
- Occupational therapists
- Speech & Language therapists
- Dietitians

The therapy workforce that is included are those who are classed as stroke specialist. This includes those that are deemed competent in the clinical area of stroke through training, achievement of professional competencies or through experience. Some therapy staff at band 5 level are included that may not be classed as stroke specialist however work under the direct supervision of a senior stroke specialist therapist and has dedicated time to commissioned stroke beds.

Senior staff time to operationally lead teams or strategically develop stroke services have been omitted from the workforce numbers. Generalist therapy staff who provide ad hoc cover are not included in the workforce analysis.

All therapy workforce included in this report have a mix of WTE from defined stroke financial resources and some dedicated from core professional services budget. Therapy Service Managers have prioritised WTE from core service budgets to stroke services in combination with dedicated stroke financial investment as services developed.

Stroke services within ABUHB covered within this report:

- Grange University Hospital (GUH) – 15 beds; 12 hyper-acute, 3 GM/TIA
- Ysbyty Ystrad Fawr (YYF) – 17 beds; 3 acute, 14 rehabilitation
- Royal Gwent Hospital (RGH) – 24 beds; 6 acute, 18 rehabilitation
- Neville Hall Hospital (NHH) – 21 beds; 5 acute, 16 rehabilitation
- Early Supported Discharge (ESD) via CNRS\* – average 348 patients per year

Data was provided by therapy services on current workforce. Skill mix of workforce and split over multiple units was obtained. General subjective assessment of working within settings was also discussed with the senior staff within each of the therapy professions.

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

The therapy workforce has recommended standards of staffing levels per beds or number of beds from several sources. For this report, clinical recommended standards for therapy workforce were used as follows:

- Hyper-acute and acute services
  - RCP National Clinical Guideline for Stroke (Royal College of Physicians, 2016)
- Rehabilitation in-patient services
  - Specialised Neuro-rehabilitation Service Standards (updated May 2019) (British Society of Rehabilitation Medicine, 2019)
  - As mid-point level 2a to 2b (pp. 5)
- CNRS (ESD) Services
  - 'A Consensus on Stroke: Early Supported Discharge' (Fisher et al, 2011)

Within the standards for ESD services there were no recommended workforce levels for dietitians. These standards are now in effect 10 years old and although reference need for access to dietetics, several articles state dietitians must be part of the multi-disciplinary team. As a result, this report was unable to determine recommended dietetic workforce needs in the ESD service.

All workforce figures are based on services for 5 days a week for both stroke beds and CNRS service. Where Saturday services have been trialled, this did not include additional workforce but stretched the working week.

### **Findings – Commissioned Stroke beds**

Total workforce for each of the therapy professions for all HB commissioned beds can be seen in table below 'Therapy Workforce Analysis in total; 77 stroke beds in ABUHB'. All professions have a gap in workforce against the relevant recommended standards for bed type (i.e. hyper-acute, acute or rehabilitation). The percentage gap can be seen for each profession ranging from 36 to 51% over all sites.

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

| <b><u>Therapy Workforce Analysis for total; 77 (29 acute, 48 rehabilitation), Stroke bed in ABUHB</u></b> |  |                  |                  |       |
|---|--|------------------|------------------|-------|
| Profession  | Required workforce from clinical standards | Actual workforce | Gap in workforce | % Gap |
| Physiotherapy   | 17.7                                       | 11.4             | -6.4             | -36   |
| Occupational Therapy  | 17.5                                       | 8.8              | -8.7             | -50   |
| Speech & Language Therapy   | 6.9  | 3.4              | -3.5             | -51   |
| Dietetics   | 2.7  | 1.6              | -1.1             | -40   |

As the commissioned stroke beds are split across 4 hospital sites within the Health Board. The next table 'Therapy Workforce Analysis per site' shows the breakdown of each profession's workforce at each site. Against each of the profession's relevant standards per bed type (i.e. hyper-acute, acute or rehabilitation) some sites are better staffed than others. Only 1 site, GUH has the sufficient staffing levels for only 1 profession, occupational therapy, but this is not consistent with the other professions. Generally, physiotherapy appears to be the most adequately staffed over all sites but is still in all areas below recommendations.

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

| Therapy Workforce Analysis per site |             |               |                                      |                  |                  |                      |                                      |                  |                  |                           |                                      |                  |                  |            |                                      |                  |                  |
|-------------------------------------|-------------|---------------|--------------------------------------|------------------|------------------|----------------------|--------------------------------------|------------------|------------------|---------------------------|--------------------------------------|------------------|------------------|------------|--------------------------------------|------------------|------------------|
| Site                                | Bed numbers | Profession    | Required workforce against standards | Actual workforce | Gap in workforce | Profession           | Required workforce against standards | Actual workforce | Gap in workforce | Profession                | Required workforce against standards | Actual workforce | Gap in workforce | Profession | Required workforce against standards | Actual workforce | Gap in workforce |
|                                     |             | PHYSIOTHERAPY | WTE                                  |                  |                  | OCCUPATIONAL THERAPY | WTE                                  |                  |                  | SPEECH & LANGUAGE THERAPY | WTE                                  |                  |                  | DIETETICS  | WTE                                  |                  |                  |
| GUH                                 | 15          |               | 2.2                                  | 2.0              | -0.2             |                      | 2.0                                  | 2.0              | 0.0              |                           | 1.0                                  | 0.7              | -0.3             |            | 0.5                                  | 0.2              | -0.3             |
| YYF                                 | 17          |               | 4.4                                  | 2.5              | -1.9             |                      | 4.3                                  | 2.0              | -2.3             |                           | 1.6                                  | 0.9              | -0.7             |            | 0.6                                  | 0.0              | -0.6             |
| RGH                                 | 24          |               | 6.0                                  | 3.6              | -2.4             |                      | 5.9                                  | 2.8              | -3.1             |                           | 2.3                                  | 0.8              | -1.5             |            | 0.8                                  | 1.0              | 0.2              |
| NHH                                 | 21          |               | 5.2                                  | 3.3              | -1.9             |                      | 5.2                                  | 2.0              | -3.2             |                           | 2.0                                  | 1.0              | -1.0             |            | 0.8                                  | 0.4              | -0.4             |

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

The following 4 tables below show the breakdown of therapy staffing per site including percentage gap of each profession. The best staffed site from a therapy perspective is GUH (as seen in table 'GUH Therapy Workforce Analysis'). Although the gap varies greatly between each profession, for example, with no gap if staffing for occupational therapy to 60% staffing gap in Dietetics.

| <b>GUH Therapy Workforce Analysis</b> |  |                  |                  |       |
|---------------------------------------|--|------------------|------------------|-------|
| (15 acute beds)                       |  |                  |                  |       |
| Profession                            | Required workforce from clinical standards | Actual workforce | Gap in workforce | % Gap |
| Physiotherapy                         | 2.2  | 2.0              | -0.2             | -9    |
| Occupational Therapy                  | 2.0  | 2.0              | 0.0              | 0     |
| Speech & Language Therapy             | 1.0  | 0.7              | -0.3             | -30   |
| Dietetics                             | 0.5  | 0.2              | -0.3             | -60   |

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

| <b>YYF Therapy Workforce Analysis</b><br>(17 beds; 3 acute, 14 rehab) |   |                  |                  |       |
|---|---|------------------|------------------|-------|
| Profession  | Required workforce<br>from clinical standards | Actual workforce | Gap in workforce | % Gap |
| Physiotherapy   | 4.4   | 2.5              | -1.9             | -43   |
| Occupational<br>Therapy   | 4.3   | 2.0              | -2.3             | -53   |
| Speech &<br>Language Therapy  | 1.6   | 0.9              | -0.7             | -44   |
| Dietetics   | 0.6   | 0.0              | -0.6             | -100  |

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.



| <b><u>RGH Therapy Workforce Analysis</u></b><br>(24 beds; 6 acute, 18 beds) |   |                  |                  |       |
|---|---|------------------|------------------|-------|
| Profession  | Required workforce<br>from clinical standards | Actual workforce | Gap in workforce | % Gap |
| Physiotherapy   | 6.0   | 3.6              | -2.4             | -40   |
| Occupational<br>Therapy   | 5.9   | 2.8              | -3.1             | -53   |
| Speech &<br>Language Therapy  | 2.3   | 0.8              | -1.5             | -65   |
| Dietetics   | 0.8   | 1.0              | 0.2              | 25    |

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

| <b><u>NHH Therapy Workforce Analysis</u></b><br>(21 beds; 5 acute, 16 rehab) |   |                  |                  |       |
|--|---|------------------|------------------|-------|
| Profession   | Required workforce<br>from clinical standards | Actual workforce | Gap in workforce | % Gap |
| Physiotherapy  | 5.2   | 3.3              | -1.9             | -37   |
| Occupational<br>Therapy  | 5.2   | 2.0              | -3.2             | -62   |
| Speech &<br>Language Therapy   | 2.0   | 1.0              | -1.0             | -50   |
| Dietetics  | 0.8   | 0.4              | -0.4             | -50   |

YYF, RGH and NHH were similar in their inadequacy of staffing. YYF featured a slightly worse in the gap average over the professions. This site had no specialist stroke dietetic cover so a 100% gap in the specialist dietetic profession recommended workforce. Interestingly, YYF was the site with the poorest SSNAP scores overall (score D). Other than GUH all other sites were at 50% gap in therapy workforce on average or higher.

#### **Summary of Findings - Commissioned stroke beds:**

- There is insufficient specialist therapy workforce to commissioned stroke beds
- Gaps in therapy workforce vary between professions and between sites
- GUH is the best staffed site overall but still carries significant gaps in therapy workforce
- 1 site has no specialist stroke dietetic workforce
- Only 1 site, GUH overall has sufficient staffing for only 1 profession, OT
- Site will lowest gap in therapy staffing performed better in SNNAP targets (see table below)

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

| <b>Percentage gap in therapy staffing mapped to stroke target score for each stroke site</b> |                             |                    |
|--|-----------------------------|--------------------|
| <b>Stroke Site</b>   | <b>Therapy staffing gap</b> | <b>SSNAP score</b> |
| St. Woolos (beds transferred to GUH)   | 14%                         | B                  |
| YYF  | 50%                         | D                  |
| RGH  | 45%                         | C                  |
| NHH  | 49%                         | C                  |

To safely staff commissioned stroke beds without enhancement in the existing therapy workforce then the current bed capacity would need to be reduced. This is not a recommendation of this report as this should be set according to population needs for stroke incidents. The table below theoretically represents the beds numbers each profession in therapies could safely staff in line with recommended workforce levels. Current bed numbers total 77 across the health board. The number of sites would also impact on the ability to logistically work well. The geographical area would also dictate this in reality. Whilst collocating could bring efficiencies in current staffing levels it still would not solve the deficient in therapy workforce staffing. Efficiencies are possibly use of better skill mix of workforce, cover during leave and reduction in travel of staff who cover multiple sites

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

| <b><u>Number of stroke beds safely staffed from existing therapy workforce</u></b> |                          |  |
|--|--------------------------|--|
| Profession   | Existing Workforce (WTE) | Beds safely staffed from existing workforce* |
| Physiotherapy  | 11.4                     | 49   |
| Occupational Therapy   | 8.8                      | 39   |
| Speech & Language Therapy  | 3.4                      | 38   |
| Dietetics  | 1.6                      | 46   |

\*Assuming the current hyper-acute, acute, rehabilitation bed type ratio is the same

### **Findings – CNRS Service**

Analysis of workforce against recommended clinical standards in the CNRS can be seen in the table below. Overall, physiotherapy, occupational therapy and speech and language therapy workforce are insufficiently staffed to patient's numbers. As discussed earlier there are no recommendations for dietetic workforce. The Therapy assistant practitioner workforce appears to be staffed above recommended standards.

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

| <b>Therapy Workforce Analysis for ESD Service in ABUHB;<br/>based on average 385 patients per year</b> |  |                  |                  |        |
|--|--|------------------|------------------|--------|
| Profession   | Required workforce from clinical standards | Actual workforce | Gap in workforce | % Gap  |
| Physiotherapy  | 3.9  | 2.5              | -1.4             | -36    |
| Occupational Therapy   | 3.9  | 3.0              | -0.9             | -23    |
| Speech & Language Therapy  | 1.5  | 1.2              | -0.3             | 20     |
| Dietetics  | no std                                     | 0.4              | no std           | no std |
| Unregistered   | 1.0  | 5.4              | 4.4              | 440    |

The patients per year data was based on an average of the last 2 years. However, the patient numbers have grown year on year and so the workforce is likely to be increasingly insufficient as the year's progress and the gaps underestimated with current year to date.

CNRS Service:

- All qualified therapy staff, where standards of workforce exist, are insufficient
- Gaps in workforce per patient numbers per year are likely to be underestimated and as demand grows this gap will worsen and impact on service capacity

With current workforce levels the table below shows per profession how many patients can be safely managed in the CNRS. On average this equates to 283 patients per year which is

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

much lower than the current average of 385 which has already been suggested as below current year forecast of 409.

| <b><u>Number of ESD patients per year safely staffed from existing therapy workforce</u></b> |                                 |  |
|--|---------------------------------|--|
| <b>Profession</b>  | <b>Existing Workforce (WTE)</b> | <b>Patient numbers/year safely staffed from existing workforce</b> |
| Physiotherapy  | 2.5                             | 250  |
| Occupational Therapy   | 3.0                             | 300  |
| Speech & Language Therapy  | 1.2                             | 300  |
| Dietetics  | 0.4                             | unknown  |

## **Discussion**

### **Commissioned beds**

Overall, all sites where there are commissioned stroke beds are understaffed for therapy workforce.

Only 1 site met only 1 professions standards and that was Occupational Therapy services at GUH. Without an MDT there is limitations in each profession to support patients to achieve their overall expected outcomes of recovery from stroke and prolonged hospital stay.

With multiple sites to staff across the therapy professions, this adds its own inefficiencies. Any potential efficiencies identified may not be possible even if staffed appropriately and further detrimental with staff levels low due to the multiple site model. The multiple sites, whilst also

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

needing to be suitable for the population needs and accessibility adds further concerns to the ability to treat patients following a stroke for several reasons suggested below:

- With staff covering more than 1 site, daily targets for therapy are not met as the majority of therapy professions do not have the staffing requirements to cover all sites 5 days a week. This was identified in delivery unit review 2019 (Appendix A).
- Not all professions able to attend MDT depending on day they visit site. Recommendation in SSNAP (2021).
- Travel between sites is inevitable and therefore a loss of clinical time. Mostly staff coordinate their week to minimise travel during the day, adhering to one site per day however this means patient referrals, assessments or follow-ups will have to wait until the therapist next visits. Alternatively, telephone support or more generalist staff support can be sought but is not in line with standards of clinical treatment in stroke for therapies and can impact of patient's stroke recovery and potential outcomes.

Where hyper-acute, acute and rehabilitation are not delivered in the same site, therein results in the need to transfer patients. This again can result in inefficiencies in therapy staffing provision. Concern was also raised by the therapy staff for a need to improve the patient pathway for stroke. Points were raised and discussed by staff as follows:

- With no rehabilitation beds at the site of the HASU this means transfer to other site impacting on services for transfer and therefore flow within site rather than between sites for stroke patients.
- Frequently prior to COVID stroke patients were not on the designated stroke beds but on other wards (outliers).
- Stroke patients, cared for in non-stroke beds were not in the most appropriate environment to enable stroke specialist care due to space, equipment available causing restrictions to rehabilitation that could be achieved.
- Stroke beds often would have general medical patients (particularly in NHH and YYF) and so therapy team would pick up non stroke work as well as seeing outliers in non-stroke beds.
- Often OT stroke staff would keep patients requiring complex discharge planning support in stroke beds and covered by these staff. It aids reducing 'hand-offs' and minimising length of stay but is not accounted for in staffing requirements for stroke services.
- Self-presenting patients were not always transferred to the correct site for the stroke pathway treatment needed

The staffing figures in this report are based on the 5 days service only for both stroke beds and CNRS service. The SSNAP target recommend 7 day services to improve patient outcomes. Where the therapy services are already understaffed across 5 days, to stretch to a 7 day service to meet SSNAP targets would dilute the weekday service without extra investment therefore further impacting patient outcomes.

Whilst work has been trialled to deliver a 6 day service, which included Saturdays, this showed the Occupational therapy, Physiotherapy and Speech and language therapy staff spread thinly as no additional resource was added to support the increase in cover. Therefore, this diminished the therapy services overall. The Therapy Stroke team also, over a period of 12 weeks, monitored a period of no weekend working, which showed limited impact on stroke patients overall compared to the 6 day/week pilot.

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.



All of the four therapy professions provide band 5 rotation programmes through the specialist stroke service. This is accepted as staffing resource in the standards reviewed given, they are supervised by a stroke specialist. Whilst this has benefit training staff and increasing recruitment of specialists in future it also adds an extra pressure into the need for specialist stroke therapists to train. The rotations can vary in length but are generally 12 month in duration. The re-training of staff takes significant time and likely to impact on the time to deliver clinical care. This impact is significant in Speech and language therapy where it takes a minimum of 6 months to achieve specialist level dysphagia competencies, a key skillset for stroke intervention.

Most of the therapy professionals have part of their senior specialist work as team/strategic lead in addition to their highly skilled clinical work. Whilst this is imperative to service improvements, ensuring staff are appropriately trained and supported and evaluating excellent care to patient it does take up time from multiple staff. DU suggested a multi-professional lead similar to ESD. This would have more benefits to replicating team leads across each therapy and therefore diluting remaining time in work for clinical. It may also show efficiencies for inter-disciplinary working as basic as structuring the day, hand overs, replicating paperwork and QIM reporting.

Whilst there are no specialist stroke recommendations for therapy support worker staff, they remain a vital part of the specialist stroke therapy workforce. Most professions utilise therapy support worker hours either solely for the clinical area or as part of a wider generic caseload. Whilst in the stroke units, supervision by specialist therapists would be in place. By utilising support workers in addition to the qualified therapy workforce this provides an effective workforce skill mix, but support workers should not replace only compliment qualified therapists.

Other discussion points raised for the teams DU report in 2019 includes use of clinical staff for clerical tasks. Many of the qualified therapist carry out clinical administrative tasks but also considerable amount of non-clinical administrative tasks. This was identified in the DU report and a regular frustration of staff. To quantify efficiencies with adequate administrative support is difficult to determine. However, currently utilising qualified staff for admin duties diminishes clinical time and will continue to do so if not addressed.

Lastly for commissioned stroke beds, the DU report also noted that focus should be made on increasing the intensity of therapy not simply the quantity. With a staffing level below recommended this will be difficult to achieve with the deficit in demand already.

## **CNRS**

Within the CNRS there is a deficit across all professions in comparison to the Fisher 2011 consensus, although Dietetics cannot be mapped to this. The current service is above the recommendations for unregistered staff, with these staff likely to be supporting some but not all of the gaps in qualified therapists. Psychology has not been included in the review although is recommended with the ESD standards.

The original service was set up using the staffing establishment suggested by Fisher 2011. This consensus statement is limited in that it is ten years old and so may not take into account relevant recent research into ESD services and neither does it include all relevant professions i.e. Dietetics. However, there is not a more recent consensus in the evidence base to use. SSNAP also reference access to dietetics as a recommendation. It is thought that further

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

research and publication will include dietetics as a recommended need of the ESD MDT with many NHS services already including a dietitian as part of their local ESD teams. CNRS within ABUHB does have dedicated dietetic supported within the team. It is to be determined locally if this is effective and sufficient for the population needs.

For the purposes of this staffing review the average number of accepted referrals into the service over the last 2 years was included. It should be noted that the service is growing year on year with a predicted 14% increase between 2019-2020 and the projection for 2020-2021. For 2020-2021 only the first 9 months was included and so the year total was estimated based on a forecast from the first 9 months. This does not take into account any capacity needed around those referrals not accepted i.e. with triage and in reach.

During the pandemic in-reach services have been replaced with a trusted assessor model. On review by the team, there has been no significant impact of using this change in model and may be able to be continued longer-term to improve team efficiencies.

The CNRS has increased its scope to accepting more severe strokes into the service. On discussion with staff, when they have reviewed this, they found little improvement in patient outcomes for this cohort. Accepting these patients impacts the service for the mild to moderate patients due to the greater demands on therapy time from the more severe strokes.

Similar recommendations were made by the DU (2019) report releasing more time for clinical task by considering better reporting systems to streamline therapists' work. Introducing nursing establishment as per the ESD service standard recommendations may also release therapist's time for therapy interventions.

All of the above posts with the exception of 2.0 WTE band 4 Therapy Assistant Practitioner and the Clinical Psychologist have been funded via the ICF route ending in 2022. Although this staffing resource has been appointed to permanently this is now a financial risk for the organisation.

As in commissioned stroke bed discussion. The staffing resource of CNRS is based on a 5 day service. Whilst there are recommendations for this is work as a 7 day service this too would require additional investment so not to dilute the weekday service.

## **Conclusion**

The report objectives were set out as follows:

1. Mapping of existing therapy workforce for hyper-acute stay unit (HASU), acute & rehabilitation beds
2. Mapping of existing therapy workforce for CNRS
3. Comparison of therapy workforce levels against clinically recommended levels in each setting
4. Identification of gaps in therapy workforce for stroke services in ABUHB
5. Identification/suggestions for efficiencies to explore to improve workforce of therapy workforce for stroke services

Objectives 1- 4 have been addressed as part of the findings of this report. The current therapy workforce is significantly below the recommended standards for hyper-acute, acute,

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

rehabilitation and CNRS overall. In addition to the low workforce provision a number of factors compound the limited resources available including multiple sites providing specialist stroke care, need for a clear stroke pathway for patients, rotational therapy staff, need for 7 day services as per recommendations and clinical time used for non-clinical administrative tasks.

Whilst investment appears to be needed to improve the Therapy workforce to meet standards there are several other opportunities to improve the efficiency of the therapy workforce and would be remiss to not further explore whether these are feasible to improve care for stroke patients.

### **Recommendations**

The purpose of this report is to identify any efficiencies or gaps in therapy workforce to ensure stroke services and therefore stroke survivors are assessed and treated by an adequately staffed workforce that are skilled and competent.

The last objective; Identification/suggestions for efficiencies to explore to improve workforce of therapy workforce for stroke services, is addressed in the recommendations below. Ultimately, investment of Therapy resources is the most urgent and clear need but there are also opportunities to improve efficiencies. This would improve efficiencies in, not only the current workforce clinical time, but also even if further invested, enabling a more effective therapy workforce:

#### **Commissioned beds**

- Investment into increasing therapy staff levels to recommendations as set out in this report per commissioned stroke bed
- Explore the current need for administrative support for the 4 sites to release clinical time
- Review of stroke bed sites available both from the case of multiple sites but also multi stroke treatment need (i.e. hyper-acute, acute, rehabilitation) thus reducing transfer of patient between sites
- A clear stroke pathway for stroke patient's i.e. ring-fencing beds for stroke care so not used by general medical and reducing outliers of stroke patients on other wards.
- Consideration of increasing therapy workforce above recommendations were rotational staff form a large percentage of the allocated specialist workforce including identification of most effective skill mix to enable continuity of patient care and training of staff to increase future workforce.
- With time deducted from several professions for 'team lead' or service development needs consideration of multi-professional leads similar to CNRS. Explore the benefits from inter-disciplinary working not only for staff efficiencies but better patient experience and outcomes.
- Consideration of inter-disciplinary therapy assessments to enable regular therapy monitoring or intervention and efficiencies for blended therapy approach and supervision particularly around reporting to MDT's if not all qualified staff available daily

#### **CNRS**

- Investment into increasing therapy staff levels to recommendations as set out in this report as per service demand.

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

- Permanent financial investment in CNRS with scope to increase based on service demand to reduce impact on hospital beds, delays to discharge and potential readmissions
- Mapping of local population need to dietetic services for CNRS. To internally identify the current need and whether provision meets this. To identify any gaps in demand and capacity with CNRS for dietetic support.
- Maintain the 'trusted assessor' model rather than physical in reach into services. This has been implemented during COVID with positive feedback from staff and no reported negative impact on flow.
- Consideration of the introduction of nurse provision into CNRS establishment to release therapist time
- Review of reporting systems and ability to streamline and release therapy time back to clinical
- Review the current practice of accepting more severe stroke patients. Currently accepting patients with higher needs with no obvious improvement for those patients and causing a reduction in intensity of therapy for the rest of the caseload.

These recommendations outlined not only would improve therapy provision but likely to have a positive impact on other professions ensuring no impact on ability to meet patient outcomes for stroke survival.

## **References**

British Society of Rehabilitation Medicine (2019). *Specialised Neurorehabilitation Service Standards*. Available at: <https://www.bsrn.org.uk/downloads/specialised-neurorehabilitation-service-standards--7-30-4-2015-pcatv2-forweb-11-5-16-annexe2updatedmay2019.pdf> (Accessed: 3 May 2021).

Fisher, J et al (2011). 'A Consensus on Stroke: Early Supported Discharge'. *Stroke*. Vol: 42: pp. 1392-1397.

Kings College London (2021). *Sentinel Stroke National Audit Programme*. Available at: <https://www.strokeaudit.org/Home.aspx> (Accessed: 3 May 2021)

Royal College of Physicians (2016). *National Clinical Guideline for Stroke*. Available at: [https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-\(1\).aspx](https://www.strokeaudit.org/SupportFiles/Documents/Guidelines/2016-National-Clinical-Guideline-for-Stroke-5t-(1).aspx) (Accessed: 3 May 2021).

Welsh Government (2017). *2017-2020 Stroke Delivery Plan: A Refreshed Delivery Plan for NHS Wales and its Partners*. Available at: <https://gov.wales/sites/default/files/publications/2018-12/stroke-delivery-plan-2017-to-2020.pdf> (Accessed: 3 May 2021).

\*The ESD service is delivered from the Community Neuro Rehabilitation Service in ABUHB. This service is described as both ESD and or CNRS throughout this document but is referring to the same service. The standards refer to this service as ESD.

# National Review of Patient Flow

## a journey through the stroke pathway



## Content

## Page

---

|   |    |
|---|----|
| Foreword  | 4  |
| Summary   | 6  |
| Context   | 12 |
| What we did                                       | 14 |
| What we found                                     | 21 |
| 1. Health Protection and Stroke Prevention        |    |
| 2. Signposting patients for medical assistance    |    |
| 3. Impact of flow on WAST + ED                    |    |
| 4. Impact of flow on Assessment, and admission    |    |
| 5. Impact of flow on treatment and therapies      |    |
| 6. Impact of flow on patient discharge, workforce |    |
| Conclusion  | 84 |
| What next   | 85 |
| Annex A: Recommendations                          | 86 |

# Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

## Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

## Our values

We place people at the heart of what we do.

We are:

- Independent - we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

## Our goal

To be a trusted voice which influences and drives improvement in healthcare

## Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.





## Foreword



I am pleased to be publishing this report which presents the findings from our National Review of Patient Flow: a journey through the stroke pathway. The focus of this work was to understand the risks and challenges associated with inefficient patient flow, and what impact this has on patients.

We know from our programme of assurance work that poor patient flow can have a hugely negative impact on the quality of services being provided. This has been a common factor in our inspections of Emergency Departments, and our previous review looking at ambulance handover delays to hospitals.<sup>1</sup> Poor flow can have a detrimental impact on the ability of staff to deliver safe and consistent standards of care and affects the experience and outcomes for patients.

It is fair to say that examples of poor patient flow are well known, and not just cited in the work of HIW. Every one of us is likely to know someone who works in a healthcare service; has been a patient who has encountered this during a hospital stay; or indeed, works in a service area where patient flow is a daily challenge.

What our review has done, however, is to highlight what these challenges mean in reality, to patients and to staff at various points on a journey from hospital admission through to discharge.

The impact of poor patient flow is ultimately felt by patients, who are not always receiving the care and treatment they need in the most timely manner. Delays in treatment can substantially impact the likelihood of developing further complications. This was particularly evident in stroke patients whom we considered as our case study. What is crucial now, is that all aspects of the health and social care system work together as effectively as possible to address poor flow and achieve better outcomes for patients in Wales.

As healthcare services continue to face unprecedented demands, and staff work tirelessly to provide safe and effective care to patients, it is clear that renewed efforts are required from the health and social care sectors, alongside Welsh Government, to tackle the issue of poor patient flow.

---

<sup>1</sup> [Review of patient safety, privacy, dignity and experience whilst waiting in ambulances during delayed handover](#)

I am pleased that our work has enabled us to identify areas for improvement, and to highlight areas of good practice. Not just in relation to the stroke pathway, but also for all patients.

I want to take this opportunity to thank staff working within both health and social care sectors who endeavour to provide safe and effective care to people on a daily basis. Their dedication and commitment provide a strong and positive basis upon which to improve.

Alun Jones

Chief Executive

Healthcare Inspectorate Wales

## Summary

This report sets out the findings from our National Review of Patient Flow: a journey through the stroke pathway.

The review explored the experiences of people accessing care and treatment for stroke at each stage, from calling an ambulance, transfer to hospital, assessment, inpatient treatment, through to discharge.

Patient flow is the movement of patients through a healthcare system, from the point of admission to the point of discharge. When patient flow is impeded or is inefficient, it has significant repercussions on the quality and safety of patient care.

Our review has highlighted that across Wales, there are significant challenges which are having a negative impact on the efficiency of patient flow, and this means patients are not always receiving the care they need in a timely and appropriate manner. These challenges are wide ranging; the high demand for inpatient hospital beds combined with the complexities with discharging medically fit patients from hospital, leads to the inpatient healthcare system across Wales operating under extreme pressure. This impacts on the delivery of safe and timely care.

Whilst we found a range of initiatives, different models of care, and approaches being taken within health and social care to tackle the problems arising from poor patient flow, these have not sufficiently tackled the problem. Although there is no single solution, our review identifies opportunities for the health and social care systems to make improvements across each stage of the patient pathway, which may help lessen the impact of poor patient flow. The positive initiatives and approaches identified by our review, should be considered across Wales as services attempt to tackle their challenges with poor patient flow.

We specifically examined the journey of patients through the stroke pathway. This was to understand what is being done to mitigate any harm to those awaiting care, as well as to understand how the quality and safety of care is being maintained throughout the stroke pathway.

Demand is exceeding supply in relation to the healthcare system, and during our fieldwork almost all hospitals we visited were under level four 'extreme pressure', as highlighted in the National Emergency Pressures Escalation and De-escalation Action Plan<sup>2</sup>. The demand was having a knock-on impact on Welsh Ambulance Services NHS Trust (WAST) and its timely response to emergency calls.

---

<sup>2</sup> [National Emergency Pressures Escalation and De-escalation Action Plan](#)

Despite hospital patient flow teams across Wales working tirelessly 24 hours a day seeking to manage patient flow, we found that patient flow issues were negatively impacting on every stage of stroke care. This was from the point of needing to access healthcare at home, through to discharge from hospital.

A key area requiring improvement identified by our work, relates to the need for healthcare services to engage with people, to better understand the barriers to them accessing or choosing from the range of healthcare services available in Wales. The range of healthcare services includes pharmacies, Minor Injury Units, mental health helplines, online NHS consultations, and the NHS 111 Wales service. Once the barriers are understood, this should in turn be used to influence service design. Ongoing engagement with people about the range of available services may reduce the need for people to attend their GP surgery or attend an Emergency Department (ED) when their health concern is not an emergency.

There were prolonged patient handover delays from ambulances to ED at all hospital sites we visited. These delays were significantly impacting on the ability of WAST to respond to emergency calls in the community and increase the risk to patients requiring emergency treatment and transportation into hospital.

It was positive to find that patients suspected as having had a stroke, were prioritised for ambulance handover, and transferred into ED promptly in line with the stroke pathway. However, we found that achievement of the Welsh Government 15-minute target for handover of stroke patients was challenging. This target aims to ensure that time critical investigations and treatment are undertaken promptly to ensure the best outcome for patients.

Challenges with the demand on EDs meant that some patients waited longer than expected for triage and ongoing assessment or treatment. This is a particular risk for those patients who self-present at an ED and have not had any clinical input prior to their arrival.

We found that the recognition of stroke and its prevention is a key area that needs attention across Wales. More needs to be done by NHS healthcare providers and Public Health Wales (PHW) to educate people about this debilitating condition, to help minimise their risk of developing a stroke, and to seek immediate help if symptoms arise. This is of relevance to certain population groups who are at a greater risk of having a stroke, such as those who smoke, have high blood pressure, high cholesterol, diabetes, are obese, or who excessively consume alcohol<sup>3</sup>.

Evidence also suggest that Black and Asian people are at a higher risk of developing a stroke. Health boards and PHW should therefore work closely with these communities to understand the specific issues they face and ensure ongoing engagement with them, in support of better health outcomes.

It was disappointing to find that in 2022, the performance of most acute hospitals in Wales which provide stroke services had deteriorated since 2019.

---

<sup>3</sup> [Causes of Stroke](#)

As highlighted within the UK's Sentinel Stroke National Audit Programme (SSNAP) data, there was an increase from three, to 11 out of 14 acute hospitals who were performing poorly and were categorised as either a D or an E grade (lowest).

However, it is important to note that this period coincided with the global Covid-19 pandemic, and there was an unprecedented demand on hospital beds nationally, which was significantly impacting on patient flow in general, and throughout the stroke pathway.

As highlighted earlier, during our fieldwork almost all hospitals were under level four 'extreme pressure'. To help manage the pressure and patient flow through hospital systems, patient flow meetings were held regularly in all hospitals. They were well attended by the key staff responsible for a patient's journey through hospital. In some health boards, a Hospital Ambulance Liaison Officer (HALO) was also present during patient flow meetings, to discuss the handover delays and plans for longest wait patient handovers. We found this to have a positive impact in managing the issues associated with delayed patient handovers from ambulance crew to ED staff.

Overall, we found that patient flow teams appeared to manage meetings well, and we concluded that they had a strong understanding about which patients needed beds or moves to other wards. This included the oversight of patient specialty outliers in other service groups, such as medical patients cared for in surgical beds and vice versa.

Due to pressure on bed availability, hospitals were not always able to admit patients to the right bed or ward for their treatment. These patient outliers, as they are known, were a consistent finding across Wales. This meant that it was not always possible to move patients, which included stroke patients, to the most appropriate ward or specialty for their care and treatment. It was concerning to find that because of poor patient flow, patients are regularly being treated on a ward that would not usually care for that condition.

Patients who are not allocated to the right bed or ward, can at times experience an increased length of stay. This may lead to other complications, creating additional challenges for care teams and adding to the issue of poor flow. A stroke patient who has been admitted to hospital is likely to have a much better outcome if they are treated on a stroke ward.

During our work, it was positive to find that Improvement Cymru<sup>4</sup>, was undertaking a pilot within three acute hospitals supporting teams to improve their patient flow systems. Together with the health boards, they implemented a Real Time Demand Capacity methodology to focus on the flow process. This focuses on discharge and improving flow in small increments.

---

<sup>4</sup> [Improvement Cymru website](#)

Whilst it does not assist with the existing flow issues which relate to social care, it supports patient flow daily, by preparing patients for earlier discharge times on the proposed discharge date. We noted that this pilot was making a positive difference to the flow process and overall management of beds, and it is an approach that should be considered nationally.

We found that in all cases, staff endeavour to achieve a brain scan for a symptomatic stroke patient within an hour of arrival at hospital. However, although infrequent, it was concerning to find in our clinical records review, that some patients were not receiving a brain scan within the one-hour target. In addition, the SSNAP data we reviewed for the period of April to June during 2019, 2021 and 2022, showed that performance had reduced in nine out of 12 sites, with an increased number of patients suspected as having a stroke waiting more than one hour for a brain scan.

Following assessment and a subsequent stroke diagnosis, it was positive to find that overall, the treatment (called thrombolysis) to help dissolve the clot in the brain, was commenced promptly in ED if there were no beds available to administer this on the acute stroke ward. Thrombolysis is used for certain categories of ischaemic stroke diagnosis and must usually be undertaken within 4.5 hours of the known onset times of stroke symptoms. However, within the updated *National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023*<sup>5</sup>, this treatment window has now been increased to nine hours in some instances, if there is specific evidence of the potential to salvage brain tissue through CT perfusion imaging<sup>6</sup>. Therefore, it is important that WAST works with health boards and Welsh Government to consider the protocol when sending an ambulance to stroke patients, and the increased treatment window.

An alternative procedure to thrombolysis therapy, is surgery to remove a blood clot which is known as a thrombectomy. Thrombectomy can be effective up to 24 hours from onset time of stroke symptoms and can significantly reduce the severity of disability a stroke can cause. This can result in better patient outcomes than those treated with thrombolysis. The only health board in Wales which provides a thrombectomy service is Cardiff and Vale University Health Board. This service operates Monday to Friday from 9am to 5pm, when expert interventional neuroradiology staff and radiology facilities are available to undertake this treatment.

All other health boards in Wales must refer patients for thrombectomy, either to North Bristol NHS Trust, where the service is available to patients from Wales daily between 8am and midnight, or to the Walton Centre NHS Foundation Trust in Liverpool, which offers a 24/7 service. Given the geographical challenges and the availability of ambulances across Wales due to handover delays, this can have a negative effect on the timely provision of a thrombectomy and is of particular concern when thrombolysis is not clinically appropriate.

---

<sup>5</sup> [National Clinical Guideline for Stroke for UK and Ireland](#)

<sup>6</sup> [CT Perfusion - The Walton Centre NHS Foundation Trust](#)

Treating stroke patients with thrombectomy can have better long-term outcomes for people. According to SSNAP data, the annual thrombectomy treatment number between April 2020 and March 2021 within England, Northern Ireland and Wales was 1,763<sup>7</sup>.

It is concerning to find that in Wales, only 13 patients received a thrombectomy at the University Hospital of Wales, just 16 patients from other health boards received treatment in North Bristol and only four at the Walton Centre. More needs to be done to provide equitable access to thrombectomy treatment across Wales.

To give a patient the best possible chance of recovery, specialised stroke unit care must be initiated as soon as possible after the onset of stroke symptoms. Due to the range of specialist treatment they provide, acute stroke units can provide care and treatment to reduce long-term brain damage, physical disability, and healthcare costs. It was, therefore, disappointing to find several delayed admissions to acute stroke wards from ED. This was often due to a lack of available beds owing to delayed transfers to rehabilitation wards, or delayed discharges out of hospital impacted by the inability of social care providers to deliver timely social care.

To help mitigate this issue and maintain flow for stroke patients, most stroke wards aim to ring-fence a stroke beds. However, we found these beds are repeatedly used for non-stroke patients across Wales, due to the persistent issues with the demands on ED services. This is a concern since some stroke patients may not receive the most appropriate and timely care for their condition, including timely ongoing treatment needed to help with their recovery.

We considered whether organisations can provide stroke services through the Welsh language active offer, and whether patients were offered the opportunity to communicate through the medium of Welsh. We found that Welsh speakers worked within or were accessible to stroke patients in all health boards. However, this was not easily identifiable, such as staff uniforms promoting the NHS ‘Gwaith Iaith’ badge.

Across Wales, we found inconsistencies with the provision of rehabilitation to people following their stroke. Overall, we found that the health boards with stroke rehabilitation wards provided an environment that facilitated specific multidisciplinary stroke rehabilitation care, although in some hospitals both acute and rehabilitation care were undertaken in the same environment. We also found inconsistencies across Wales in the provision of the 45-minute daily target for physiotherapy, occupational therapy and speech and language therapy. This was attributed to the challenge with recruiting staff into key therapies posts, and the ability to provide timely services on wards that manage both acute and rehabilitation care to stroke patients.

HIW found good collaborative working between the stroke multidisciplinary teams

---

<sup>7</sup> Annual thrombectomy April 2020 to March 2021



in relation to patient discharge preparation.

However, a key issue which significantly impacts on patient flow and overall patient progress, is the delayed transfer of care and discharge for patients who are medically fit to leave acute care. This can be due to the availability of care home beds or social care and rehabilitation therapies provided within the home.

Unnecessarily long stays in hospital due to delayed discharge can place patients at risk of hospital acquired infections, deconditioning or deterioration whilst awaiting discharge, all of which further impact on flow. The bottleneck at the point of discharge has a knock-on impact on EDs, WAST response times, inpatient care, primary care, planned admissions and overall staff wellbeing.

It is therefore essential that Welsh Government, health boards and social care providers redouble their efforts and work collaboratively to help improve the persistent issues with discharging people from hospital.

To support us with the social care aspects of our review, we utilised the help of Care Inspectorate Wales (CIW)<sup>8</sup>. Through collaboration with CIW and its peer reviewer, we found several factors aligned to social care which also contributed to discharge delays. One issue was frequent delays with social worker allocation causing unnecessary discharge delays for patients who are medically fit to go home. This was identified as an issue in most health boards. Another challenge impacting timely discharge is the ability to provide timely or appropriate domiciliary care packages to people in the community, or the availability of beds in care homes. We found the most significant issue was the recruitment and retention of domiciliary carers, who are needed to provide the social care people need at home. Patients who cannot support themselves at home or who have no other means of care support, cannot be safely discharged. This in turn, increases the flow bottleneck at the hospital 'back door'.

Adding to the complexity of organising packages of care, some hospitals discharge patients to numerous local authorities within their own health board boundary, to local authorities within the boundaries of another health board, or even across the border to England. Sometimes the process in each can be different, adding to the existing challenges, which may include different referral processes or different IT systems. This makes the processes difficult to navigate and more challenging, therefore causing further unnecessary discharge delays and impacting on patient care.

It is evident that staff working within patient flow and stroke services are dedicated to helping patients move through hospital systems. However, our review indicates that health and social care services are not operating as efficiently as they could be. This inefficiency increases the risk of complications arising from delayed discharge and has a significant impact on the overall health and care system in Wales.

In our report, we have identified various areas that require improvement, and have

---

<sup>8</sup> [Care Inspectorate Wales website](#)

made recommendations for action to address these issues. We firmly believe that more can and should be done to tackle the problems highlighted by our review.

## Context

In our Operational Plan for 2021-22, we committed to a programme of national reviews which considered the risks and challenges facing health services as they continue their response to, and recovery from, the pandemic.

Poor patient flow is one of the biggest challenges facing our healthcare system in Wales. This is caused by severe congestion within our hospital systems. There are ongoing pressures on the ability of healthcare systems to manage patients effectively and with minimal delays, as they move through each stage of care through to discharge or moved onto an appropriate care pathway.

Poor patient flow leads to congestion and overcrowding within our EDs, with patients waiting for admission into bed on the wards. Consequently, this also impacts on delays with patient handover from ambulances into EDs. This is consistent within several findings during previous HIW inspections of EDs across Wales, including Ysbyty Glan Clwyd<sup>9</sup>, University Hospital of Wales<sup>10</sup> and Glangwili General Hospital<sup>11</sup> which were undertaken during 2022. In addition, patients in the community must often wait unacceptable lengths of time for an emergency response from WAST and transportation into hospital. This results in increased risks to those patients, as they have not yet been clinically assessed. Poor patient flow frequently impacts negatively on the whole of a patient's journey through the healthcare system.

Our most recent WAST review<sup>12</sup> highlighted how patient handover delays are a consequence of wider systemic patient flow issues through NHS healthcare systems and social care systems. The impact of inadequate bed/trolley availability in EDs is that there are occasions where multiple ambulances are waiting together outside EDs for prolonged periods of time to handover their patients.

---

<sup>9</sup> HIW Hospital Inspection Report - (Unannounced) - ED, Ysbyty Glan Clwyd - Betsi Cadwaladr University Health - 03, 04 & 05 May 2022

<sup>10</sup> HIW Hospital Inspection Report (Unannounced) Emergency Unit and Assessment Unit, University Hospital of Wales, Cardiff, and Vale University Health Board - Inspection date: 20, 21 and 22 June 2022

<sup>11</sup> HIW Hospital Inspection Report (Unannounced) Emergency Unit and Assessment Unit, University Hospital of Wales, Cardiff and Vale University Health Board, Inspection date: 20, 21 and 22 June 2022

<sup>12</sup> HIW WAST review: Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances

The consequences of poor patient flow are well known nationally and can include:

- Delayed ambulance response times to calls
- Delayed ambulance handover
- Overcrowding in EDs
- Patients admitted as ‘outliers’ to wards that are not best suited to manage their care, which may mean they have worse clinical outcomes
- Ambulatory care services, clinical decision units, even catheter labs and recovery units may be used with patients waiting for ward admission
- Inpatients are also often moved between different wards to accommodate new patients
- Staff are overstretched, and routine activities slow down dramatically
- Clinical outcomes can be measurably worse, particularly for frail older people, who suffer more harm events and may decondition due to extended periods in hospital beds.

We recognise there are pressures through the stroke pathway to deliver effective person-centred stroke care, which relate to:

- Timely access to effective care, including transfer to hospital, assessment, key diagnostic interventions, thrombolysis<sup>13</sup> and/or thrombectomy
- Timely admission to an acute stroke ward/unit<sup>14</sup> (or other relevant ward), and other acute care requirements
- Timely therapeutic assessments and treatment
- Stroke rehabilitation and preparation for life after stroke
- Discharge with social care pressures, access to required therapies and ensuring the right support.

As a result of these issues, and our intelligence and other data sources, media reports, and the issues identified through our previous ED inspections, and within both our WAST reviews in 2019-20<sup>15</sup> and in 2020-21<sup>16</sup>, we decided to undertake a review of patient flow with a focus on the stroke pathway. This is because stroke is a complex condition, and timely assessment, treatment, rehabilitation, and

---

<sup>13</sup> Thrombolysis is a procedure to disperse a blood clot and return the blood supply to the brain. Some people with ischaemic stroke are eligible for thrombolysis which, for most people, needs to be given within 4 ½ hours of stroke symptoms starting.

<sup>14</sup> An acute stroke ward/unit is an area in the hospital that is staffed by a specialist stroke multidisciplinary team.

<sup>15</sup> HIW local review report of WAST - Assessment of Patient Management Arrangements within Emergency Medical Service Clinical Contact Centres

<sup>16</sup> HIW review report of Welsh Ambulance Services Trust - Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during delayed handovers

recovery for patients affected by a stroke, requires support from a range of health and social care professionals, with specialist knowledge and skill.

## What We Did

### Focus of Review

The focus of our patient flow review was to consider the patient journey through the stroke pathway from the point of requesting an ambulance or people self-presenting at ED, through to discharge from hospital or transfer of care to other services.

The pandemic introduced unique and unprecedented pressures on the healthcare system; in view of this, our retrospective review of clinical records considered the time-period from March 2020, through to the time of our fieldwork between March and August 2022.

Throughout our review we explored the experiences of people accessing care and treatment for stroke at each stage of care, from calling for an ambulance, to assessment, inpatient treatment, and through to discharge.

Throughout, we considered the following key questions:

- How are healthcare services ensuring that timely access and treatment is provided to patients on the stroke pathway?
- What steps healthcare services are taking to ensure that safe and effective quality care is provided at each stage of care, minimising the impact of delays?
- What measures are healthcare services taking to ensure that patients are able to be discharged effectively, and safely from hospital services?

When planning our review, we were aware work was (and still is) ongoing to tackle the issue of patient flow, with various approaches and initiatives in progress at a national level.

### Scope and methodology

To review the areas detailed above, we requested relevant documents and key information from health boards in Wales and WAST. This helped us to understand the degree of insight each health board has of its strengths and areas for improvement with the processes in place for patient flow on the quality and safety of stroke patients awaiting assessment and treatment. It also helped us to understand what is being done to mitigate any harm to those awaiting care, as well as understand how the quality and safety of care is being maintained throughout the stroke pathway.

We also considered local and national performance data and statistics. The Sentinel Stroke National Audit Programme<sup>17</sup> (SSNAP) aims to improve the quality of

---

<sup>17</sup> [The Sentinel Stroke National Audit Programme](#)

stroke care by measuring both the structure and processes of stroke care against evidence-based standards. The SSNAP targets are informed by the *National Clinical Guideline for Stroke for the United Kingdom and Ireland*, and national and local benchmarks. The SSNAP clinical audit collects a minimum dataset for stroke patients in England, Wales, and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of six-month assessment. All patients with a stroke admitted to hospital in Wales are included on the SSNAP database, which is used to monitor and audit stroke treatment and outcomes.

Over the course of our review, we undertook interviews with a variety of health board staff across Wales. We developed and shared several staff surveys and a survey of stroke patients, or their family members or carers.

We also completed fieldwork focusing on retrospective case studies and current cases of people travelling through the stroke pathway, which included the period of the Covid-19 pandemic.

### **Professional staff surveys**

We developed and launched a staff questionnaire to obtain views from health board staff involved throughout the stroke pathway and their patient flow within the pathway.

In addition, we designed and distributed a questionnaire to obtain views from staff at WAST to gain their opinion of the flow of stroke patients to and from hospitals.

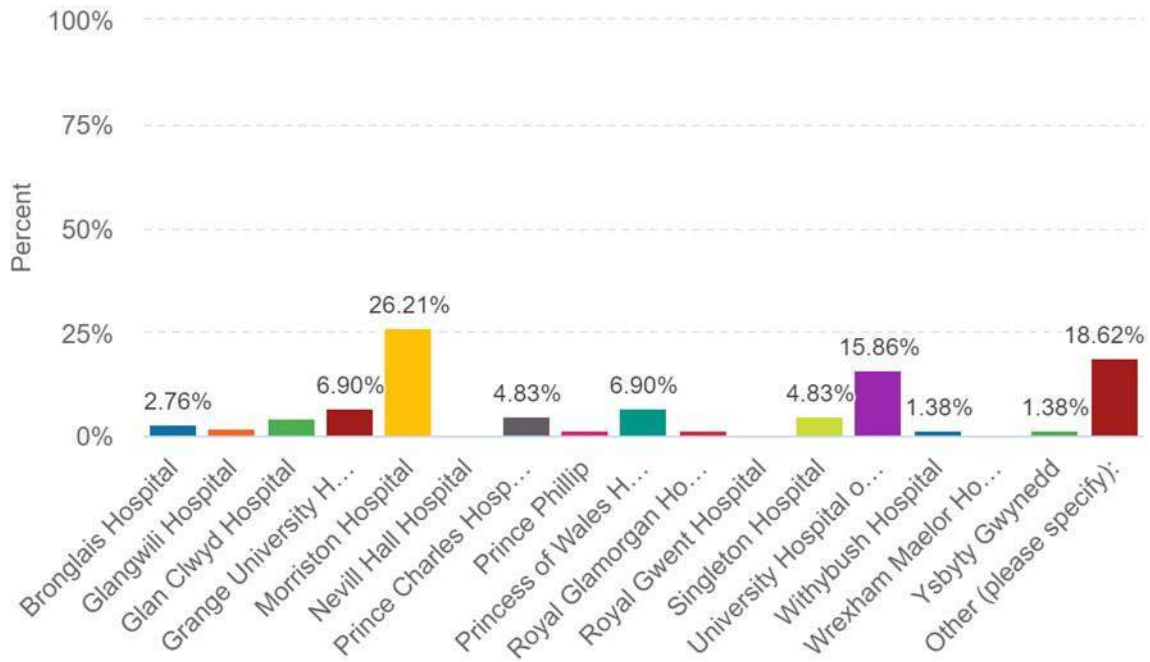
In conjunction with the Care Inspectorate Wales (CIW) we also developed and distributed two additional questionnaires. These were to obtain the views of staff working in social care and local authority staff on their opinion of the challenges faced in effective discharge of patients from hospital.

### **Health board staff survey**

We had a total of 146 respondents who fully completed the health board staff survey.

Our survey found 75 respondents worked directly within stroke services, 20 worked within Patient Flow, 32 worked for emergency departments, 13 were senior management, 16 were site/bed management, 6 were discharge staff and the remainder were made up of various other roles.

The respondents worked within the hospitals highlighted in the chart below:



### Social Care providers and Local Authority staff surveys

Both Social Services staff and Local Authority staff surveys were emailed to staff for completion in May to July 2022.

We had 26 staff respond to our social care provider survey from 16 of the 22 local authorities in Wales, which includes:

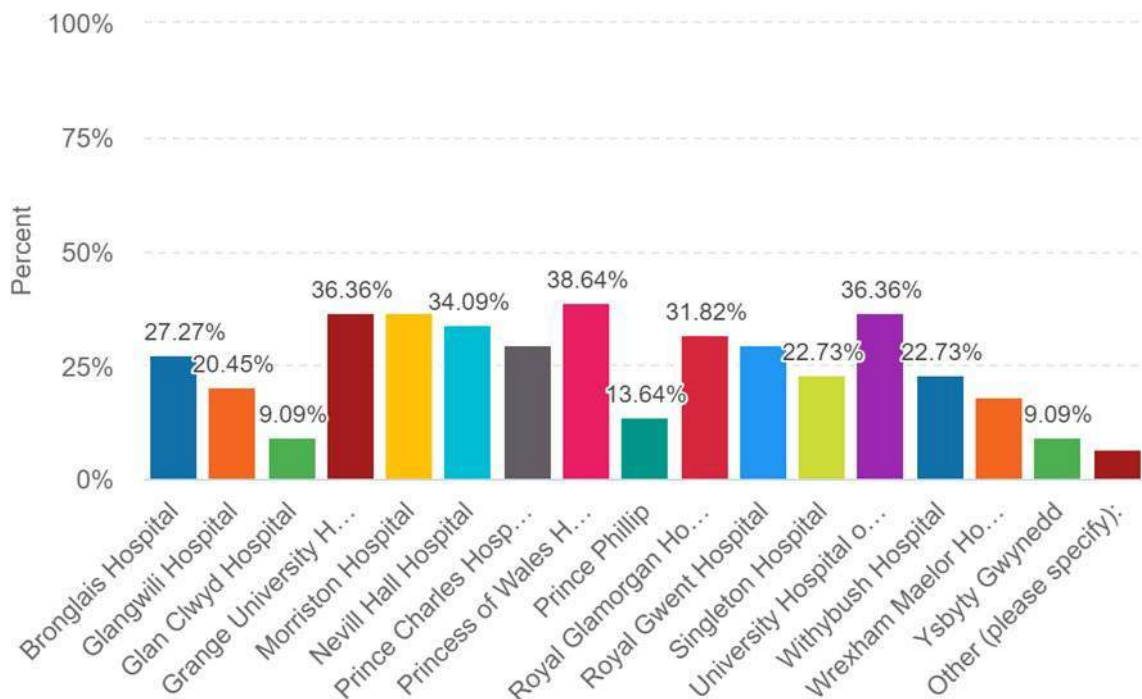
- 7 Registered Managers
- 7 Service Managers
- 6 Care Home Managers
- 3 Responsible Individuals
- 3 Other

Due to the limited number of responses, we have not undertaken a quantitative analysis, however, where applicable, we have considered comments from our qualitative analysis within the report.

### WAST staff survey

The survey was emailed to staff for completion in May to October 2022.

We had 44 staff respond to our survey who worked with the following hospitals:



### Public survey

We conducted a survey to capture the views of stroke patients who had used healthcare services, or the views of their family members or carers. The patient questionnaire was designed and distributed by HIW, with the input of the Stroke Association, to obtain views from patients on the quality and safety of care throughout the stroke pathway.

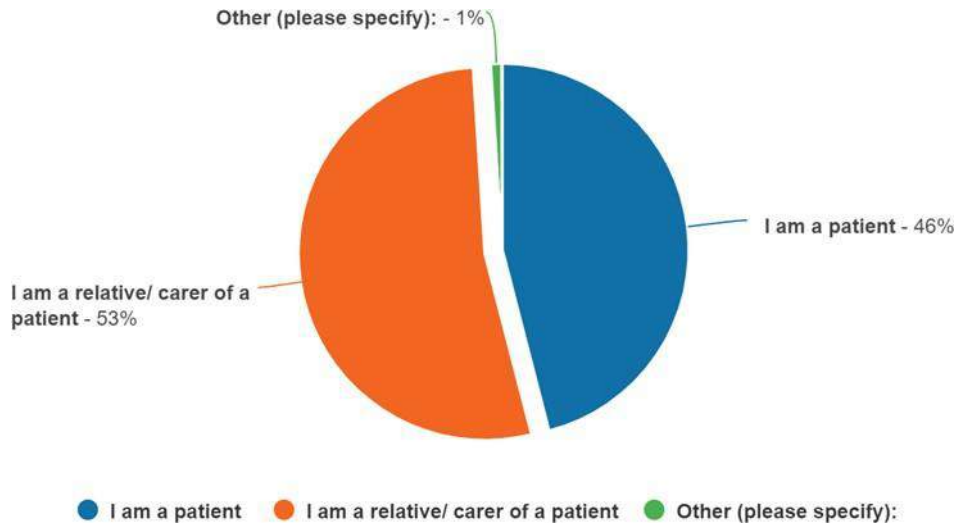
The survey was promoted for completion from May to September 2022.

We received a total of 106 responses to our survey. Some partially completed or skipped some questions, but all 106 responses have been considered as part of this analysis. When asked of their gender identity, 52.5% said they identified as female, 42.5% as male and the remaining preferred not to say.

Only 81 respondents answered our multiple-choice question relating to ethnicity. 61 answered 'white', 29 answered 'Welsh/English/Scottish/Northern Irish/British', and one person answered 'Irish'. There were zero responses to all other available options, for example, black, Asian, mixed ethnicity, gypsy/Irish travellers, or other ethnic groups.

The 106 responses were received from patients, carers or relatives, or other:





The ‘other’ response was a friend of a stroke patient. All respondents were asked to respond to questions on behalf of the patient. There was a good distribution of responses across Wales.

### Fieldwork

Currently 12 hospitals across six of the seven health boards provides emergency services for stroke patients. Powys Teaching health board does not provide acute stroke services but accesses services from NHS England and Welsh health boards. All 12 sites listed below provide acute stroke services including thrombolysis treatment for patients with an acute, ischaemic stroke.

- The Grange University Hospital, Cwmbran
- Prince Charles Hospital, Merthyr
- University Hospital of Wales, Cardiff
- Princess of Wales Hospital, Bridgend
- Morriston Hospital, Swansea
- Prince Philip Hospital, Llanelli
- Withybush Hospital, Haverfordwest
- Glangwili Hospital, Carmarthen
- Bronglais Hospital, Aberystwyth
- Ysbyty Gwynedd, Bangor
- Glan Clwyd Hospital, Rhyl
- Wrexham Maelor Hospital, Wrexham

As highlighted above, we attended one acute site within every health board area during the period from March to August 2022. Most of our onsite visits were conducted over three days. Our approach to the fieldwork conducted within Powys Teaching Health Board was reduced to a two-day visit to a rehabilitation ward, given the absence of an acute stroke ward.

Our fieldwork included face to face interviews with ED staff, stroke services staff and patient flow/discharge managers. We were unable to visit all the acute sites providing stroke services within Wales; however, to understand the challenges faced with patient flow through the stroke pathway at every site, interviews were held via Microsoft Teams. We held in the region of 250 interviews with health board staff across Wales.

During our onsite visits, we also attended board rounds, multidisciplinary team meetings (MDT) or equivalent for stroke patients, bed or site management meetings and patient discharge meetings. Where we were unable to attend in person, and for sites we did not carry out fieldwork, these meetings were attended via Microsoft Teams.

Our focus during our fieldwork was on reviewing patient records and key documents within each health board, both on a retrospective review of patient clinical records from 2020 onwards, and the records of patients in hospital travelling through the stroke pathway at the time of our site visits.

The inspection team for each onsite visit consisted of:

- HIW Senior Healthcare Inspector (review lead)
- HIW Healthcare inspector (review support)
- Up to three clinical peer reviewers
- CIW peer reviewer (to interview key staff involved with the discharge of stroke patients from hospitals across Wales).

It was positive to note that during our onsite fieldwork site visits we did not identify any areas of immediate concern for patient safety, and we therefore did not need to implement our immediate assurance process.

In November 2022, we wrote to all health board Chief Executives with a summary of the initial key general findings to date. We did not require any specific action to be taken in response to these findings at that time.

### **Relevant guidance for patient flow and the stroke pathway**

In considering the effectiveness of patient discharge, we looked at whether hospital wards follow the Welsh Government principles of 'SAFER Patient Flow

Guidance'<sup>18</sup>. This guidance provides good practice to promote safe and timely discharge, improve patient flow and prevent unnecessary waiting for patients.

Throughout this report, we often refer to the NICE guideline '*Stroke and transient ischaemic attack in over 16s: diagnosis and initial management*' (NG128)<sup>19</sup>. In addition, the *National Clinical Guideline for Stroke for the United Kingdom and Ireland 2023*<sup>20</sup>. We also refer to the NICE *Stroke Rehabilitation in Adults* clinical guideline (CG162)<sup>21</sup>. This relates to stroke rehabilitation for adults and young people aged 16 and over who have had a stroke with continuing impairment, activity limitation or participation restriction.

### Welsh language 'active offer'

We considered whether organisations can provide stroke services through the Welsh language active offer, and whether patients were offered the opportunity to communicate through the medium of Welsh.

We found that Welsh speakers worked within or were accessible to stroke patients in all health boards. However, this was not easily identifiable, such as staff uniforms promoting the NHS 'Gwaith Iaith' badge.

Within our staff survey, 22 people said their first language was Welsh, although every questionnaire was completed in English, despite the choice available to complete this in Welsh. Our patient survey identified that eight people speak Welsh, with just one who said they were offered the opportunity to speak Welsh.

In most cases during our clinical records review, we found no evidence or reference to a patient's language choice. However, in one hospital, it was recorded that patients were English speaking only within the records reviewed. We also saw in one patient record, that a patient was asked for their preferred language, as part of the Occupational Therapy cognition test.

## What We Found

### Patient flow: a journey through the stroke pathway

Poor patient flow is one of the biggest challenges facing our healthcare system in Wales. It is caused by severe congestion within our hospitals, and there are ongoing pressures within health and social care services to manage patient journeys effectively. The challenge within both systems can impact on timely hospital discharges, and often, people do not always receive the right care, at the right time, in the right place, which may impact on their safety.

To explore the complexities of patient flow through the healthcare system, we focussed on a patient journey through the stroke pathway. It is therefore important to highlight the significance of stroke and its prevention first.

---

<sup>18</sup> [Welsh Government SAFER patient flow Guidance](#)

<sup>19</sup> [NICE guidance stroke-and-transient-ischaemic-attack-in-over-16s](#)

<sup>20</sup> [National Clinical Guideline for Stroke for the UK and Ireland](#)

<sup>21</sup> [NICE Stroke rehabilitation in adult's Clinical guideline](#)

## What is a stroke?

Stroke is the fourth leading cause of death in Wales and can have a significant long-term impact on survivors. The Stroke Association<sup>22</sup> suggests that currently, there are around 69,000 stroke survivors living in Wales, and NICE<sup>23</sup> suggest around 8,000 people in Wales experience a stroke each year.

As highlighted above, NICE highlights that stroke is a leading cause of death and disability, causing around 38,000 deaths each year in the UK, and in addition, in the UK there are approximately 1.3 million stroke survivors. The number of hospital admissions per year due to stroke is approximately:

- 126,000 in England
- 9900 in Scotland
- 8000 in Wales
- 5000 in Northern Ireland.

There are three different types of strokes, these include:

- **Ischaemic stroke** - caused by a blockage, such as a blood clot, cutting off the blood supply to a part of the brain
- **Haemorrhagic stroke** - caused by bleeding in or around the brain
- **Transient Ischaemic Attack (TIA)** - also known as a mini-stroke - brief blockage in supply of blood to parts of the brain.

It is critical that people know how to spot the signs and symptoms of stroke, and they should call 999 immediately, due to the time critical nature for the treatment.

The signs of stroke are highlighted below and are represented as the acronym

**‘FAST’:**

|               |   |
|---------------|---|
| <b>Face</b>   | Has their face fallen on one side? Can they smile?  |
| <b>Arms</b>   | Can they raise both their arms and keep them there? |
| <b>Speech</b> | Is their speech slurred?                            |
| <b>Time</b>   | Time to call 999!                                   |

## Stroke prevention

In its 2018 report, *A Healthier Wales: our Plan for Health and Social Care*<sup>24</sup>, Welsh Government set out a long-term future vision of a ‘whole system approach to health and social care’. It places a greater emphasis on preventing illness, by supporting people to manage their own health and wellbeing, and to enable people

---

<sup>22</sup> [Stroke Association](#)

<sup>23</sup> [NICE - What is the prevalence of stroke and TIA in the UK?](#)

<sup>24</sup> [A Healthier Wales \(gov.wales\)](#)

to live independently for as long as possible, supported by new technologies and by integrated health and social care services.

As part of our review, we considered what information is available to advise the people of Wales on the risks associated with having a stroke, and its prevention. The Royal College of Physicians<sup>25</sup> estimate that up to 70% of all strokes could be avoided if the risk factors were treated and people adopted healthier lifestyles.

### **The role of Public Health Wales in stroke awareness and prevention**

Public Health Wales NHS Trust (PHW)<sup>26</sup> is the national public health agency in Wales. Through its work, the aim is to protect and improve the health and wellbeing of people and reduce health inequalities across Wales. As highlighted earlier, our review considered patient flow through the stroke pathway. It is, therefore, important to understand what PHW is doing to help prevent people in Wales having a stroke.

We considered how PHW were engaging with people to raise their awareness of the risk factors associated with a stroke, and their understanding of stroke symptoms. Additionally, what the Trust is doing locally or nationally to target certain groups of people who may be at the highest risk of sustaining a stroke. This may include Black and Asian people, and those living with high blood pressure, high cholesterol, diabetes, excessive alcohol intake, smokers, and those with Atrial Fibrillation (AF).

AF is a heart rhythm problem and increases the risk of a stroke due to a risk of blood clots forming in the vascular system (blood stream), which may travel to the brain causing a stroke. The Stroke Association<sup>27</sup> highlights that AF can happen to anyone, including people who are otherwise fit and well. It usually affects adults, and the risk increases with age, but also for people with conditions, such as heart disease, diabetes, obesity, high blood pressure, and in smokers.

In our survey, when we asked respondents about their ethnicity, there were zero responses indicating people were from Black, Asian, or other ethnic groups.

According to the Stroke Association and Different Strokes organisation<sup>28</sup>, strokes may happen more often in people who are black or from Asian families. In addition, it is suggested that within these groups, people may need to get checked at an earlier age for diabetes, particularly if they have any risk factors, such as being overweight<sup>29</sup>.

In 2021, Different Strokes Organisation launched a national outreach program, to raise awareness of stroke risk amongst Black and Asian communities, and to develop a longer-term plan, to break down barriers preventing Black and Asian stroke survivors from accessing its support services. Through the outreach programme, the organisation found there was lack of awareness of the risk of

---

<sup>25</sup> [The Royal College of Physicians](#)

<sup>26</sup> [Home - Public Health Wales \(nhs.wales\)](#)

<sup>27</sup> [Stroke Association - Atrial Fibrillation](#)

<sup>28</sup> [Different Strokes](#)

<sup>29</sup> [Stroke Association - What is stroke, are you at risk of stroke](#)

stroke at all ages, and Black and Asian people were not aware of their increased risk of stroke. They also found limited information available regarding stroke for people from Black or Asian communities, or for people whose first language is not English. Additionally, they found in UK-wide NHS campaigns, there was a limited representation for these communities, such as a lack of images of Black and Asian people, meaning that when they were looking at stroke campaigns, they would not see themselves in the images or the stories shared.

The Different Strokes Organisation has developed an engagement strategy to tackle the issues highlighted above, which plans to support and raise awareness of younger stroke amongst Black and Asian communities in the UK. The equality and diversity statics in Wales for 2018-2020 indicate that 95% of the population described their ethnic group as White, and 5% described themselves as Asian, Black, or as being from mixed or multiple ethnic groups or from another ethnic group<sup>30</sup>. The Different Strokes Organisation alone cannot raise the profile of stroke in Black, Asian and ethnic communities, therefore, health boards, Welsh Government and PHW must make a concerted effort with reaching out to people within these communities through stroke awareness education and campaigns.

### **Stroke and health inequality**

Socio-economic factors also impact on the risk of stroke. Health inequalities disproportionately affect certain communities and socio-economic deprivation is linked to worse health outcomes<sup>31</sup>. Strokes occur more commonly in areas of deprivation, therefore, highlights the inequalities in people's health status<sup>31</sup>. It is therefore important that when engaging with the public on stroke awareness and stroke prevention, health boards, Welsh Government and PHW should ensure they reaches out to people affected negatively by socio-economic factors.

---

<sup>30</sup> <https://www.gov.wales/review-evidence-socio-economic-disadvantage-and-inequalities-outcome-summary-html>

<sup>31</sup> <https://phw.nhs.wales/services-and-teams/local-public-health1/cwm-taf-morgannwg-public-health-team/cwm-taf-morgannwg-public-health-documents/cwm-taf-annual-report-of-the-director-of-public-health-2018-a-public-health-approach-pdf/>

#### Recommendation 1:

Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning between themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.

#### Recommendation 2:

Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.

#### Recommendation 3:

Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.

### Stroke management performance in NHS Wales

To demonstrate their performance in managing stroke services, hospital sites in Wales (and the UK), are graded in line with SSNAP data. Each hospital which manages stroke patients is required to regularly submit their performance data to SSNAP. The grade for performance is categorised from A (highest) to E (lowest).

In 2019, just three out of 16 hospitals in Wales who manage stroke patients, received a D or E grade. In 2022, the data reflects an increase to 11 of 14 hospitals who received a D or E score. This is concerning, not only as each hospital is graded in the lower categories, but it also highlights hospital performance has declined significantly across Wales in the past three years. However, it is important to note that this period did coincide with the COVID-19 pandemic.

The extreme and unprecedented demand for hospital beds during the pandemic had a significant impact on flow through healthcare systems, to the extent that field hospitals were implemented to cope with the overwhelming demand for beds. Health and care staff across all roles and services showed huge resilience in the face of unprecedented demands and pressures and adapted quickly with different ways of working to keep themselves and people safe. Staff worked in extremely difficult circumstances to care for people not only with COVID-19, but for others with other healthcare needs.

Despite their best efforts to protect people, tragically, many of those they cared



for died, and some staff also had to deal with the loss of colleagues.

## What is Patient Flow?

Patient flow is the movement of patients through a healthcare system. It involves the clinical care, physical resources, and the internal processes and systems needed to move patients from the point of admission to the point of discharge.

Within its *Programme for Government 2021-2026*<sup>32</sup>, Welsh Government committed to the provision of urgent and emergency care services in the right place, first time. It developed the *Six Goals for Urgent and Emergency Care*<sup>33</sup>, which supports the health and social care system in the delivery of the programme for government commitments.

Improvement Cymru<sup>34</sup> is the improvement service for NHS Wales. Its aim is to support the establishment of the best quality health and care system for Wales, so that everyone has access to safe, effective, and efficient care in the right place and at the right time. During our onsite fieldwork, we found that Improvement Cymru was undertaking a pilot in three hospital sites and was supporting teams to improve their patient flow systems. Together with the health boards, they implemented a Real Time Demand Capacity (RTDC) methodology to focus on the process, using improvement methodology. This will be highlighted further, later in the report.

### Managing people through the stroke pathway

In 2021, Welsh Government published its 5-year plan<sup>35</sup> to improve the quality of stroke services and outcomes. The new quality statement for stroke, sets out the future vision for stroke services in Wales and was developed with Wales' Stroke Implementation Group.

The Stroke Implementation Group provides guidance to the government and advice to key stakeholders and is developing a delivery plan<sup>36</sup> which is overseen by the National Clinical Lead for stroke in Wales. The plan will outline how services must improve the quality of stroke care and reduce variations in care across Wales. The group will also be supporting health boards to develop a network of comprehensive regional stroke centres, supported by regional operational delivery networks that work across boundaries to improve care, from acute treatment to rehabilitation.

However, to successfully achieve the above, effectively managing patient flow is pivotal.

The Senedd Health and Social Care Committee, undertook an inquiry into hospital discharge and its impact on patient flow through hospitals.

---

<sup>32</sup> [Welsh Government Programme for government: update | GOV.WALES](#)

<sup>33</sup> [Welsh Government - Six Goals for Urgent and Emergency Care - A policy handbook 2021-2026](#)

<sup>34</sup> [Improvement Cymru website](#)

<sup>35</sup> [New plan for Stroke care announced for Wales | GOV.WALES](#)

<sup>36</sup> This is a Service Specification which is being developed by a sub-group of the Stroke Implementation Group, led by the Clinical Lead for Stroke in Wales and comprises clinical, third sector and academic partners

The report<sup>37</sup> was published in June 2022, and highlights several challenges facing the health and social care sectors. The inquiry identified the need to take radical steps to reform health and social care systems and made 22 recommendations for improvement to Welsh Government.

We found that several of the recommendations align with the improvements needed identified as part of our review. Our review highlights that whilst work is ongoing nationally to tackle patient flow, it is not clear how effective these work streams have been to date since the complex issues with patient flow remain unchanged.

### **How do health boards manage patient flow?**

To manage the demand for beds across Welsh hospitals, designated teams within each health board hold regular meetings to address the issues with hospital admissions and discharges.

These meetings are held several times a day, 365 days a year. They are commonly referred to as patient flow, bed management or site management meetings. In addition to these, further regular meetings take place internally with members of the executive team such as the Chief Operating Officer, to consider the movement of patients across hospital sites within health boards. In addition, external meetings are held with other health boards and WAST. These consider the wider impact on flow across health board boundaries and the impact this may have on WAST providing services to people in the community. This will be highlighted later in the report.

For ease, throughout this report, we will refer to the meetings above as ‘patient flow’ meetings.

### **Patient flow meetings**

During our fieldwork, we attended several patient flow meetings across Wales, and considered how effective they were in managing flow to provide timely, safe, and effective care to patients.

Patient flow meetings were held regularly, at least three times each day across the sites visited as part of our review. They were well attended by the key staff responsible for a patient’s journey through hospital, such as patient flow managers, department managers, different MDT members, senior managers, and discharge co-ordinators. The meetings enable everyone to have a collective understanding and a joint ownership of patient risk and safety across the whole hospital site.

In some health boards, a Hospital Ambulance Liaison Officer (HALO) was also present during patient flow meetings, to discuss the ambulance handover delays and plans for longest wait patient handovers.

Actions and plans were also discussed on how to off-load certain patients into ED,

---

<sup>37</sup> [Welsh Parliament Health and Social Care Committee, into hospital discharge and its impact on patient flow through hospitals](#)

to release an ambulance from the hospital. In the absence of a HALO, this input was provided by staff from ED.

### Ambulance Immediate Release Protocol

To help manage the constant issue found across Wales with ambulance handover delays, in June 2022, WAST in conjunction with NHS Wales, developed its first draft of the *All-Wales Immediate Release Protocol*<sup>38</sup>.

When a person calls 999, there is a triage process which is completed by a call handler who enters data into the Medical Priority Dispatch System (MPDS)<sup>39</sup>. The response provided by the caller and data entered in the MPDS, generates a WAST priority code to determine the clinical response required for the patient. The system prioritises the most urgent patients, who are categorised as Red, Amber (1 and 2), and Green. Details of call categories are highlighted on the WAST website<sup>40</sup>.

The immediate release protocol outlines the principles and processes for managing the immediate release of ambulances when new calls are categorised as ‘Red or Amber 1’. This aims to minimise safety risk for people awaiting an ambulance response in the communities. This is usually invoked when ambulance capacity is reduced, when the time for patient handover at EDs is prolonged. The handover standard is 15 minutes and is considered extended beyond 30 minutes.

Data provided by WAST for the period 1 July 2022 to 5 September 2022, reflects a high volume of Immediate Release Directions (IRDs) being made. The data reflects the pressures that EDs across Wales are experiencing, which results in patient handover delays and patients in the community experiencing long waits for an ambulance response. During this period, a total of 1,900 IRDs were made. Around 30% of these related to ‘Red’ priority calls and 70% for ‘Amber 1’. Whilst a high percentage of IRDs relating to immediately life-threatening incidents were accepted, only 35.5% of the directions between April 2021 to June 2022, received this decision within the 8-minute response target for ‘Red’ calls. In addition, there remains a high percentage (62%) of declined directions for Amber 1 IRDs, despite the new protocol stating that they must not occur.

#### Recommendation 4:

Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.

### Patient flow dashboard

---

<sup>38</sup> [NHS Wales Immediate Release Protocol](#)

<sup>39</sup> MPDS is a unified system used to dispatch appropriate aid to medical emergencies including systematized caller interrogation and pre-arrival instructions.

<sup>40</sup> [How WAST Responds to Emergency 999 Calls](#)

Each acute hospital site had a patient flow dashboard (commonly known as the ‘SitRep’ (Situation Report)) displayed within the patient flow meeting rooms. It presents all key details for patient flow throughout the hospital, which was reviewed systematically and was referred to appropriately throughout the meetings. They were used to visualise the key areas requiring discussion, and to help plan timely management of all patients from ambulance handover, the ED and through to the wards (and operating theatres), to patient discharge.

During the patient flow meetings, we found the Chair would consider all aspects of flow systematically through the SitRep. This was from the ED (‘the front door’), to discharge or transfer from hospital (‘the back door’). In addition, consideration was given to the workforce requirements, such as staffing on the wards or in ED. The escalation status of the hospital was determined within the flow meetings, based on the availability of the beds available, ambulance waits, ED capacity and ability to admit people for key treatment or surgery.

### Hospital escalation Status

To establish a hospital escalation status consistently across Wales, Welsh Government, health boards and WAST, jointly approved a National Emergency Pressures Escalation and De-escalation Action Plan<sup>41</sup>. The action plan defines the four main escalation status levels for health boards and WAST. These levels and the triggers are used to determine the appropriate response to escalating and de-escalating emergency pressures, and the actions necessary to protect core services. This is to help provide the best possible level of service with the resources available.

### Levels of Escalation

The table below defines the four main escalation status levels for health boards and WAST.

|                |                          |  |
|----------------|--------------------------|--|
| <b>Level 1</b> | <b>Steady State</b>      | Ensure all standard operating processes are functioning as efficiently as possible to maintain flow.               |
| <b>Level 2</b> | <b>Moderate Pressure</b> | Respond quickly to manage and resolve emerging pressures that have the potential to inhibit flow.                  |
| <b>Level 3</b> | <b>Severe Pressure</b>   | Initiate contingencies.<br>Escalate when applicable.<br>Prioritise available capacity to meet immediate pressures. |

<sup>41</sup> National Emergency Pressures Escalation and De-escalation Action Plan

|                |                         |   |
|----------------|-------------------------|---|
|                |                         | Put contingencies into action to bring pressures back within organisational control.<br><br>De-escalate when applicable.  |
| <b>Level 4</b> | <b>Extreme Pressure</b> | Ensure all contingencies are fully operational to recover the situation.<br><br>Executive command and control of the situation.<br><br>De-escalate when applicable. |

Throughout our onsite fieldwork, almost all hospitals were at a level four escalation at some point during our visit, which represents extreme pressure on the hospital system overall.

### Focus of flow across departments

Overall, we found that patient flow teams appeared to manage meetings well. We witnessed discussions about each ward systematically, which included bed capacity and staffing of each ward and specialty of patients within the ward beds. Concerns were highlighted and discussed appropriately during all meetings we attended, with effective communication regarding the challenges with flow through the hospital system.

Updates were given from each area which includes the following examples:

- Patient handover delays from ambulances including the longest wait and number of ambulances waiting outside ED, and plans for the handover
- Demands and risk within ED, including the number of patients awaiting admission to a ward bed
- Numbers of patients on each ward, such as medical, surgery, paediatric, critical care
- Situation on ringfenced beds, including stroke
- Department staffing and resources
- Infection prevention and control issues
- Number of patients requiring surgery that day
- Total number of patients awaiting discharge or repatriation
- Action required on patients awaiting discharge and repatriation.

Overall, we saw that patient flow teams had a good understanding of which patients needed beds or needed moves to other wards. In addition, they had knowledge of the patients requiring transfer or repatriation to other hospitals or

community settings, and discussions took place on transport requirements. This included stroke patients who were deemed appropriate for transfer from acute settings to community rehabilitation wards. It is positive to note that 87% of stroke services staff who responded to our survey said, patient flow staff were involved with the stroke patient's journey throughout their care.

### **Patient outliers on different specialty wards**

We found adequate oversight of patient specialty outliers in other service groups or hospital areas, such as medical patients being cared for in surgical beds and vice versa. Patient outliers was a consistent finding across Wales, due to pressure on the system and the high demand for beds. It was also an issue prior to our review and is frequently evident through HIWs annual inspection process.

It was clearly not always possible to move patients, which included stroke patients, to the most appropriate ward or specialty for their care and treatment due to bed availability. Whilst this is a common occurrence across Wales, it is concerning since patients are regularly being treated on a ward that would not usually care for that specialty. Whilst it was not always possible to place people on the correct ward, staff and flow teams risk assessed the most suitable patient to place to a different specialty ward. Effective management at patient flow meetings can help to ensure this happens effectively.

When considering the stroke pathway, some healthcare staff explained issues with demand and capacity in stroke services, as there were more acute stroke beds available than rehabilitation beds. Consequently, this can have a negative impact on patient flow through stroke services because patients were waiting in acute beds longer than necessary, before being moved to a rehabilitation ward.

We also found in some health boards, wards cared for both acute stroke patients and those in their rehabilitation stage on the same ward. Within one health board, we found patients were placed in an area of a ward which was previously a rehabilitation gym. Whilst this enabled stroke care in the right ward, losing the gym area was impacting on the prompt rehabilitation of all patients. Like this finding, a staff member commented in our survey as below:

*'Currently even with good MDT working and effective discharge planning, there is no step-down from acute to help flow. Patients that are no longer having active treatment then increases bed pressures in other areas of the hospital and often these patients still require input from a discharge planning point of view and reduce time spent with acute / rehab patients receiving active treatment. This then means there is increased pressures on staff and reduced available time to meet stroke guidelines and directly having a knock-on effect to patient progression and the time it takes to reach a safe level of discharge with increase length of stay and inhibits flow.'*

### **Bed capacity pressure**

We interviewed patient flow staff across Wales, who told us that pressures on the hospital patient flow system had been exacerbated by the pandemic, and the pressure continues to rise. We were told that 'winter pressures' have become an

all-year-round issue, with hospitals finding it difficult to recover during the spring and summer months due to demands on the ED and ward beds.

During the winter period, many health conditions, including respiratory diseases such as asthma, can be caused or worsened by cold weather. Those issues along with higher incidences of so-called 'seasonal illnesses, such as flu and norovirus, can mean the NHS often faces much greater pressure during winter, due to demand on healthcare services. This not only impact on hospitals, but also within community services, such as GPs, community nursing teams and pharmacy services.

During our staff interviews, we found other reasons which can affect ED capacity, therefore impacting on patient flow. This includes:

- Difficulties in people accessing primary health care, such as GP appointments, means more people are self-presenting to EDs when they do not require emergency care
- An increased demand on ED services from people needing mental health support, as adequate community support is not available when needed.

Our interviews with patient flow staff, also found consistent problems with the timely discharge of patients. This was an issue across Wales, from both acute and rehabilitation wards, and was negatively impacting on patient flow and overcrowding in ED. This includes:

- Difficulties in admitting patients to a Ward from ED, due to a lack of available ward beds, as wards cannot discharge medically fit people due to social care capacity
- Insufficient capacity for patients who require rehabilitation or intermediate care after their acute phase.

### **Patient flow - discharge discussions**

During the patient flow meetings, the number of patients medically fit for discharge were discussed in all hospitals we visited. Staff told us that on average, approximately one third of patients on a hospital site were fit for discharge.

However, they either had no social worker allocation, set plan or date for a social care package to commence at home, or there was a lack of beds available within nursing or residential homes, if they were unable to return to their previous residence.

We found in some but not all hospitals, that when a patient was likely to be discharged on a given day, an action plan would be developed and discussed at the patient flow meetings with a view to ensure the discharge is fulfilled as planned.

This may include completing timely blood tests, ensuring take home medication was prepared in advance of discharge, and hospital non-emergency patient transport was arranged in a timely manner.



These actions would sometimes be followed up at the next meeting and addressed in subsequent meetings if incomplete. We found examples where such actions were expedited effectively and saw progress had been made by the next meeting, or the patient had been discharged or placed within the hospital's discharge lounge awaiting transport. However, there were some occasions when actions had not been delegated appropriately, which impacted on the timely discharge process.

#### Recommendation 5:

Health boards must communicate with each other to establish the good practices taking place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.

Further details relating to the challenges faced for effective discharge of patients, are highlighted later in the report.

#### Improving flow with Improvement Cymru

As highlighted earlier, during our onsite fieldwork we noted that an Improvement Cymru team was undertaking a pilot to support three acute hospital sites to help manage their patient flow. This was done using a Real Time Demand Capacity (RTDC) methodology. We engaged with the Improvement Cymru team, to gain an understanding of their work and any progress made since the onset of the pilot.

The goal of the RTDC tool is to improve patient flow processes by developing a situational awareness amongst staff teams within hospitals. This is to ensure staff fully understand the demand and capacity, and to establish an appropriate awareness and understanding of the bottlenecks and constraints impacting on flow. This would help structure the planning process to improve flow and to pre-empt or predict demand and capacity, and to manage flow more effectively.

The RTDC methodology focuses on discharge and improving flow in small increments, particularly in the earlier part of the day. Whilst this does not assist with the existing flow issues which relate to social care challenges impacting on discharge, it supports patient flow daily, by preparing patients for earlier discharge times on the proposed discharge date. This can result in earlier availability of ward beds, which allows for a timelier transfer of patients from ED to the wards or minimise delays with theatre list start times. This in turn, impacts positively on the timeliness of patient handovers from ambulances to ED, hence releasing ambulance crews to attend emergency calls within the community, or to repatriate or transfer patients home from hospital when applicable.

The Improvement Cymru team highlighted to us some themes found which contribute to delays in patient discharge. This included transport delays and the timely management of take-home medication. They found that often, take-home medication was not being prescribed and sent to pharmacy until the same morning that the patient is due to be discharged, which adds to unnecessary delays. This is consistent with our findings in our review of *Patient Discharge from Hospital to*

### *General Practice*<sup>42</sup>.

During the first week of the RTDC project at one hospital, the Improvement Cymru team found significant delays in the undertaking of blood tests and obtaining the results for these in a timely manner. An immediate action to improve this was for the health board to allocate ten priority slots with phlebotomy services to ensure patient blood tests were completed early in a timely manner, for those being discharged that day. This had a positive impact on preventing some delays with discharge.

#### Recommendation 6:

Health boards must review and consider processes for prescribing take home medication so that these can be obtained from pharmacy more promptly in order to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).

#### Recommendation 7:

Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timely discharge.

We spoke with several staff from the three pilot sites about their engagement with the Improvement Cymru team. This was to establish what impact the RTDC methodology was having on their patient flow processes. One person said that one of the challenges they identified was the Ward Manager engagement with the RTDC process, and for them to understand how this would benefit their ward flow.

We were told by several patient flow managers that the flow processes currently in place in their hospitals had remained the same for many years, and to help change the process was a significant challenge. This would require strong leadership at both department and flow team level. The flow teams told us that to support the process, templates were developed to capture key information, and they would attend the wards in person to engage with ward managers, to support them in identifying solutions themselves, to help resolve delays in flow issues at a local level.

It was also explained to us that the RTDC methodology allows all departments across hospital sites to take ownership of the safety and risk associated with patient flow, and staff are now more engaged to share resources to help mitigate and balance the risk and safety of flow barriers across the whole hospital site.

As a result of the RTDC pilots, we also observed some positive processes implemented for improving flow discussions and the overall management of beds,

---

<sup>42</sup> [HIW - Patient Discharge from Hospital to General Practice: Thematic Report 2017-2018.](#)

which included analysis of bottlenecks and challenges with patient discharge. We heard from staff in one hospital that work was in progress to analyse data of the key flow issues. This was to support predicted planning arrangements to improve the overall flow processes. An example of this includes data analysis of ambulance attendances at the ED, both daily and weekly, to understand and predict potential patterns for demand on the service with the aim to help reduce capacity issues.

We found some disparities across Wales with directorate clinical oversight of patient flow at more senior levels, such as Senior Nurses or Lead Nurses. In some hospitals, senior nurses would be placed on a daily directorate rota for effective senior clinical oversight of patient flow for their directorate, such as one for medicine and one for surgery. They would attend the daily flow meetings, and visit the relevant wards across their directorate frequently, to ensure staff teams were making timely progress to discharge patients, consult with senior nurses from other directorates (rostered to manage flow), challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding patient needs. They would also establish a plan for proposed discharges for the following or subsequent days. However, in some hospitals there was no daily senior nurse/ clinical oversight. We found that where a senior nurse oversight for flow was part of the daily process, the daily ward discharge process and planning for subsequent days was more effective. Any actions and discharges appeared to progress timelier, than hospitals without clinical flow oversight.

#### Recommendation 8:

Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timely patient flow.

#### Recommendation 9:

Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.

#### Recommendation 10:

Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. This could also support early planning for patient discharge.

## Non-emergency clinical care in the community

To help understand how people can access the most appropriate clinical support, if they have urgent, but not emergency healthcare needs, we considered what supportive measures were in place within the community.

## Reducing the burden on GPs and EDs

Signposting people to other resources can help improve patient flow by reducing the burden and pressure on GPs or local EDs. Using other community services where appropriate, may reduce the overcrowding that occurs in EDs, and ensure people are getting the right care, in the right place, first time.

Welsh Government is currently promoting the ‘*Help Us to Help You*’ campaign. This highlights to people that better health starts with them, and educates people on how to access relevant advice, support, or care for their health concern, with any new or existing condition.

The campaign and information on the ‘*Better Health Starts with You*’ webpage<sup>43</sup>, highlights the many ways to access healthcare in Wales. This includes using pharmacies, Minor Injury Units (MIUs) and mental health helplines, or using other online NHS consultations, to reduce the need for people to attend their GP surgery, or attending ED when their health concern is not an emergency.

Key messages relating to this campaign include advice on using the *NHS 111 Wales service*<sup>44</sup>, which starts as a symptom checker and advises people of what steps to take prior to attending the GP or ED. There is also guidance available on accessing other local services and MIUs, and signposts support for mental health needs. We were told by Welsh Government that the reach and impact of this campaign is being measured at regular intervals; however, no data was provided to us to support this.

WAST also launched its campaign around awareness for the NHS 111 Wales service on their website<sup>45</sup>. It supports the *Help us to Help You* campaign by highlighting the 111-symptom checker. If a person feels their health concern is urgent, they can call 111 and speak with highly trained call handlers who will provide advice over the telephone and can arrange a call back from a clinician if needed. Using NHS 111 Wales first, can reduce pressure on the emergency 999 service and EDs.

The NHS 111 Wales service has now implemented further support for people needing help with their mental health, where they call the usual 111 number and press OPTION 2<sup>46</sup>. The service is available for everyone, 24 hours a day, 7 days a week to ensure those in need of mental health support can access it quickly when they need it most. The number is free to call from a landline or mobile, even to those with no credit on their phone.

When considering the *Help Us to Help You* measures in place across Wales, we explored whether it was having a positive impact on WAST and its ability to manage emergency calls in a more timely and effective way. We interviewed a senior manager within WAST who informed us that despite the promotion of the NHS 111 campaigns in Wales, the Trust continues to have multiple 999 calls for non-life-threatening emergencies. We were also told that the winter of 2022/2023

---

<sup>43</sup> [Better Health Starts with You](#)

<sup>44</sup> [NHS 111 Wales](#)

<sup>45</sup> [NHS 111 Wales: Healthcare advice you can trust - Welsh Ambulance Services NHS Trust](#)

<sup>46</sup> <https://www.gov.wales/nhs-111-press-2>

had been particularly challenging for the service, with a high number of calls, and particularly from patients with respiratory issues. WAST regularly manages the data relating to calls and categories of need.

A key area requiring improvement is for healthcare services to engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this should in turn be used to influence service design. Ongoing engagement with people about the range of available services may reduce the need for people to attend their GP surgery or attend an Emergency Department (ED) when their health concern is not an emergency.

#### Recommendation 11:

Welsh Government should consider strengthening its promotion of the *Help Us to Help You* campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.

#### Recommendation 12:

Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.

## Impact of flow on WAST

### WAST patient pathway

We considered the stroke patient's journey through WAST services as the primary frontline service for emergency transport into hospitals across Wales.

In 2015, WAST introduced a framework which replaced the time-based targets for measuring response times of ambulances. The framework is a five step Ambulance Care Pathway, which focuses on the patient journey and is more aligned to the patient outcomes and experiences.

Using the Ambulance Care Pathway framework, we sought to understand how a potential stroke patient is managed from the time of calling 999 for an ambulance, the outcomes they might expect, and the impact of poor flow on WAST's ability to respond to emergency calls.

These include:

### Help me to choose

We have already discussed the benefits of people in choosing the most appropriate service for their health concern through NHS 111 Wales. This is to help prevent the need to use the resource of the GP or attend ED. However, when a stroke patient

feels it necessary to call 999 for an ambulance, the data available from Stats Wales<sup>47</sup> shows on average, around 1400 stroke related calls can be received by WAST each month.

### Answer my call

As highlighted earlier, when a person calls 999, a call handler completes a triage process and enters data into the MPDS. This allows the MPDS to generate a priority code to determine the clinical response required for the patient, as either Red, Amber, or Green.

If a caller is suggesting symptoms of a stroke, the MPDS will prompt the call handler to undertake the ‘Act FAST’ test. If the patient is conscious and breathing with positive stroke symptoms, and the onset of symptoms are known to be less than five hours, the call is prioritised as ‘Amber 1’. If the symptom onset time is over five hours, the call will be prioritised as an ‘Amber 2’. This is because the time to treat a clot in the brain must commence within four hours of known onset of symptoms, and to be considered for thrombectomy for symptoms in less than six hours.

Results from our staff survey reflected seven views on call categorisation, and a feeling that stroke callers should be categorised as ‘Red’ and not ‘Amber’, if they are to meet the therapeutic timescales for treatment. This is to help ensure a better patient outcome. One comment included:

*‘From a WAST perspective, strokes are categorised as an Amber 2, when they should be a red, as the quicker we can attend and recognise, the sooner we can get them to hospital’.*

In HIWs previous review of WAST<sup>48</sup>, the findings recommended that work was required to consider stroke patients as an emergency who need a ‘Red’ response. This is due to the time critical nature for treatment. WAST, as a commissioned service cannot make this decision to change alone; it is dependent on guidance from NHS Wales, commissioners, and Welsh Government. Discussions and votes at Senedd Cymru on 26 October 2022<sup>49, 50</sup>, confirmed that stroke patients will remain within the ‘Amber’ category.

When a patient is waiting for an ambulance, there is a process in place to monitor a patient’s clinical status if necessary. If a call handler has concerns for a patient’s well-being, they would ‘flag’ the call on the MPDS to notify the WAST clinical team that a telephone review is required. Whilst this process is in place, it was concerning to find that over the Christmas period in 2022, there were occasions when over 200 callers awaiting a WAST vehicle response, who needed clinical team’s intervention.

---

<sup>47</sup> StatsWales is the Welsh Government’s free-to-use online repository for detailed statistical data for Wales.

<sup>48</sup> [Local Review of the Patient Management Arrangements within the Welsh Ambulance Service Trust](#)

<sup>49</sup> [Y Senedd - Votes and Proceedings Plenary - 26 October 2022](#)

<sup>50</sup> [Y Senedd TV - Plenary 26 October 2022](#)



## Come to see me

The ability of WAST to send a response to a caller is dependent on the resources available at the time. This is often impacted by the number of ambulances waiting outside EDs to handover their patients. We found this was a consistent issue across Wales because of poor flow within hospital sites. WAST call handlers or the clinical team are usually aware of prolonged waits for an ambulance to attend callers in the community. Therefore, guidance with a script is available which staff use to recommend the caller makes their own way to hospital, if it is safe to do so, as opposed to losing time whilst waiting for an ambulance to arrive.

## Give me treatment

When WAST staff attend a patient suffering with a stroke, they will undertake a further assessment at the scene, which follows the *Joint Royal Colleges Ambulance Liaison Committee (JRCALC) Clinical Practice Guidelines*<sup>51</sup>. The guidelines identify stroke as a ‘time critical’ medical emergency and references the time dependency for thrombolysis (clot dissolving treatment). The guidance also states that patients must be transferred to an appropriate hospital as quickly as possible, to commence treatment once the stroke diagnosis is suspected.

## Take me to hospital

There are arrangements in place for ambulance crews across Wales to provide pre-alert calls to ED. WAST has guidance in place for clinicians to follow when a stroke has been confirmed during assessment. We were informed that it is the decision of the clinician at the scene of the incident to determine which is the most appropriate hospital to transport a patient, according to their condition (including stroke). On occasion, this may be a hospital across the border, such as for patients living within Powys.

We considered how patients in rural areas would access timely treatment for stroke. We were told that there are challenges with this, and during our fieldwork, we found that work was ongoing in some areas of North Wales and Powys to try to improve transfer arrangements. WAST has been working with healthcare services across the border in England to ensure that arrangements are in place to review and treat stroke patients promptly when required.

Within our staff survey, it was positive to find a good response from WAST staff who felt well equipped to undertake their role with managing a stroke patient.

Almost 85% of staff told us in the survey they had received training to support and manage stroke patients, however, only 77% of respondents said they understood the WAST stroke pathway. In addition, we found that only 49% of WAST respondents said they always allocate or take a stroke patient to a specialist stroke unit.

We recognise the challenges faced by WAST in its ability to deliver a timely response to life-threatening emergencies. This is due to increased pressures on the

---

<sup>51</sup> [JRCALC Clinical Practice Guidelines - aace.org.uk](http://aace.org.uk)



healthcare system overall, with prolonged ambulance handover delays to EDs all over Wales. It is, however, a concern that patients in the community have prolonged waits for ambulance resource, which places them at increased risk of deterioration and harm. This was also found in our two previous WAST reviews.

The impact of this is significant for stroke patients, due to the time critical nature of the investigations and treatment which are required to manage a stroke patient. Any delays to treatment will likely have life-long consequences for people.

We were told of a pilot project which is due to take place within one health board to evaluate a Pre-hospital Video Triage (PVT), which has been successful in several Trusts in England. A structured pre-hospital assessment will take place with WAST and the health board's stroke team while the patient is at home. If it is assessed that the patient is likely to have had a stroke, they will be immediately transferred to hospital and taken directly for a CT scan on arrival, bypassing the ED. In addition, when there is a pre-alert call from WAST to the ED, patients will be pre-registered within the department, which will reduce delays to thrombolysis and thrombectomy. This pilot is due to commence in August 2023.

#### Recommendation 13:

WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.

#### WAST initiatives to manage patients in the community instead of hospital

During our WAST interviews, we found that the Trust is exploring a new process with the aim of reducing the number of ambulances being sent to patients by 50%. This, however, will require increased establishments of staff within the clinical desk, advanced paramedic practitioner teams, ambulance paramedics, nurses, midwives, and mental health practitioners.

The response to calls via the clinical desks will be a Multidisciplinary Team (MDT) approach, which will determine how best to respond to patients instead of inappropriately sending an ambulance. The proposed timescales to fully implement this model is three years which will need additional Welsh Government funding.

However, we were informed that funding had not yet been approved for this.

Evidence has been collated which reflects the benefits of having people treated at home via advanced paramedic practitioners.

We were provided with data which outlines the number of patients who have been managed at home or referred to other services, as well as those who are taken to hospital. It reflects that on the occasions where advanced paramedic practitioners have been sent to see patients, as opposed to ambulance paramedics, in the region of 65-70% have been treated at home without the need to go to hospital. Advanced Paramedic Practitioners can administer a greater range of medication than an ambulance paramedic, which means that more patients can be treated at home, and can be referred to ongoing services, such as their GP practice, physiotherapy

services, or healthcare clinics, such as for TIA where appropriate.

We were told that the service will need to develop and implement different types of resource to operate, such as an increased number of Advanced Paramedic Practitioners. To implement this type of service, staff need to be supported to develop their skills and knowledge, to enable them to work in these roles.

Early implementation of the new WAST model should have a positive impact on the pressures on our hospital system across Wales by reducing the number of patients being transported to EDs by ambulance. A reduction in the first bottleneck of patient flow at 'the front door' of Welsh hospitals, could lead to a reduction in pressure across the whole hospital system and an improvement in patient flow.

#### Recommendation 14:

Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.

### Patient transfer to hospital

We explored the ways in which a patient can arrive at the ED seeking treatment, and this is highlighted below.

#### Patient arrival at ED

Patients can arrive at EDs in several ways, such as by ambulance, by GP or clinicians through the 111 service, or by referral from other healthcare practitioners, such as district nurses, or by people self-presenting. In our interviews with ED staff across Wales, we were told that people frequently attend ED who do not require emergency care.

There are many occasions where ED staff could redirect patients to alternative care pathways following initial clinical assessment, which would lessen the burden on ED, but also reduce waiting times at ED. The examples provided to us highlighted that people are often turned away from ED to use the services of their MIU, GP, community services, dentistry, and paediatric assessment units. However, some staff said that at times, there is a reluctance by ED staff to re-direct patients elsewhere and away from EDs, as they are risk averse and are not always confident to do so.

#### Stroke pre-alert calls

The stroke pre-alert call is used to notify ED staff of inbound patients that require immediate attention and is a key component in the stroke care pathway. The call enables the receiving hospital to have the specialist staff available upon the patient's arrival and aims to improve the timeliness of the treatment a patient receives.

We were informed by WAST that they have developed, in partnership with the

relevant stroke units across Wales, a standardised pathway to enable the conveyance of a patient to the appropriate hospital first time. The WAST clinician, upon suspecting a diagnosis of stroke, will pre-alert the ED of a hospital with a stroke unit capable of undertaking a scan, and when appropriate undertake thrombolysis treatment.

WAST staff told us that despite the effectiveness of the pre-alert call, issues can arise when hospital services are under extreme pressures due to poor patient flow. This can result in patients being assessed on the ambulance, then receiving their initial investigations and brain scan, and then returned to the ambulance due to pressures on ED services. This was supported by results from our WAST staff survey, which confirmed that a stroke patient is normally pre-alerted to the hospital, but often EDs are full and are unable to accept patients into the department.

During our onsite fieldwork, we found that some patients who were pre alerted or not, still showed signs of being FAST positive on arrival to ED. Some ambulance crew had documented on arrival at ED, that these patients were then a query Transient ischaemic attack (TIA)<sup>52</sup> as opposed to stroke, however, not all symptoms had resolved.

To support the stroke assessment process, NICE guidance for stroke, states that the diagnosis of people admitted to ED with a suspected stroke or TIA, should be established rapidly, by using a validated tool, such as ROSIER (Recognition of Stroke in the Emergency Room). The aim of the ROSIER assessment tool is to enable medical and nursing staff to differentiate patients with stroke and stroke mimics, such as TIA.

Since the use of ROSIER is a recommended tool within NICE guidelines to differentiate Stroke from TIAs, it may be beneficial for WAST to train its paramedic staff in the use of the ROSIER assessment tool, alongside the FAST assessment.

The ROSIER assessment tool is discussed later in the report.

#### Recommendation 15:

WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.

It is positive to note that 94% of ED staff who responded to our survey said they were informed by a pre-alert call from ambulance services if it was a FAST positive patient. This was also supported by our interviews with ED and stroke services staff across Wales.

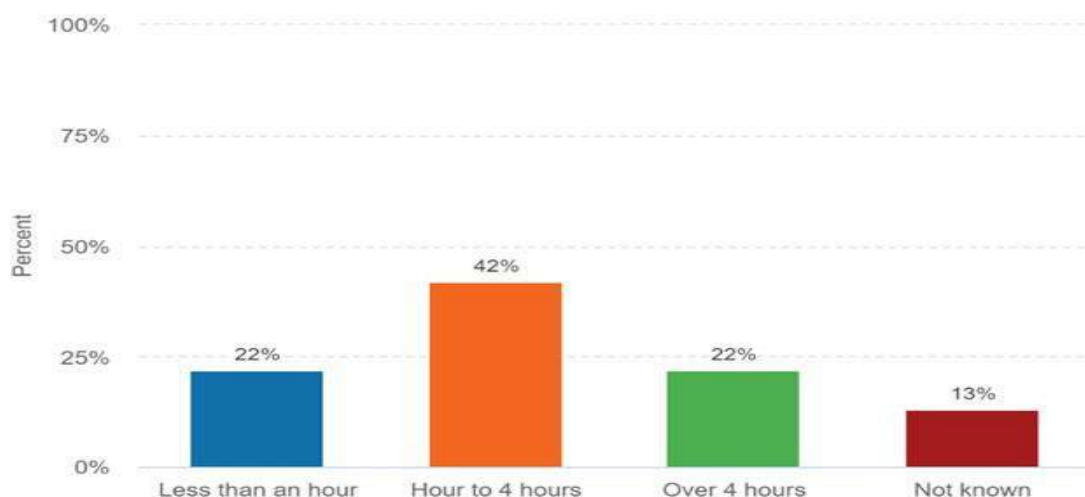
As highlighted above, we established that stroke patients arrive at EDs in different

---

<sup>52</sup> A TIA is a warning sign that you're at increased risk of having a full stroke in the near future. See: [Transient ischaemic attack \(TIA\) - Treatment - NHS \(www.nhs.uk\)](https://www.nhs.uk/conditions/transient-ischaemic-attack-tia-treatment)

ways, such as by ambulance, GP referral, or patients who self-present at EDs. Therefore, there is a risk to some patients of missing their therapeutic window for thrombolysis treatment if there are delays in transfer or receiving timely assessments.

We asked people in our survey how long before arriving at hospital did their stroke symptoms start. The chart below highlights the times reported to us:



The above chart reflects that 64% of patients arrived at hospital within the time critical thrombolysis window.

### People self-presenting at hospital

We were told by some patients and staff that due to the timely availability of an ambulance, some people self-present to ED. We were told that this can present risks to a patient if they did not clearly raise their stroke symptoms to the receptionist on arrival to ED, which consequently may impact on their triage and assessment time.

In addition, if a patient self-presents at a hospital that does not treat stroke patients, such as a MIU instead of ED, this may also present a risk for timely treatment.

This is because they may need to be transferred to a hospital that can appropriately scan and treat patients with a stroke. This in turn, may delay the time they have in the therapeutic treatment window of four and a half hours.

We considered the training provided to reception staff to help identify red flag

#### Recommendation 16:

Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation processes are in place if a receptionist is or is not sure a patient may be suffering with a stroke.

symptoms<sup>53</sup> of stroke, and to prioritise and escalate triage for patients if symptoms are present. We found that in general, most (but not all) reception staff had received training for this. Despite being non-clinical, they still have a vital role to play in the potential identification of stroke patients.

### Impact of delayed ambulance handovers for stroke patients

We considered whether ambulance handover delays were having a negative impact on patients along the stroke pathway. In our staff survey, most ED staff said they were familiar with the hospital's handover policy to stroke services, and that the policy was easy to follow and was achievable. Whilst this finding is positive, delays in the ability of ambulance crews to hand over patients to ED staff are frequent and common.

Throughout our onsite fieldwork, we saw ambulances waiting outside EDs across Wales, waiting to handover and offload patients to the departments. Despite this, it was positive to find that patients suspected of having a stroke (and others with life threatening conditions), were prioritised and transferred into the ED promptly in line with the stroke pathway.

### Timely assessment and treatment in ED for stroke patients

We observed stroke patients being assessed, investigations were undertaken, and treatment was commenced in a timely manner. We saw staff consider the risks and appropriately mobilise other lower acuity patients throughout the department, to accommodate those confirmed as stroke positive. This was to ensure timely assessment and treatment promptly.

Through our discussions with ED staff, we were told that in the event of no trolley space being available in ED to offload a stroke patient, assessment would take place onboard the ambulance if the appropriate ED staff suspected stroke.

We were told that whilst stroke patients would always be prioritised for transfer into the departments, there are occasions when this was not possible. In such instances, staff explained that investigations, such as blood tests and a CT scan would still be undertaken, although the patient may return to the ambulance until a decision on commencing treatment is made. This was to help maintain a timely response to the patient's needs. In response to our staff survey, one person said:

*'At some hospitals there may be delays with handover, but assessment, and interventions are completed despite trolley or bed availability.'*

In contrast to this, it was concerning to find that most respondents to our WAST survey said that ambulance offload delays are negatively impacting stroke patients. Several comments were received which included concerns with delayed

---

<sup>53</sup> Red flag symptoms of stroke may include complete paralysis of 1 side of the body, sudden loss or blurring of vision, being or feeling sick, dizziness, confusion, difficulty understanding what others are saying, problems with balance and co-ordination, difficulty swallowing (dysphagia), a sudden and very severe headache resulting in a blinding pain unlike anything experienced before, loss of consciousness.

response to those waiting in the community, timely offloading of patients to ED, and delayed patient assessment due to the bottlenecks within ED. One comment included:

*‘There doesn’t appear to be any urgency when we pre alert a still FAST+ patient into ED. Or we are asked to take patient back onto vehicle. Not really appropriate when symptoms of a stroke have a good chance of being reversed if treatment is given promptly’.*

The findings in our clinical records review were overall positive. Most FAST positive patients were taken into ED within the 15-minute Welsh Government handover target time. However, we did find instances of delays in handover and no investigations had been instigated by ED staff. This is a concern, particularly when stroke treatment is time critical, and delays may have life-long consequences.

#### Recommendation 17:

WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.

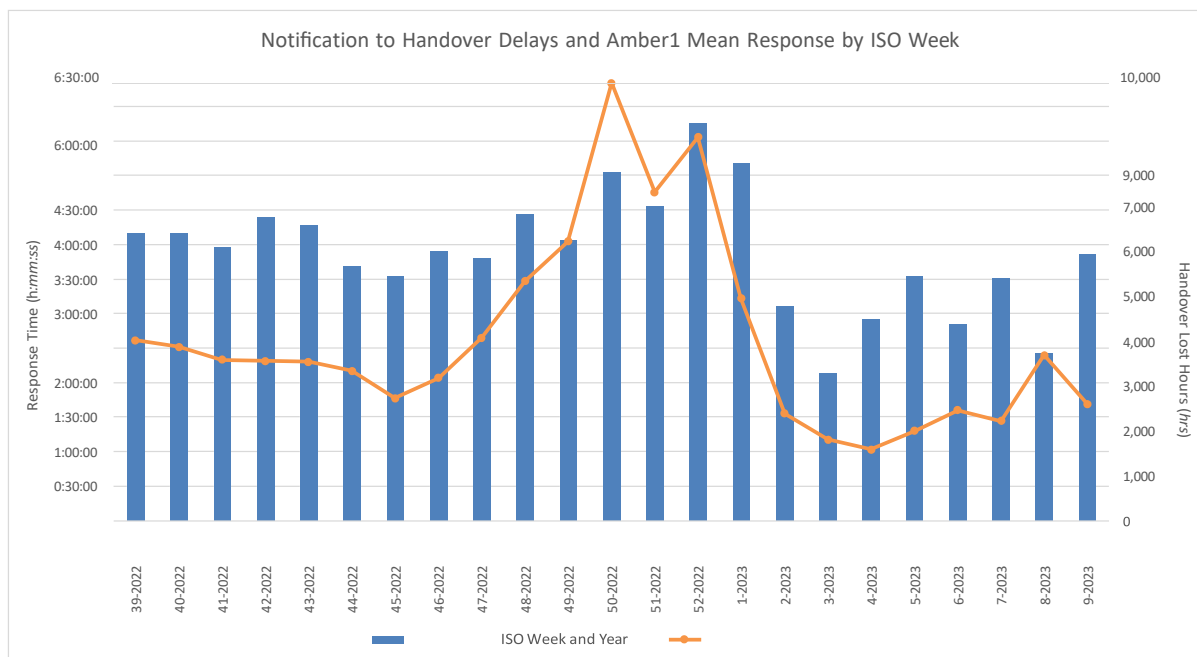
During our staff interviews, we were consistently told about the unprecedented increase in emergency care demand, impacting further on the ability to offload and handover patients from ambulances. Handover delays have been a challenge for WAST for a prolonged period, because of poor flow in hospitals. This has led to the service to re-evaluate its service delivery model, to help improve services, as highlighted earlier in the report, relating to the use of advanced paramedics in the community.

In our report, *Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover*, it is highlighted that in December 2020, 11,542 hours of ambulance crew resource was lost due to delays experienced with hospital handover.

We also found the data for this in September 2022 was significantly worse, with around 25,166 lost hours due to handover delays.

This increase is concerning and is attributed to poor patient flow. The flow is impacted further by the ability of hospitals to discharge patients in a timely manner, because of the delays with social worker allocation, availability of social care packages or placements available in care homes.

Data provided by WAST in the chart below, highlights a clear correlation between lost hours due to handover delays, and the Amber 1 response times over a six-month period.



The chart reflects that in week 52 of 2022, 8,835 hours were lost due to handover delays, and the mean time of an Amber 1 category call response (which includes most stroke calls), for that week was 5.33 hours. Given the time critical nature of potential treatment for stroke patients, the delays in the ability of WAST resources to attend patients in the community is of particular concern.

We are aware of the ongoing work nationally to improve handover delays; however, despite this, our review has found that the challenges remain. To address these issues, is not something WAST or a health board can do alone, and collaborative work is required between Welsh Government and key stakeholders in health and social care systems, to analyse the issues in order to make improvements.

**Recommendation 18:**

Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving

**Impact of flow on stroke assessment and admission to hospital**

**Stroke pathways**

We considered whether health boards had a clear process in place for managing patients in ED with a stroke in line with NICE guidance. Overall, we found there are clear stroke pathways in place across Wales which focus on timely assessment, investigation, and ongoing treatment. All health boards follow a similar but not



identical pathway when stroke patients are admitted through ED. In general, the pathways include assessment, diagnosis, and treatment for thrombotic or haemorrhagic stroke, and for those where treatment is not a viable option, due to the extent of their stroke.

### **Timely assessment on arrival at hospital**

We highlighted earlier that the incidences of people self-presenting at EDs with a suspected stroke is increasing. This is due to delays with the availability of ambulance resources in the community. This can prove challenging, since EDs are not pre-alerted to the arrival people self-presenting, which may present a risk in the timely assessment or diagnosis of stroke for some people.

During our onsite fieldwork, we found the challenges with the demand on ED, impacted by poor hospital flow, meant that some patients waited longer than expected for triage and ongoing assessment or treatment. Whilst this may not have impacted on FAST positive stroke patients, such delays may pose a risk to self-presenting patients who do not display easily identifiable stroke symptoms.

### **Stroke team assessment**

When FAST positive patients are pre-alerted and arrive at hospital (and within the thrombolysis or thrombectomy treatment window), the relevant stroke team is alerted by an emergency stroke bleep of the imminent arrival of a patient. We found that all acute sites who provide stroke services have the stroke bleep system in place.

We considered the effectiveness of the relevant team response to the emergency stroke bleep. Our staff interviews found that the response to the bleep varied across Wales, according to the time and day, and who is on-call to respond.

Through the health board self-assessment responses and our interviews with staff, we found that when there is a Clinical Nurse Specialist (CNS) or Advanced Nurse Practitioner (ANP) for stroke available in acute sites across Wales, and their response is generally rapid. They will also facilitate prompt investigations and diagnosis, and the required treatment and plans for patients within the stroke pathway.

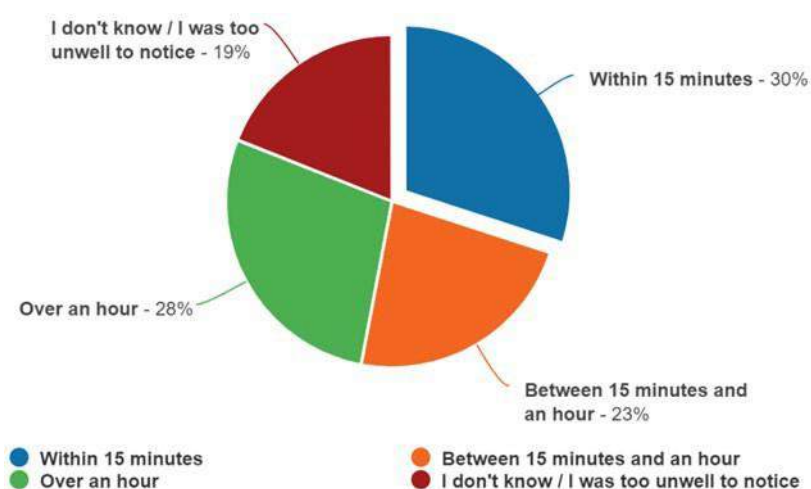
We found that during out of hours periods (such as nights or weekends), or in the absence of a Stroke CNS, ED staff and medical teams are alerted by the stroke bleep and arrange investigations and treatment for stroke patients. The medical team responders would also have access to an on-call stroke consultant.

We considered the process for those who self-present at hospital, and we found that the process was the same.

Through our clinical records review, we found positive responses from a designated on-site stroke team for attending ED. However, the timeliness of the bleep response was not always adequate. Some clinical records highlighted that triage and assessments were not always conducted in a timely manner, which may negatively impact on the ability to promptly assess and treat patients. Whilst we could not always identify the reason for this inconsistency, often the medical

teams were dealing with other in-hospital medical urgencies and emergencies on the wards.

We asked patients in our public survey how soon they were reviewed by a nurse or doctor following arrival at hospital. It was disappointing to find that over half the patients were not seen within 15 minutes, and 28% of those waited over one hour for assessment. However, it is important to note that for patients who completed the survey, their concept of time during their acute stroke episode may not have been a true reflection of their episode. Our survey findings are highlighted in the chart below:



Within our staff survey, we also found that just 28% of ED staff felt patients were assessed within 15 minutes, 60% said sometimes, and 12% said patients are not assessed in a timely manner. This again is a concern due to the time critical window for stroke patients receiving treatment.

**Recommendation 19:**

Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.

**Recommendation 20:**

Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a tertiary referral centre is relatively close to the ED.

## The CNS and ANP for stroke care

It is evident that prompt stroke care is essential for better patient outcomes, and the role of the CNS and ANP is beneficial in facilitating prompt progress through the stroke pathway.

We explored the CNS and ANP role further and found that it not only includes rapid assessment of patients for possible thrombolysis, but CNSs and ANPs also coordinate post-thrombolysis monitoring and acute stroke care. Their role was found to be significant in liaising between ED staff and acute stroke wards to facilitate prompt flow of stroke patients to an appropriate bed on a stroke ward, in line with national targets.

During our interviews, ED staff highlighted the benefits of the Stroke CNS and ANP to attend patients in ED. Staff reported that their presence assisted greatly in providing a prompt expert clinical opinion, and with ensuring stroke patients moved efficiently through the stroke pathway to the acute stroke ward. This also took pressure off the ED nurses and allowed them to focus on other patients requiring urgent clinical attention.

Across Wales, we interviewed staff within EDs and stroke services, and found consistently, that a key barrier to effective and timely stroke care, is the absence of a CNS or ANP for stroke service 24/7. Whilst medical teams have the appropriate knowledge and skills to manage stroke patients, there are occasions when their attendance at ED is delayed whilst they deal with other emergencies across the hospital. Such instances may negatively impact on stroke patients and their ability to be reviewed and treated in a timely manner.

Our interviews found that all hospitals aspire to have a 24/7 CNS for stroke services. However, we found inconsistencies across Wales in the provision of the CNS/ ANP service. The absence of a CNS/ ANP out of hours, such as nights and weekends, may impact negatively on patients due to the commitment of medical teams dealing with issues elsewhere across the hospital.

We found that issues with funding for the posts, or challenges in the recruitment for these key roles did not always enable a 24/7 service. Through our communication with the National Allied Health Professionals Lead for Stroke in Wales, it was highlighted that CNS or ANP for Stroke should be resourced to cover as much of the peak periods of stroke presentations to EDs as is possible, particularly during thrombectomy referral and the service availability time periods. It is therefore important that health boards regularly audit their stroke presentation and demand times on the service.

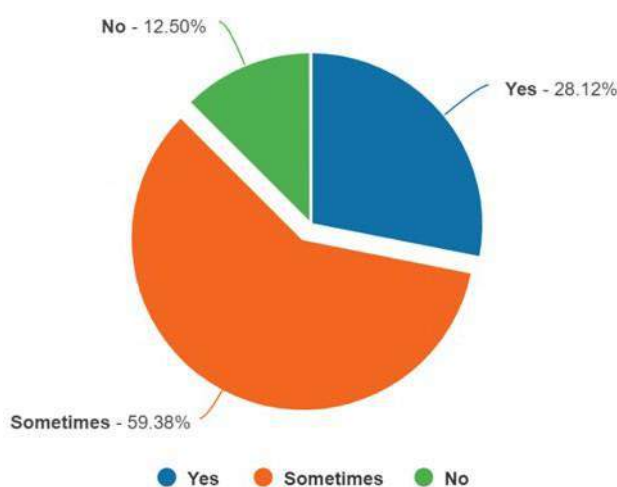
In the absence of a CNS/ ANP, we considered whether stroke patients were reviewed promptly by other stroke team members or medical teams. In our clinical records review, we found that most stroke patients arriving at EDs by ambulance were prioritised appropriately. We also saw evidence of patients who had self-presented at EDs receiving timely and appropriate assessments and investigations. However, we found that patients were not always assessed as promptly and did not

progress through the stroke pathway as effectively, in the absence of a Stroke CNS.

#### Recommendation 21:

Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.

In our survey, we asked staff whether they could assess stroke patients in a timely manner. Their response is highlighted in the chart below:



It is concerning that only 28% said they were able to assess people in a timely manner, and whilst 12.5% said no, the majority (60%) said they sometimes could.

The reasons highlighted to us as barriers to achieving a timely assessment include:

- Staffing issues or staff capacity
- High volume of patients to assess
- Lack of space or trolley bays in ED
- Increase of patients self-presenting at hospital

In response to our staff survey, we received the following comment which highlights the risk with people self-presenting with a stroke:

*'Accident and Emergency unit staff need to be trained to pinpoint stroke pathway. Sometimes when patients have been admitted to hospital, they are not able to access the stroke pathway as efficiently as a patient attending the hospital in an Ambulance, this issue needs to be addressed. If all staff received training, it would benefit patients.'*

## Recommendation 22:

Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.

### Stroke assessment tools

As highlighted earlier, to support the stroke assessment process, NICE guidance for stroke states that the diagnosis of people admitted to ED with a suspected stroke or TIA, should be established rapidly, by using a validated tool, such as ROSIER. This will ensure the prompt diagnosis prior to scan of a potential stroke or TIA.

A key example of the benefits for using the ROSIER tool is; if the stroke call is put out by ED staff to alert the medical team of an imminent arrival, and a triage and ROSIER assessment is undertaken by the ED staff promptly, then a CT scan can be booked by the medical team and the patient can be taken directly to the scanner. This is to help ensure no time is lost in diagnosis, particularly when the ED is full, and ambulances are waiting outside to offload patients. Patients could then be moved directly into a space in ED to receive treatment, or placed back on board the ambulance if thrombolysis or thrombectomy is not indicated, to await the next available space in ED, if admission is needed.

The example above further questions if there is a need for WAST paramedics to be trained in ROSIER assessment as highlighted earlier in the report. This assessment could be undertaken at the scene in the community when a patient is displaying stroke symptoms, which may help with the timeliness of assessment, imaging, diagnosis, and treatment at the receiving hospital.

We found that stroke assessments and interventions were being undertaken by clinicians with appropriate expertise in neurological disability, and nursing and medical staff had the appropriate knowledge, skills, and experience to recognise and manage stroke patients. However, we considered whether an assessment tool, such as ROSIER tool was being used in EDs in all health boards.

Whilst the ROSIER tool was in use across Wales, during our fieldwork, this was not always consistent. Our clinical records review and our staff interviews found inconsistencies in the tools used across Wales. Overall, we found good examples of assessment and the use of appropriate tools, however, in some records we did not find evidence that a tool had been used to support diagnosis or treatment plan.

### Recommendation 23:

Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.

### Recommendation 24:

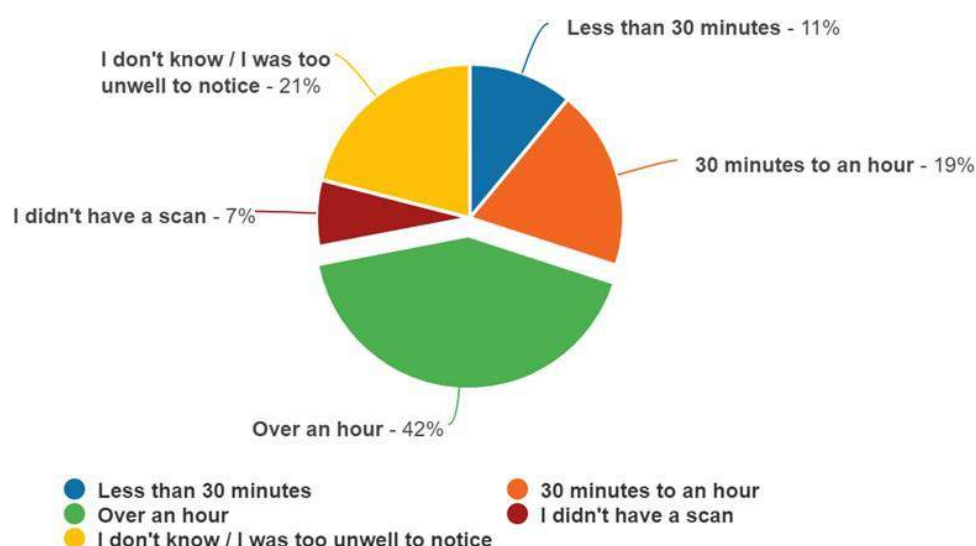
Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.

## Timely imaging

We considered whether patient flow issues through departments impact on timely brain scans. The NICE guidelines for stroke state that specific categories of suspected stroke need to receive a CT scan immediately. That is defined in the guidelines as, ideally the next slot and definitely within 1 hour of arrival at hospital, whichever is sooner. The CT scan will diagnose whether the stroke is due to a clot or a bleed on in the brain and will help determine the required treatment promptly.

In our public survey, we asked people how long they waited before receiving a brain scan after they arrived at hospital. However, it is important to note that for patients who completed the survey, their concept of time during their acute stroke episode may not have been a true reflection of their episode.

Our survey findings are highlighted in the chart below:



On analysis of the survey results, it is concerning to find that 42% of patients felt that they waited over an hour for a scan after they arrived at hospital, which is beyond the recommendations within NICE guidance.

We explored this further through our interviews with staff. We found that staff

endeavour to achieve a brain scan for a patient within an hour. We found good working relationships existed between ED and stroke or medical staff and the radiology teams, which supported timely imaging for stroke diagnosis. We also found that scans are reviewed and reported on promptly by relevant radiology staff. In some health board areas, an after-hours radiology service<sup>54</sup> is utilised to provide interpretations of scans and ensure specialist expertise and round-the-clock support. This means that scans are sent electronically to a radiologist to obtain a rapid report of the scan.

We found a positive initiative within one acute site, where the stroke pathway facilitates symptomatic FAST positive patients (identified by ambulance paramedics), by-passing the ED, and being transported directly to the CT scanning department. This is to help mitigate against any delays with handover at ED and enables prompt diagnosis and subsequent treatment as appropriate.

We were told that the advance imaging can be supported by Artificial Intelligence (AI) for stroke imaging. The all-Wales procurement of AI stroke imaging was completed in Dec 21, and it is now in the implementation phase. This will have a positive impact on the prompt identification of patients for thrombectomy and thrombolysis through stroke imaging. Therefore, patients can access the treatment they need in a timely manner.

#### Recommendation 25:

All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.

As highlighted earlier, to support the diagnosis of stroke, consideration should be given to WAST paramedics training in the use of the ROSIER assessment tool for stroke patients. Health boards across Wales in conjunction with WAST, may wish to explore the benefits of direct admission by paramedic to CT scan for FAST positive stroke patients where appropriate.

Through our clinical records review, it was concerning to find that some patients were not consistently receiving a CT scan within the one-hour target. Whilst reasonable explanations were documented in the records for some patients, such as patients not presenting with typical stroke symptoms, other records provided no explanation for the delay.

We also considered SSNAP data of patients scanned within one hour of arrival at hospital. The data reviewed considered the period of April to June 2019, 2021 and 2022. Of the 12 acute sites who now deliver stroke services within Wales, the performance of nine sites dropped between 2019 and 2022 signifying that an increased number of patients waited more than one hour for a brain scan. As highlighted earlier in the report, consideration to the timing of the pandemic must be given when reviewing this data.

---

<sup>54</sup> Everlight Radiology provide immediate access to radiologists 24/7 and are often replied upon for out of hours service.



## Recommendation 26:

Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.

### Swallow assessment

In line with NICE guidelines, patients with acute stroke should have their swallow screened by an appropriately trained healthcare professional, such as a speech and language therapist or other competently trained healthcare professional on admission or within four hours. If the screen shows signs of difficulty, the swallow should be assessed within 24-72 hours and before the person is given any oral food, fluid, or medication. We considered whether patients received a swallow screen and/or assessment within the timeframe, particularly in the event of a delay in them being transferred from ED to the stroke ward.

During our interviews with ED staff, we were told that rosters aim to ensure there are sufficient staff on duty to complete timely swallow screen and/or assessments within ED, however, this was not always possible due to high turnover of staff at some acute sites, and a high number of bank or agency staff on duty.

Staff in one health board told us that training had recently been completed for ED staff, to help further identify stroke patients and the importance of swallow assessments, which is in line with within the NICE guidance. They told us that this positive action had benefitted patients with timely assessments and demonstrated improvements in their SSNAP data.

Through our clinical records review, it was positive to find that in general, most patients had received a swallow assessment within the four-hour target as recommended by NICE. This included patients who remained in ED awaiting an inpatient bed, and for those who had been transferred to an acute stroke ward.

### Impact of flow on prompt stroke treatment

#### Thrombolysis

People who are diagnosed with an ischaemic stroke and who are eligible for thrombolysis, should usually receive treatment within 4.5 hours of the known onset time of stroke symptoms. However, within the new *National Clinical Guideline for Stroke*, this treatment window has now been increased to nine hours in some instances, if there is specific evidence of the potential to salvage brain tissue through CT perfusion<sup>55</sup>. Therefore, in line with national guidance, treatment can be started between 4.5 and nine hours of known onset of symptoms, or within nine hours of the midpoint of sleep, when they have woken with symptoms<sup>56</sup>.

We considered whether issues with flow prevented patients receiving thrombolysis

---

<sup>55</sup> Perfusion CT is an X ray examination that looks at blood flow and the amount of blood within the brain.

<sup>56</sup> [National Clinical Guideline for Stroke for the United Kingdom and Ireland](#)

treatment in a timely manner. Our clinical records review found that decision for thrombolysis was done on an individual patient basis, and is influenced by factors, such as pre-existing conditions and the timing of the onset of symptoms. We found the rationale for decisions were recorded in all relevant notes we reviewed, and treatment commenced in an appropriate time.

We found in some records that thrombolysis was not clinically appropriate, and the rationale for this was documented appropriately. However, it was concerning to find that some reasons for this included a delay in obtaining a CT scan, and delays in patients seeking medical assistance following onset of symptoms. Evidence in one of the records reviewed reflected that one patient who lived in a rural area had been significantly disadvantaged due to their travel time to hospital, which resulted in them missing the four-hour thrombolysis window.

We also considered which staff were trained in thrombolysis administration outside of the stroke or medical teams. Across Wales several appropriately trained ED nurses can administer thrombolysis where required, this therefore meant delays for thrombolysis treatment was minimised.

When staff were asked whether they felt they have had appropriate training to undertake their role, the majority (72%), agreed they had. For those who disagreed, the following reasons were provided:

*'I have had no additional stroke training since starting my role, I have learnt on the job.'*

*'I have been given the opportunity to take part in training however, due to operational pressures I often do the work in my own time.'*

*'This is very much caseload dependent and staffing dependent. We have significant staffing issues currently therefore our priorities are mainly clinical.'*

When reviewing SSNAP data, we found inconsistencies across Wales in the timeliness of thrombolysis treatment. This is not conducive to equitable treatment to people across Wales.

#### Recommendation 27:

Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the *National Clinical Guideline for Stroke* updated in April 2023.

#### Recommendation 28:

Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.

#### Recommendation 29:

Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.

### Thrombectomy

An alternative procedure to thrombolysis therapy is surgery to remove a blood clot, which is known as a thrombectomy. In the Stroke Association's publication, *What we think about: Thrombectomy*<sup>57</sup>, it highlights evidence demonstrating that thrombectomy treatment can significantly reduce the severity of disability a stroke can cause, therefore can result in better patient outcomes.

When clinically appropriate, the NICE guidance states that a thrombectomy should be offered for people with acute ischaemic stroke as soon as possible, and within six hours of symptom onset.

We considered the provision of thrombectomy treatment across Wales. Only Cardiff and Vale University Health Board provides a thrombectomy service.

The service is available Monday to Friday from 09:00am to 5:00pm, and only when expert interventional neuroradiology staff, and the appropriate radiology facilities are available. The service is provided mainly to people who live within the health board boundary. All other health boards in Wales must refer patients for thrombectomy, either to North Bristol NHS Trust where the service is available to patients in Wales daily 8am-midnight, or to the Walton Centre NHS Foundation Trust which offers a 24/7 thrombectomy service. Given the geographical challenges and the impact of ambulance delays across Wales due to handover delays, this impacts negatively on the ability of some people receiving thrombectomy in a timely manner, particularly when thrombolysis may not be clinically appropriate for them.

According to SSNAP data, the annual thrombectomy treatment number between April 2020 and March 2021 within England, Northern Ireland and Wales was 1,763<sup>58</sup>.

---

<sup>57</sup> [https://www.stroke.org.uk/sites/default/files/new\\_pdfs\\_2019/our\\_policy\\_position/psp\\_-\\_thrombectomy.pdf](https://www.stroke.org.uk/sites/default/files/new_pdfs_2019/our_policy_position/psp_-_thrombectomy.pdf)

<sup>58</sup> [Annual thrombectomy April 2020 to March 2021](#)

It is concerning to find that in Wales, just 13 patients received a thrombectomy at the University Hospital of Wales (for those living in the locality), just 16 patients received treatment in North Bristol and only four patients at the Walton Centre.

This does not appear to be conducive to equitable access to thrombectomy treatment across Wales, and those living within the Cardiff and Vale locality are at an advantage of receiving this type of treatment for stroke to those living in other health boards across Wales.

Our clinical records review found that where appropriate, stroke teams considered thrombectomy treatment for patients, although just one patient was deemed appropriate for the procedure. Whilst it was noted clearly in some records that the patients were not considered suitable for thrombectomy treatment, in several other records there was no evidence to suggest this had even been considered when it is part of the decision-making process for treatment.

Our interviews with stroke clinicians found that there was often consideration of patients who are suitable for thrombectomy, and where referrals have been accepted, there were often challenges with timely ambulance transfers to meet the treatment window target time. This was particularly challenging for cross border transfers, despite inter-hospital transfers for thrombectomy categorised as a 'Red' response by WAST. This may be due to the geographical location of a person, or the availability of an ambulance to transfer the patient in a timely manner.

We recognise that one of the aims within the quality statement for stroke services in Wales as highlighted earlier, is to improve opportunities for patients in Wales to receive thrombectomy treatment and to develop Comprehensive Stroke Centres within a network delivering thrombectomy locally. This is a significant challenge in Wales due to resources across the country and the number of suitably trained people to undertake the procedure. Work to consider this is currently ongoing nationally.

#### Recommendation 30:

Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.

#### Recommendation 31:

Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.

#### Recommendation 32:

WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms.

### Patient flow to acute stroke wards

During our review, we considered whether people are admitted to an acute stroke ward in a timely manner. NICE Guidance (NG 128)<sup>59</sup> states that hospitals should admit everyone with suspected stroke directly to a specialist acute stroke unit after initial assessment, from either the community, the ED, or outpatient clinics. Acute stroke units can provide care and treatment to reduce long-term brain damage, physical disability, and healthcare costs due to the range of specialist treatments they provide. They are staffed by a specialist stroke multidisciplinary team and should have access to equipment for monitoring and rehabilitating stroke patients.

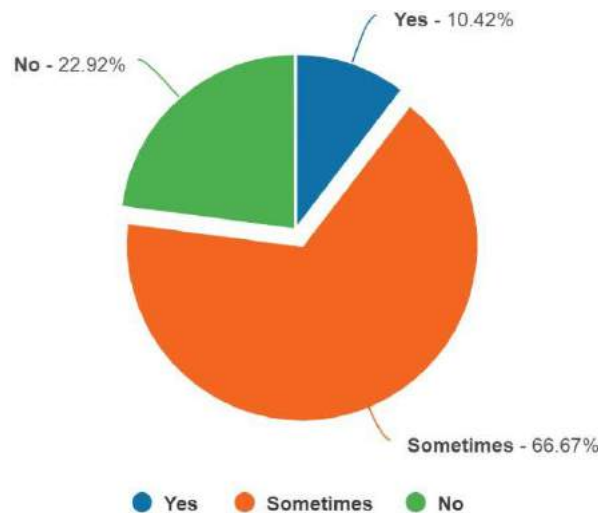
Acute specialist stroke units are associated with improved patient outcomes. Admission targets to these units should be within four hours of arrival at ED, so specialist treatment can begin as quickly as possible, in line with NICE guidance (NG 128). We found in all stroke pathways across Wales, that admission to a specialist stroke ward/unit, must be within four hours of arrival at ED.

We considered whether issues with poor hospital flow, impacted on the timely admission of people to acute stroke unit in line with NICE guidance. It is concerning to find that just 10% of those who responded to our staff survey said it was possible to transfer patients to a stroke ward when needed, and 23% said no.

This is highlighted in the chart below:

---

<sup>59</sup> [NICE guideline \[NG128\] Published: 01 May 2019 Last updated: 13 April 2022](#)



This finding was consistent with responses in our staff interviews across Wales, who suggested that poor patient flow within their hospitals prevent patients being transferred to an acute stroke ward in a timely manner.

Our interviews with ED and stroke service staff found, that every effort is made to transfer patients to the acute stroke ward within the four-hour timeframe.

However, they are consistently faced with several challenges in achieving this, which were attributed to patient flow issues.

During our fieldwork, every acute stroke ward across Wales was at full capacity. This resulted in stroke patients either remaining in ED to receive treatment and post treatment care, until a bed became available, or they were being placed as an outlier in another ward.

In our public survey, people told us of delays in their transfer to an acute stroke ward. Comments included:

*‘Day and a half in A&E before being admitted to ward.’*

*‘Admission to stroke ward not possible, still waiting 13 days after admission when writing this’.*

We attended patient flow meetings across Wales and witnessed discussions on how teams tried to accommodate stroke patients on the acute stroke ward. However, due to the system wide flow issues, this was not always possible. We also found in some wards that staff were proactively attempting to receive stroke patients from ED at the earliest opportunity when they had a bed available.

We explored the reason for delays entering the acute stroke ward. Several reasons were provided to us in the staff survey.

These included a lack of bed availability with delayed discharges due to social care issues and outliers of other specialties placed in stroke beds, due to flow issues

elsewhere in the hospital. We were also informed that stroke patients who required transfer to a stroke rehabilitation ward cannot be transferred due to capacity there.

Some comments in our survey from staff included:

*‘Often due to poor discharge flow from patients awaiting care packages and placements beds are not always readily available when a stroke patient has been identified for the pathway.’*

*‘Bed availability on acute and rehab ward becoming an increasing problem due to the inability to step down patients from the ward and into the community. Bed availability is also taken up on stroke units by non-stroke (medical) patients/admissions.’*

*‘Unfortunately, stroke patients are not always prioritised according to the stroke pathway, and when beds are available the decision on who fills stroke beds is not made by the stroke team.’*

In our staff survey, we also asked people to comment on how the NHS could improve the service it provides to stroke patients, one respondent commented:

*‘Immediate availability of access to stroke ward and the specialist patient care this would provide.’*

When beds were not available on the acute stroke wards, we considered whether patients were managed safely and effectively in ED. In our clinical records review, we did not find any evidence to suggest delays in transfer to a stroke ward negatively impacted on the safe and effective care to patients.

### **Ring-fenced stroke beds**

We found that each acute site we visited had a policy to ‘ring-fence<sup>60</sup>’ stroke beds. Whilst policies are in place to ring-fence beds, this is frequently breached due to the high escalation status of the hospital site and due to overall lack of bed availability in other areas.

Staff within stroke services told us they always aim to ring-fence a stroke bed, but it is frequently not possible due to patient flow issues within the whole system, and they are made to use the bed for a different specialty patient. This frequently results in medical outliers (non-stroke patients), being placed in the ringfenced stroke bed, and stroke patients frequently being placed as outliers on other wards.

This is concerning since this may result in stroke patients not receiving the most appropriate and timely treatment for their condition, and likewise for other

---

<sup>60</sup> A ring fence bed is a method of protecting an acute bed on a stroke ward from use by patients who are not stroke patients.



specialty patients.

Our staff interviews found that ring-fencing a stroke bed was essential to maintain flow in the stroke pathway. In addition, we asked staff in our survey if they had comments on what could be improved with the flow of patients along the stroke pathway. The most common theme in the feedback related to the need to ring-fence stroke beds for stroke patients. We received 22 comments suggesting the need to maintain a ring-fenced bed.

One comment included:

*'We had a ring-fenced bed for a while, but hospital pressures have meant that this is rarely available and so patients need to be moved about to get an appropriate bed on the stroke ward, that can cause delay.'*

### **Delays in accessing stroke beds**

We explored the issues around outlying patients on different wards in relation to stroke. The aim was always to transfer patients to a stroke ward as soon as a bed was available. We also found examples that at times, patients may be swapped from other wards to allow for stroke patients to be in the best environment to manage their needs.

Our clinical records review found that patients remained in ED for prolonged periods of time. Some records found overnight delays and instances where patients had remained in ED over 24 hours, prior to their admission to the stroke ward.

Whilst this is not acceptable in the appropriate management of a person within the stroke pathway, it is positive to note that evidence demonstrated that patients received the required care from other specialties, such as therapies staff, in a timely manner.

Despite the continual issues with patient flow to the stroke wards, we found some positive patient experiences for timely transfer. Several clinical records showed that patients had been transferred to the acute stroke ward within the four-hour timeframe. One record highlighted that a patient remained in ED until their condition had stabilised and were transferred to the acute stroke ward within the four-hour timeframe. Other records demonstrated that a bed on the stroke ward was ring fenced for a patient and was not used whilst they received urgent care in ED. Whilst overall, the clinical records were clear and legible, in some records it was not always clear to establish times and dates of transfer of some to the stroke ward.

It is evident from exploring the timely transfer of patient flow to the stroke wards, that there is significant pressure on the whole of the system. Patient flow is a problem across all specialties, and for stroke patients, they are not always placed in right bed in the right place at the right time, due to the high demand on beds.

#### Recommendation 33:

Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.

#### Recommendation 34:

Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.

### Impact of flow on stroke rehabilitation

NICE guidance (NG128), states that stroke rehabilitation is essential for better patient outcomes. Ideally, this should be provided within a dedicated stroke inpatient unit, and by a specialist stroke team within the community if required.

Across Wales, we found clear inconsistencies for the provision of rehabilitation to people following their stroke. Some hospitals provide rehabilitation within the acute stroke ward since there is no separate ward available to provide this elsewhere. Other health boards have a dedicated rehabilitation ward within the same hospital site, or stroke rehabilitation may be provided within a different hospital site, such as community hospitals.

#### Early Supported Discharge

Early Supported Discharge (ESD) is an intervention for adults following a stroke which allows their care to be transferred from an inpatient to a community setting<sup>61</sup>. ESD enables people to continue their rehabilitation therapy at home, with the same intensity that they would receive in hospital. However, this may not always be suitable for everyone following a stroke, or in all circumstances, and the decision to offer ESD is made by the stroke MDT, after discussion with the person and their family or carer if applicable.

The stroke MDT will assess whether ESD is suitable for adults who have had a stroke.

The assessment will consider the person's functional, cognitive, and social circumstances, such as the person's ability to transfer from bed to chair independently or with assistance, and whether a safe and secure environment can be provided at home.

When considering the provision of ESD for people following a stroke, we found inconsistencies with the service available across Wales. Not all health boards provide this service and for those that do, there is no standardised format in the

---

<sup>61</sup> [Early Supported Discharge - NICE](#)

provision of ESD. Access to the service across Wales is varied and there is a lot of variation in the service provided in terms of frequency of home visits and intensity of rehabilitation provision).

Our interviews with ESD staff highlighted the significant benefits and positive outcomes for patients who have received ESD. The risks associated with remaining in hospital are minimised, and the psychological impact on patients improves with the ability to be discharged from hospital. We also found that where the service was available, staff reported improvement in patient flow due to savings on patient bed days.

Despite the benefits of ESD, it was disappointing to find inconsistencies across Wales with its provision. When speaking with staff about this, it appears there is a lack of resource or funding available to provide ESD services in some health board areas. This therefore highlights the inconsistencies with equitable access to ESD for people who may benefit from this.

#### Recommendation 35:

Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to hospitals, with earlier discharge improving flow through the stroke pathway.

### Stroke rehabilitation wards

Overall, we found that hospitals with stroke rehabilitation wards provide an environment which facilitates multidisciplinary stroke care, such as nursing, medical and therapies treatment. For hospitals that do not have separate rehabilitation wards, our staff survey highlighted several comments which suggested the need for a step down or rehabilitation ward for treatment to assist with the flow of patients from acute stroke wards. One member of staff commented:

*'a dedicated rehabilitation area that would allow for proper dignified assessment and rehabilitation to progress people.'*

In one health board, the process was ongoing to separate the stroke ward into acute and rehabilitation wards, and it was also introducing the provision of ESD.

The rehabilitation ward was re-located to community hospital sites which were also in the process of introducing ESD for all three sites. The aim is to facilitate the provision of a seven-day therapies service on the rehabilitation ward, with plans to progress to a seven-day therapies provision at the acute site. The purpose is to improve flow for stroke patients from the acute setting to the rehabilitation ward, and to facilitate earlier discharge to the community with the support of ESD.

Another health board was providing a full therapies service over seven days. Whilst this was positive in enabling earlier discharge of patients, staff told us it was having a negative impact on the weekday provision of care, due to the thin spread

of stroke speciality staff to cover seven days. Our interviews with Senior Managers found that they were considering the options of increasing the staff establishment; however, recruitment to the site was a challenge, due to complexity with discharge planning. Therefore, a high reliance on regular agency and bank staff was necessary.

We received several comments from therapies staff in our survey in relation to this issue, which included:

*‘Occupational therapy are involved with patients they are able to assist patients to improve ability with increased level of rehabilitation for each patient however this service is very limited. Services need to be seven-day services.’*

### **Physiotherapy stroke service**

We held discussions with staff across Wales regarding the provision of physiotherapy services. It was highlighted that it was not always possible to provide the NICE recommendation for 45-minute daily treatment, which was subsequently highlighted in SSNAP data we reviewed. This was due to the high volume of stroke patients and insufficient capacity within physiotherapy teams.

Our clinical records review found inconsistencies in the provision of the 45-minute daily physiotherapy and occupational therapy across Wales. Our staff interviews found this was attributed to the challenge with recruiting staff and several sites we visited were carrying vacancies within their therapy establishments.

We considered the physiotherapy needs of patients during our clinical records review. In some records, we found evidence of patients being assessed in a timely manner and receiving regular physiotherapy as appropriate. However, in some records the physiotherapy notes were not filed within the clinical records and were kept elsewhere. This prevented us from making a judgement on the provision of the service provided to some patients. When considering other records, some demonstrated delays in referral for physiotherapy assessment, or no evidence of physiotherapy intervention despite referral. We also found examples of stroke patients placed as outliers on other wards with no physiotherapy assessments documented. This highlights the importance of stroke patients being placed on the appropriate stroke wards to prevent any issues with not receiving the required treatment.

We received some comments in our public survey relating to physiotherapy services, which support our records review findings, these included:

*‘The hospital was short of physiotherapists would have liked physiotherapy on a daily basis but this was not possible. The nurses on the ward were not even allowed to help with simple arm and leg exercises.’*

*‘No physio available cos it was a weekend.’*

*‘Treatment/physio was not frequent enough in hospital which had an effect on recovery as the first few weeks/months are critical. No physio sessions on weekends very frustrating.’*

*'I was prepared to attend physio gym every day but sadly, the facilities were unavailable on weekends, which makes for a very long day with no activity.'*

### **Occupational therapy for stroke services**

When considering the records for occupational therapy input, we found similar issues to that within physiotherapy. We found inconsistencies in the patient records, with some areas demonstrating positive evidence of timely treatment, whilst several records had no documentation completed at all.

Issues were also found at times following discharge, for example, when patients were repatriated to other health boards. Patients are sometimes repatriated from acute care, and the receiving health board has not been informed of the need for referral to other services, such as occupational therapy or physiotherapy.

Therefore, delays in the provision of care are inevitable. This is clearly not appropriate for patients who are reliant on additional timely therapies services.

The issue of insufficient provision of therapies for patients was also reflected by respondents to our patient survey when asked what the NHS could do to improve the service it provides for stroke patients. One comment included:

*'More physio and speech and language help [is needed] and for a much longer period.'*

### **Speech and Language Therapy (SALT)**

As highlighted earlier, a swallow screen must be completed within four hours of admission to hospital for stroke patients. If the assessment identifies that a patient has problems with swallowing safely, they should receive a specialist swallow assessment. This should be undertaken within 24 hours of admission, but no longer than 72 hours, as highlighted within NICE guidelines.

Our review of clinical records reflected that most patients had passed the initial swallow screen. Where patients required a referral to SALT, this had been done within the 72 hours. In addition, there was evidence to support that a plan of care had been prescribed to support the SALT assessment.

We also considered whether patients who were unable to take oral nutrition, fluids or medication received other means of nutrition, such as tube feeding with a nasogastric tube (a small tube inserted through the nostril to the stomach), within 24 hours of admission, unless contraindicated following thrombolysis, in line with NICE guidelines.

It was positive to find that for those who may be compromised nutritionally, relevant patients had been referred to Dietetics and Nutrition teams for a nutritional assessment and were prescribed individualised feeding regimes. In addition, oral medication was reviewed to amend either the formulation or the route of administration.

When reviewing SSNAP data we considered the therapy services across Wales and found variances in the provision of therapies within stroke services for patients. Inadequate therapy services have a negative impact on patient recovery from stroke and also impact on discharge planning and patient flow within stroke services. Therefore, health boards must ensure all therapy services for stroke patients are reviewed to consider how each is meeting the needs of patients in line with national guidelines.

#### Recommendation 36:

Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.

### Psychology support in stroke services

Patients with stroke may suffer psychologically because of their stroke due to the significant impact it may have on their mental and physical well-being. This may include anger, frustration, depression, and anxiety. In addition, to maintain psychological wellbeing, patients should be able to speak in the language of their choice. It is important that health and social care providers maintain the Welsh language active offer for people in Wales, as highlighted earlier in the report. In addition, providers must maintain the ability to provide a translation service for people in other languages, such as Spanish, Polish, Urdu or Chinese. We found that access to a translation service was available in all health boards.

In line with NICE guidance (NG128), people who have had a stroke should have access to a clinical psychologist with expertise in stroke rehabilitation, and who is part of the core multidisciplinary stroke rehabilitation team.

Soon after a stroke, and where appropriate, patients should receive a psychological assessment to assess whether they are experiencing any early emotional problems which may have a lasting impact.

Their psychological needs may fluctuate along the stroke pathway as they recover from the acute stroke, and the reality of any disabilities may become overwhelming. The psychological support alongside physical rehabilitation, can increase a patient's opportunities to engage with rehabilitation and help maximise the outcomes.

We considered the psychological support provided to stroke survivors across Wales and found this to be inconsistent, as not all health boards provide support in this area. Our review of clinical records highlighted the lack of psychological support to patients within several health boards. This was also highlighted through our interviews with staff. We found that one health board within Wales had recently appointed three psychologists. One for each of its rehabilitation sites, along with three assistants. In addition, the staff discussed the positive work in progress, which offers education and training around the psychological needs of the patient, to all MDT members involved with the patients journey through the stroke



pathway.

We interviewed a GP who undertakes weekly ward rounds on a stroke rehabilitation ward in one health board area, which is attended by the MDT members to discuss the progress and needs of stroke patients. They supported the need for psychology input and suggested this service would be beneficial for patients. They highlighted that for stroke patients there may be a need to prescribe anti-depressants to help with their mental well-being, and that complemented by psychology support could improve the rehabilitation process for patients. In addition, having a family member with a stroke can be challenging for families or carers to deal with, and participation in the psychologically and support could also be beneficial for them.

#### Recommendation 37:

Health boards must consider the need for psychological support for people with stroke, and ensure that adequately trained staff are providing this support to help effectively manage patient recovery.

Overall, we found that therapy services play a key role in the patient's journey through the stroke pathway, and when preparing people for discharge. We found good collaborative working between therapy teams and others within the stroke MDT, however, as highlighted above, further investment may be required in some therapy teams for patient progress, recovery, and overall wellbeing.

In line with the inconsistencies found across Wales, not all stroke services can provide the required timely therapy services to patients. This was for several reasons, such as staff vacancies, the impact of patient flow resulting in different specialty outliers using stroke beds and vice versa and demand exceeding capacity. In addition, the overall environment to conduct therapies on the wards was problematic, relating to facilities and space for timely rehabilitation services.

A holistic approach to therapies is required across Wales, to provide patients with both physical and mental support. This approach would also benefit flow within our hospital system by enabling patients to be discharged timelier and over seven days a week.

#### Recommendation 38:

Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.

#### Recommendation 39:

Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.



## The impact of delayed discharge on patient flow

### Discharge delays for medically fit patients

As highlighted earlier, in June 2022, the Senedd Health and Social Care Committee published its *Hospital discharge and its impact on patient flow through hospitals inquiry* report<sup>62</sup>. The report highlights that in February 2022, there were 1,081 patients who remained in hospital who were medically fit for discharge.

During our fieldwork, staff told us that around a third of all patients in their health board area were medically fit for discharge. Some patients had remained in hospital for months until an appropriate placement or package of care was available to facilitate a safe discharge. Health boards regularly provide up-to-date numbers to Welsh Government of the medically fit people waiting in hospital beds, for a package of care, to enable them to go home, or a care home placement.

### Impact of delayed discharge or Delayed Transfer of Care (DTC) flow

To support our review in relation to patient discharge, our team included a peer reviewer from Care Inspectorate Wales (CIW), who supported our work through interviewing key staff relating to social care and those involved in the discharge planning process. This assisted our team to gain a sound understanding of the challenges related to the provision of social care.

Our report has already highlighted the challenges with the bottlenecks at the ‘back door’ of the healthcare system with delayed discharge, which impacts on patient flow throughout a hospital. This is felt at the ‘front door’ where EDs are unable to admit patients from ambulances in a timely manner.

The conclusion to the Senedd’s Health and Social Care Committee’s inquiry highlights the lack of social care capacity is the biggest contributor to delayed discharges and restricted patient flow through hospitals.

Unnecessary stays in hospital due to delayed discharge of care (or DTC), can place patients at risk of hospital acquired infections and deconditioning, which can lead to further ongoing care needs following discharge. The bottleneck at the point of discharge can affect EDs, WAST, inpatient care, primary care, planned admissions and staff wellbeing.

To help support the more complex discharges, across Wales, we found teams of staff in post, who had the responsibility for the discharge of patients with complex needs and who, therefore, need detailed planning to implement ongoing support following discharge. This includes patients following a stroke. We will discuss the complexities throughout this section of the report.

### Discharging stroke patients

Our review found that most stroke patients have a range of complex needs both

---

<sup>62</sup> [Hospital discharge and its impact on patient flow through hospitals](#)

physical and cognitive. This may include paralysis of limbs affecting mobility, issues with speech or swallow and cognitive impairment. Therefore, they are more likely to need ongoing packages of care at home, which are often complex to arrange. The resource is not always readily available, which may further delay a patient's discharge.

Our interviews with staff consistently found reports that discharge delays and DTOC can lead to worsening outcomes for patients and can also mean that some revert into an acute bed, and also impacts on their long-term care needs. Our staff survey also found similar, and one comment relating to this included:

*'It is not good for patients' wellbeing for them to remain in hospital when they are ready to leave.'*

### Planning for discharge

We considered how the MDTs across Wales planned and prepared for patient discharges from hospital.

### Board rounds

We attended stroke board rounds where discharge planning was central to the discussions that took place. They were led by a dedicated member of staff, and had an MDT approach, highlighting key information about each stroke patient, including diagnosis, admission date, care management plan and expected date of discharge. These meetings were consistent across Wales.

We found in most instances, a summary was made at the end of each patient discussion with the aim to highlight any daily tasks required, and the delegated person and task completion date to help ensure patient progress their journey through the stroke pathway to discharge. This also allowed for the opportunity to discuss any patients who were delayed in their discharge or DTOC.

Overall, we found board rounds were dynamic, constructive, and led to clear actions. However, some lacked effective leadership, direction, and decision-making, which in turn increased a risk to timely flow through the pathway, and out of hospital.

#### Recommendation 40:

Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.

### SAFER patient flow guidance<sup>63</sup>.

The *SAFER Patient Flow Guidance* was published by Welsh Government, and acts as a key enabler for an overarching good practice guide to improving patient flow.

---

<sup>63</sup> [SAFER patient flow guidance](#)

The guide identifies ten areas of focus to support flow across the unscheduled care patient pathway, and *SAFER* fits into one of these ten areas, relating to transfers of care.

*SAFER* consists of five elements of best practice which are summarised as:

- **S - Senior review** of all patients before midday, informed by a multidisciplinary assessment
- **A - All patients** and their families involved in the setting of an Expected Discharge Date (EDD)
- **F - Flow of patients** at the earliest opportunity from assessment units to inpatient wards
- **E - Early discharge** with at least a third of patients discharged from inpatient wards by midday on their day of discharge
- **R - Review** of patients involving MDT, the patients, and their families for those with extended lengths of stay.

We considered whether the sites we visited used any tools to help manage flow at a ward level. During our staff interviews, we were told that wards use the principles of *SAFER Patient Flow*, however, our findings from clinical records did not fully support this. We found inconsistencies in the recording of an EDD, or the rationale of why a date had not been considered, and there were also inconsistencies in the evidence recorded relating to the use of ‘Red’ and ‘Green’ days<sup>64</sup>. Our attendance at stroke board rounds also found that the use of the *SAFER principles* was not consistent across Wales.

It is evident that treating patients promptly with the appropriate care in the right place at the right time, can enable a person to be supported back to their own home in a timely manner. It is pivotal that all staff work together to manage the issues that may arise through a patient’s journey, to be effective. Early planning for discharge is essential, and the individual, their family, and healthcare and social care professionals must work together, to achieve a smooth and timely discharge. This, in turn will help facilitate better patient flow through healthcare systems.

#### Recommendation 41:

Health boards should ensure that staff are utilising the *SAFER Patient Flow* principles, to promote safe and timely discharge and help improve patient flow.

### Multidisciplinary meetings

We considered how well teams work together to support the discharge process for

---

<sup>64</sup> The Red and Green Days approach is an example of using simple rules to help reduce delays for patients by making ‘non-value’ adding days (from a patient perspective) visible, and a daily topic of conversation for clinical and managerial staff. It works particularly well when it is used across inpatient wards where patients often experience significant periods of time waiting for things to happen in their plan of care.

patients. During our fieldwork, we attended several MDT meetings to observe the discharge planning process within the relevant teams. We found the discharge teams help manage the support required for stroke patients, such as arranging and referring patients to appropriate post-discharge services. The teams also consult with services to manage their discharge home from hospital, including packages of social care or transfer of care to other services.

To plan for the discharge of stroke patients from hospital, we found an MDT approach for the continuity of patient care is taken by all health boards. A patient discharge plan is developed on an individualised basis, and includes all patients' needs for their continued rehabilitation and care at home, any community services required to support them, and any equipment or other aids they will need to maintain their care and safety following discharge.

We saw effective communication through all therapy disciplines to manage the flow of a patient through to discharge. In our staff survey, 81% said that there was an effective working relationship between all Allied Health Professions. We found good examples of early planning for discharge, and for ongoing care to facilitate rehabilitation and discharge from hospital. However, there were several prolonged delays in the allocation of social workers to patients, social care packages, and delays in obtaining nursing or residential home placements. This was consistent across Wales.

In line with NICE guidelines, we observed the core multidisciplinary stroke rehabilitation teams discussing individual patients to set and follow-up on goals. The rehabilitation teams consisted of:

- Consultant physicians
- Nurses
- Physiotherapists
- Occupational therapists
- Speech and language therapists
- Rehabilitation assistants
- Pharmacy.

At some MDT meetings clinical psychologists and social workers were also in attendance, however, this varied across Wales. Through discussions with staff, we identified that prior to the COVID-19 pandemic, social workers were present at most MDT meetings to discuss and arrange the social care requirements for stroke patients who were close to the end of their rehabilitation phase and would soon be ready for discharge. Their involvement was described to us as a positive step in enabling a timely discharge. However, during our fieldwork, at most MDT meetings we attended, social workers were not present which added to the challenges of timely discharges.

Within our staff survey, all stroke services healthcare staff who responded, said

there are often delays in the discharge process, and 78% said the delays were frequent. We also received comments in our survey from local authority staff, which included:

*‘Poor communication between ward staff and social care staff appears to be one of the main reason for inadequate / ineffective discharge planning.*

*‘Social Care is often inappropriately blamed as being the cause of delays when in actual fact the delays are frequently as a result of an internal issue on the ward.’*

*‘One of the fundamental things that would see a marked improvement in discharge planning and make it a positive discharge for the patient would be evidence that a person centred/strengths based/outcome focused conversation has actually taken place with the patients themselves and health and social care staff are clear what matters to that individual. This would then help inform discharge planning and make sure we get it right.’*

### **Communication with social care providers**

When considering the perspective of staff who work within the social care system, their response to our survey highlighted issues with the communication with hospital teams. This included inaccurate or insufficient information being provided in the referral process. Only five of 17 respondents said they were given the right information about the patient to assist with discharge. Some comments included:

*‘Very little information provided, inaccurate most of the time.’*

*‘Not always given correct information in terms of functional ability and rehabilitation / recovery plans.’*

*‘We rarely get any information unless we go looking for it. We spend hours trying to contact the hospital wards and then are told different information depending on who you speak to. Its patchy and unreliable.*

*The staff nurses are unaware of their own discharge policy as the LA which health forms they need to complete. They ask the SW to take the lead in most meetings as they are just unsure of the process.’*

*‘Agency nurses used to complete referrals are a massive setback as they do not know the patients well enough.’*

The findings in our survey clearly highlight issues with communication between healthcare and social care teams. We also found that the view of local authority and social care staff were generally quite negative in relation to the health board’s discharge policy. Just over half the respondents said that the health board had not shared their discharge policy with their teams. Ten of the 16 respondents said the health board policy was not easy to understand, and almost all said the policy wasn’t followed in practice. In addition, very few said they had sight of the health board policy.

Social care providers also made comments regarding poor discharge documentation, along with the communication for patient discharge plans. These included:

*‘Hospital discharges are sent out without paperwork and guidelines.’*

*‘Communication between the hospital staff and the home has been lacking at times and the information received from discharge has been wrong.’*

*‘More effective communications between hospital and us on discharge as at times it’s very difficult to get the information required until after they are home.’*

In addition, nine of the 17 respondents to our local authority survey said it was not clear what was required from them, to meet the needs on discharge. The comments included:

*‘As information is often limited, we can only work with the information we are given. When information is missing, we do not see the full scope of needs on discharge. Following admission, we often see a higher level of need, and these are addressed when they are realised.’*

*These comments were supported by information received as part of our social services provider survey, with one staff member commenting:*

*‘Better information and planning for discharge and more communication both verbal and written, from the ward.’*

Our staff survey also found that health board staff reflected similar opinions, with around 50% agreeing that patients are discharged with a written and detailed discharge plan, but with insufficient information available to inform the social care teams to support the discharge process. Staff also suggested that the most common reasons for discharge delays, were challenges from family or carers and community support. Supporting the later comment, in our patient survey, only 55% said they had been included in the discharge planning process.

One respondent told us:

*‘There were obviously insufficient staff, my mother was left on her own feeling very confused with no one to ask about her treatment. As her next of kin, I was given no information about her post discharge care.’*

The findings above, in addition to others throughout this report, highlight the need for collaborative work between health and social care services, to improve working relationships and develop a clear understanding across service teams, as to what each sector is doing to progress a discharge and improve outcomes for patients.

#### Recommendation 42:

Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.



## Allocation of social workers

When patients are medically fit for discharge but have ongoing complex needs, they are referred by healthcare staff to Social Services for social worker allocation. Social workers are required for numerous patients, and their role in discharge is to assess individuals to determine the social needs, and to help achieve a safe discharge plan that is considered the best outcome for the patient. They take into consideration patient views and wishes, and often need to balance complex family dynamics.

When exploring the access to social workers, our interviews with healthcare staff highlighted frequent delays with patient social worker allocation and the required assessments. We were told that social worker vacancies across Wales are negatively impacting on timely allocation to patients. Supporting their reflections, nearly all local authority staff who responded to our survey said they were unable to meet the demands on their time at work, and there aren't enough staff to do their job properly.

To help mitigate against staffing issues, some social care teams use agency staff to bolster the service, particularly in areas where recruitment of social workers is a challenge. However, we were told that the use of social worker agency staff can result in some inconsistencies in the service provided. One local authority staff commented:

*'Agency [social worker] staff have no understanding of geography or rurality.'*

Through our interview process, some healthcare staff shared their frustrations around the delays in the discharge process. They explained that in some localities, the allocation of a social worker was taking up to three weeks. Once a social worker is allocated, further delays are common with their ability to attend the hospital to undertake patient assessments.

In addition, once the assessments have been completed, and care plans developed there are challenges in obtaining the social care package in a timely manner. This prolonged process is causing unnecessary discharge delays for several patients and is consistent across most health boards.

Other examples provided to us during interviews noted that once referred to social worker teams, staff would not come to assess the patient until a full referral had been completed. The nursing staff often notify the ward or hospital based social worker that a patient will need some assistance on discharge. However, the nurses were often informed that until the referral is received by fax, they would not commence the process of allocating a social worker.

It is evident through our work, that nursing staff do not always have time to sit and complete a full referral when a patient is ready for assessment, since they have several other patients to care for during their shift, as well as arrange discharges and admissions from ED. Sometimes, the referral cannot be completed until the end of a 12-hour shift, and if this were a Friday, then it would be several days before the social worker team would receive the fax and commence the process



from their department. This would unnecessarily prolong the potential discharge of a patient.

In our staff survey, healthcare staff highlighted the challenges they face with the allocation of social workers and eight people made comments in relation to this. One included:

*‘Long waits for social services and packages of care and inadequate rehabilitation staffing means we can’t optimise patients for their best recovery.’*

We did, however, find a positive example of good engagement and cross team working with social work teams in one health board area. This was because of excellent relationships between health and social care workers. This enables timely allocation, and assessment of patients to be carried out in some localities, minimising delays with the discharge process for patients.

As highlighted earlier, delayed discharges for patients who are medically fit to leave hospital can impact on some patient’s well-being. If they acquire an infection or become deconditioned whilst they are waiting to leave hospital, they may need new or additional treatment. If this does occur, we found that the process for social worker allocation and assessment is stopped if the patient is no longer medically fit for discharge. Consequently, once the patient recovers, the process of allocation and assessment must re-commence, delaying discharge further.

#### Recommendation 43:

Health Boards and social worker teams must work together to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.

#### Recommendation 44:

Welsh Government must consider the process in place for social worker teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.

### Patient Best Interest Meetings

For patients with more complex needs, and who require a Best Interest Meeting<sup>65</sup> in line with the Mental Capacity Act<sup>66</sup>, we considered whether there were delays in arranging these meetings. Consistently across Wales, we found delays in holding a timely meeting on several occasions. This was due to coordinating attendance for all required attendees, which could include MDT members, family members or

---

<sup>65</sup> Best Interest Meetings take place where a patient lacks mental capacity to make significant decisions for themselves and need others to make those decisions on their behalf.

<sup>66</sup> The Mental Capacity Act is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.

carers and social work or care home managers. This was also highlighted in our staff interviews, and within our staff survey. One person commented:

*'If a patient requires a Best Interest Meeting once clinically optimised, there are delays and difficulties in arranging the meetings to ensure all relevant stakeholders are in attendance.'*

#### Recommendation 45:

Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.

### Whole system approach to health and social care

We considered how healthcare and social care teams are working to achieve Welsh Government's long-term future vision of a 'whole system approach to health and social care', as published in its updated plan, *A Healthier Wales: Our plan for health and social care*<sup>67</sup>. The vision outlines a shift over time from the reliance on traditional hospital services providing care to people, to a seamless approach of integrated care, which includes health, local authority and third sector services.

Through our staff interviews across Wales, it is positive to find that several key areas of work are effective in progressing the process of safe patient discharges, which includes stroke patients. As part of this work, some healthcare, social care and third sector teams have been developing new partnerships and implementing new models of 'Home First' and 'Hospital to Home' services in Wales, which is highlighted in the *Home First: The Discharge to Recover then Assess Model (Wales)*<sup>68</sup>.

The model highlights the care and support offered to patients, to leave hospital and to receive ongoing assessment and recovery at home, and to limit unnecessary time in hospital settings. Since 2018 the development of Home First and Hospital to Home services and its implementation has been supported by the NHS Wales Delivery Unit, now known as NHS Wales Executive<sup>69</sup>.

We found that Home First teams are dedicated in promoting faster discharge from hospital and provide ongoing support to people and can arrange the required packages of care for people who are medically fit for discharge. Welsh Government's long-term objective is for health and social care providers to implement and scale services from a local and regional level to a national level.

Overall, it was positive to hear from staff where the Home First model is effective, and patient discharge can happen more quickly, which in turn assists with the flow of patients through hospital. Our review has identified the benefits of Home First

---

<sup>67</sup> [A Healthier Wales: Our plan for health and social care](#)

<sup>68</sup> [Home First: The Discharge to Recover then Assess model \(Wales\)](#)

<sup>69</sup> [NHS Wales Executive](#)

teams, which are making the required difference in line with the set ambition of *A Healthier Wales*. It is therefore important that health and social care teams develop this service to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.

#### Recommendation 46:

Health boards must develop and strengthen Home First services across Wales to benefit the people who need this, and to help manage the issues with patient flow through health and social care systems.

### Domiciliary care

During our interviews with discharge teams, across Wales we were told that domiciliary care-packages are difficult to obtain in most health board areas. The most significant issue highlighted, was the recruitment and retention of care workers to provide the social care people need at home. Patients who cannot support themselves at home or who have no other means of care support, cannot be safely discharged. Therefore, increasing the size of the hospital's 'back door' bottleneck.

We found that social care providers have ongoing pressures heightened since the pandemic which includes, staff sickness, low morale, and exhaustion, which impacts on recruitment and retention. It also important to highlight that the complexity of some individuals who are very frail and need higher levels of social care support, often with two carers, has placed additional pressures on social care agencies in their ability to provide care to new patients leaving hospital.

We found that healthcare staff are fully aware of the demands for domiciliary care agencies and their ability to meet demand and are always in frequent contact with them. We were told that in some health board areas, some families are encouraged to seek private domiciliary care where local authority care provision is not yet available. However, this is not always affordable to some, therefore people remain in hospital unnecessarily, which is contributing to the issues with patient flow.

Within our staff survey, most social care staff said that there were challenges of people accessing services to enable appropriate discharge. The comments included:

*'Lack of care providers to meet assessed care and support needs. Lack of carers.'*

*'Care sector is under huge pressures for staff capacity and poor discharges are a growing issue.'*

*'Lack of stroke rehab services locally both in patient and community.'*

#### Recommendation 47:

Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.

#### Care home placements

Many patients who have sustained a stroke and others who need ongoing long-term care may need to move in to a nursing or residential home following their discharge from hospital.

Our staff interviews found that some health board staff are required to have difficult conversations with patients and their carers or families, around their care home choices. This can also include their finances and potentially paying for long term care placements. We also heard examples where due to the unavailability of domiciliary care services, patients have no choice but to move into a care home for interim periods.

We were told by healthcare staff that patients are often reluctant to enter care homes, as they want to go to their usual residence and often decline a bed when offered.

Many also decline admission to an interim bed placement for reablement, as they are worried of deteriorating and not being able to go home, or they may be faced with the need to pay high charges when their funded placement ends. In addition, for patients who require long term care home placement, many homes are long distances from their usual home and their family, and they often do not wish to move to these homes. We were told that having these conversations is challenging and can be quite upsetting at times, and most do not have experience or training for managing these difficult conversations.

We found that when people need admission to a care home in Wales, the funding process can be complex. In most cases, the person is financially means tested, and in many instances people in Wales are required to self-fund their bed if they haven't more £50,000 in capital and assets. If capital and assets are less than this, then a person will likely be eligible for local authority funding. In addition, when some individuals are assessed as having long-term health needs, they may be eligible for NHS continuing healthcare funding. However, if a person does not qualify for this funding, sometimes they may be eligible for NHS funded nursing care, where the NHS will partially fund the placement, for the nursing element of the fees<sup>70</sup>.

In our staff survey, people working within social care or local authorities shared comments with us around care home placements, with one comment including:

*We have a long waiting list for both domiciliary care and residential and nursing*

---

<sup>70</sup> [Care Home Funding in Wales 2023](#).

placements.’

### Reablement services

As part of its Deliver Home First<sup>71</sup> model, Welsh Government suggests that the process of discharge from hospital is a key factor for rehabilitation, and that the lack of support an individual receives leading up to discharge and post-discharge will impact the likelihood of them requiring care in the future.

Reablement services provided support to help people regain their independence after illness or disability, and it is usually provided for a relatively short time, such as weeks rather than months. This may include some stroke patients.

We found that the Continuing NHS Healthcare (CHC)<sup>72</sup> teams and complex care teams work well in their aim is to return people home quickly, however, we were told that where reablement care is needed, there have been waits for this service in some health board localities.

### Variations in reablement services

There are variations to reablement services across Wales. Some health boards reported having Home First services available from all their sites.

We heard examples from staff, who said the availability of Home First for 10 days rehabilitation had a positive impact on discharging patients home promptly, and the health board approved funding to allow an extension of the daily working hours.

In other health board areas, we found waiting lists for patients to be discharged through the Hospital to Home schemes<sup>73</sup>; however, transition beds are available for up to six weeks, with funding agreed for up to three times a day.

We found that interim placements in care homes were available in some health boards, and patients were encouraged to utilise these when they were fit for discharge, until their home care was ready to start. These beds are funded by the health boards and at no cost to the patient but had a maximum stay of up to six weeks. Patients or their family/ carers were sometimes reluctant to utilise these beds, as they felt it would hinder their ability to return home, and if it they were not able to leave the home after the set period, they would need to pay for them after that time.

During our interviews, staff told us that the provision of interim or reablement beds in the community is often difficult to obtain. Whilst health boards can fund these beds for up to six weeks, they are associated with very high costs. During one interview, we were told that all care home beds were full within their health board and increased significant pressure on the wards to manage patient flow.

Overall, the provision of early supported discharge is inconsistent across Wales

---

<sup>71</sup> [Delivering Home First. Hospital to Home Community of practice: key learning and practice examples](#)

<sup>72</sup> Any adult who has complex needs and as a result might be eligible for Continuing NHS Healthcare. [Continuing NHS Healthcare information booklet for individuals, families, and carers | GOV.WALES](#)

<sup>73</sup> [Delivering Home First - Hospital to Home Community of Practice: key learning and practice examples](#)

with peaks and troughs being reported in these services.

### **Patient home equipment needs**

When patients need equipment or small adjustments made at home to support their discharge, we were informed by staff across Wales that this service generally works well. This was a consistent finding across Wales. These teams, based in the community, aim to provide and install home equipment or make minor adjustments quickly to support patient discharges. Overall, we were told the waiting times for equipment assessments, delivery and/or installation was quite low. However, longer waits were reported for home adaptation which required more complex structural alterations.

Whilst health board staff were positive with this in our interviews, several comments within our staff survey of social care providers were not so positive. These included:

*‘Users are sent home without the necessary equipment in place and the responsibility and stress then falls on the provider to source this and ensure the safety of the users.’*

*‘The industry is under a lot of pressure but when people are discharged unsafely without equipment, and they end up going back to hospital.’*

*‘People are discharged without assessing the environment they are returning to. This means that in some instances people return to hospital as they are unable to live independently as they do not have access to the right equipment and services.’*

It is concerning to hear the disparities in staff opinions regarding the availability of equipment. Particularly if healthcare staff suggest the service is working well, yet when social care staff attend people’s homes, the required equipment is allegedly not in place. We did not visit people’s homes as part of our review; therefore, we cannot establish whether the appropriate equipment was provided in line with assessment pre-discharge and whether the needs changed after a patient was home.

### **Positive aspects in preparing for discharge**

Despite the challenges faced by health board staff across Wales for the safe and effective discharge of patients, our staff interviews highlighted several positive findings. These included the following:

- Occupational therapists and physiotherapists are available at all acute sites and as part of community reablement teams. This means that rehabilitation happens quickly and continues at home or in the community, where possible
- Where discharge coordinator posts exist in hospitals, complex discharges are managed effectively
- Partnership working at all levels is particularly good. Senior managers in both health and social care services are well informed of the issues and challenges with discharge and patient flow. Meetings occur daily and weekly



which focus on delayed discharges

- Where there is agreement for trusted assessors, assessments and care plans are carried out quickly but there is still a delay in obtaining the necessary service provision
- One health board reported operating an effective Discharge to Recover then Assess model with the aim to assess people in their own environments
- Specialist stroke rehabilitation units, with sufficient beds, and appropriate clinical support, allows people to be discharged from acute settings where appropriate
- Step-down beds are available throughout the county at the 10 Community Hospitals
- Integrated teams work well together with all professionals and the third sector playing a key part. The intermediate care teams in the community aim to keep people at home alleviating the pressure on admissions. The health board has invested in intermediate care to support people to remain at home, virtual wards, use of community hospitals for rehabilitation and GP's operate systems of case management
- There is a strong social work team in some parts of the health board, supported by students and agency staff are used where necessary
- Allocation and assessment of cases is therefore carried out speedily in those areas
- The health board has invested in Discharge Liaison Nurses who are part of the multi-disciplinary team.

Overall, we found that when patients were deemed medically fit for discharge, there were frequent lengthy delays in obtaining packages of care for patients across Wales as a whole, with minimal knowledge in some cases of when these packages could commence.

Where a patient was awaiting a placement in a nursing or residential home, we found dates were often set for transfer out, or plans were in place to cover the interim period elsewhere in reablement beds, before the placement was available, however, this was not consistent across Wales due to bed availability.

### **Discharge or repatriation to several localities**

An additional challenge faced by several health boards is the need to discharge to several local authority areas, and the requirements in each can be different.

Whilst overall, relationships with different local authorities were described as good, we were told there are different referral routes, processes, and IT systems in place, which can make the processes difficult to navigate and more complex at times, delaying the discharge process unnecessarily. We were also informed some local authorities receive people to their homes from NHS Trusts in England, or from other health boards, where discharge processes may be different again from the usual discharging health board. This often makes discharge communication more



complex and challenging.

### The day of discharge

To help facilitate daily discharges, we considered whether the hospitals we visited had a discharge lounge. A discharge lounge can help improve flow on a daily basis, as patients who are due to be discharged that day can be moved to the lounge to await transport home, or to await medication from pharmacy to take home. This can free up ward beds earlier in the day, which will help with flow across the hospital.

We found that most sites had a discharge lounge. Some lounges had flexible spaces which could be adapted according to demand and patient requirements, such as for a chair or bed. Access to the discharge lounge also varied across Wales, with some open from 8am to 6pm or 8pm, Monday to Friday with no weekend provision.

Our clinical record review found that some discharges took place late afternoon or in the evening. However, in some records reviewed, it was not clear what time of day the patient left the ward, or whether they went to a discharge lounge or other means. Therefore, it was not clear whether the wards had formally completed the timing of discharge process on the electronic patient system, therefore making them appear that they were still in the ward bed. This would make it difficult for patient flow managers to know when the bed is available (or not), which is important particularly when EDs are full, and beds are needed.

We recognise that use of the discharge lounge and accelerated discharge processes may not be clinically appropriate for all stroke patients, particularly those with complex needs, such as physical or cognitive impairments. Staff told us that some stroke wards use their day room for patients to wait for their discharge to help improve the flow through stroke services.

#### Recommendation 48:

Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.

#### Recommendation 49:

Health boards must identify the hospital sites that do not have a discharge lounge service and consider the positive benefits on patient flow of implementing this service.

#### Recommendation 50:

Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed has become available, to help manage timely patient flow.

## Conclusion

It is clear from our findings that the healthcare system across Wales is frequently operating under extreme pressure, with hospitals regularly operating at the highest level of escalation. Poor patient flow is a fundamental issue causing this pressure, and our review has brought to the surface the negative impact this can, and is, having on all patients, not just those on the stroke pathway.

Whilst we have reflected in our review an intention and ambition to tackle this problem, as well as examples of good practice that have made a positive impact in alleviating flow problems, more needs to be done. It is clear that no single solution exists to solve poor flow, rather a range of approaches are required in combination to release the pressures on the health and social care system.

These solutions range from doing more to help inform and educate the public about the choices they make when accessing healthcare services, spreading the positive learning that exists from flow management initiatives within acute hospital settings, and strengthening collaboration and processes around discharge from hospitals between the health and social care sector in particular.

This review used stroke to understand the impact and dynamic nature of flow, and overall, our view is that the stroke pathway is operating effectively to some extent. People receive timely assessment, imaging, and thrombolysis treatment where appropriate. However, access to thrombectomy and the ability to progress people through their recovery and rehabilitation phase, following their stroke, is inconsistent across Wales and needs attention.

Poor patient flow is undoubtedly having a detrimental impact on aspects of the stroke pathway. We have seen the lack of timely packages of domiciliary care, and the availability of community hospital beds or care home beds, resulting in patients remaining in hospital much longer than is necessary. This can lead to patients become deconditioned with a risk that they are no longer medically fit for discharge and require further treatment.

Blockages in the discharge process can cause challenges and pressures across hospital beds, and lead to overcrowded EDs, causing significant issues in the ability of WAST to respond to patients who need emergency care in the community in a timely manner.

It is clear there is an unprecedented pressure across the whole of the health and social care systems in Wales, which has been intensified by the Covid-19 pandemic, however, this pressure is continuing to prevail. Staff are working tirelessly to help manage the flow through hospitals and out to the community. However, despite their best efforts, for a variety of reasons outlined in this report, including demand and system weaknesses this is not leading to a significant improvement in the overall position. Tackling the issue of flow is a multi-faceted challenge that needs the health and social care system, along with Welsh Government, to come together and ensure all is being done to address the issues highlighted by our review.

## What Next?

We expect the health boards, Welsh Government, WAST, PHW and Local Authorities to carefully consider the findings from this review and act upon the 48 recommendations set out within the report and listed within Appendix A.

We hope this review will be used to help health boards to improve flow, by encouraging health board teams to collaborate with each other in relation to good practice and innovative practice. In addition, that this work can be a catalyst for improved relationships between health and social care teams.

All relevant stakeholders highlighted within this report are required to submit an improvement plan in response to the review's recommendations. This is to ensure that the matters raised by our review are being addressed.

The findings highlighted in our report, and the responses that we receive, will support HIW in considering whether to undertake further, local or national work.

## Appendix A

### Recommendations

As a result of the findings from this review, we have made the following recommendations in the table below.

|   | Recommendations   |
|---|---|
| 1 | Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.                                   |
| 2 | Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation. |
| 3 | Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes.                        |
| 4 | Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.   |
| 5 | Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.                               |
| 6 | Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).  |
| 7 | Health boards should consider the benefits of dedicated 'discharge phlebotomy slots' for managing the necessary blood tests, to assist with effective and timelier discharge.   |
| 8 | Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.  |
| 9 | Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.  |

|    |  |
|----|--|
| 10 | Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days. |
| 11 | Welsh Government should consider strengthening its promotion of the <i>Help Us to Help You</i> campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.  |
| 12 | Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.  |
| 13 | WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.   |
| 14 | Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.  |
| 15 | WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.   |
| 16 | Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.   |
| 17 | WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.  |
| 18 | Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.   |
| 19 | Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.   |
| 20 | Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED.   |

|    |   |
|----|---|
| 21 | Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.   |
| 22 | Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.                               |
| 23 | Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA.   |
| 24 | Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.  |
| 25 | All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.   |
| 26 | Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.   |
| 27 | Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the <i>National Clinical Guideline for Stroke</i> updated in April 2023. |
| 28 | Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.   |
| 29 | Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.  |
| 30 | Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.                         |
| 31 | Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.   |
| 32 | WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms                       |
| 33 | Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.  |
| 34 | Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards  |

|    |   |
|----|---|
|    | must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED.   |
| 35 | Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.   |
| 36 | Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.   |
| 37 | Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.  |
| 38 | Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.   |
| 39 | Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.   |
| 40 | Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.  |
| 41 | Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.   |
| 42 | Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies. |
| 43 | Health Boards must work collaboratively with social worker teams to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.   |
| 44 | Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.   |
| 45 | Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.   |
| 46 | Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.  |



|           |  |
|-----------|--|
| <b>47</b> | Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.   |
| <b>48</b> | Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.   |
| <b>49</b> | Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.   |
| <b>50</b> | Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow. |

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

**Communications Manager**  
**Healthcare Inspectorate Wales**  
**Welsh Government**  
**Rhydycar Business Park**  
**Merthyr Tydfil**  
**CF48 1UZ**

Or via:

**Phone:** 0300 062 8163

**Email:** [hiw@gov.wales](mailto:hiw@gov.wales)

**Website:** [www.hiw.org.uk](http://www.hiw.org.uk)

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

WG47778

Digital ISBN 978-1-83504-616-6

© Crown copyright 2023

| Action | GIRFT Recommendation  | Progress              | Responsibility                  | RAG Rating | Current Metric (if applicable)                                      | Further notes   |
|--------|---|-----------------------|---------------------------------|------------|---|---|
| 1      | Record data in real time, with audit compliance and assurance processes built into the individual sites' Health Board wide audit programme. Clinical and audit team to meet on a regular basis to undertake a review of the accuracy of the registered SSNAP data for clinical assurance.   | Complete              | Stroke Directorate              |            | SSNAP Rating : A (90%+)   | Data referenced: SSNAP Quarterly Report April - Jun '23   |
| 3      | Improve the pre-hospital identification service model to reduce unwarranted variation in access to imaging. ABUHB to embed the Optimal Stroke Imaging pathway. The use of first line MRI for patients with mild symptoms or with diagnostic uncertainty may release bed capacity. Refer to NOSIP, page 17 <a href="https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf">https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf</a> . | Complete              | Stroke Directorate Radiology    |            | SSNAP Rating : A (90%+)   | Data referenced: SSNAP Quarterly Report April - Jun '23   |
| 6      | Take advantage of the quality improvement opportunities along the thrombolysis pathway, SSNAP modelling has identified that up to 15-20% of stroke patients may be eligible for thrombolysis.   | Complete              | Stroke Directorate              |            | 17.00%  | Data referenced: SSNAP Quarterly Report April - Jun '23   |
| 17     | Ensure nutrition screening is completed for all patients using a validated nutrition screening tool and that patients are seen by a dietician by discharge; the documentation of assessment needs to be standardised and a weekly 'compliance' meeting put in place to provide assurance.   | Complete              | Therapies                       |            | 96.40%  | Data referenced: SSNAP Quarterly Report April - Jun '23   |
| 18     | Ensure mood and cognition is assessed by discharge and is documented consistently. A weekly compliance meeting should be held to provide assurance.   | Complete              | Therapies Psychology            |            | 97.00%  | No weekly meeting planned, report on exception basis if rate is <95%  |
| 4      | <b>ABUHB to develop a strategy to improve direct access to the stroke unit within 4 hours of presentation.</b>  | In Progress (Need Sup | Stroke Directorate Patient Flow |            | SSNAP Rating : E  |   |
| 5      | Ensure access to the stroke unit for stroke patients for 90% of their stay. A reduction in delays for imaging should help to release bed capacity and increase access.  | In Progress           | Stroke Directorate Patient Flow |            | 75.00%  | Data referenced: SSNAP Quarterly Report April - Jun '23   |
| 7      | Ensure 24/7 availability of stroke specialist nurses to assess all presenters to the emergency department with a suspected stroke.  | In Progress           | Stroke Directorate              |            | 5/5 Recruited to cover 12 Hour service (note next steps challenges) | Recruitment & retention challenges. All posts substantively appointed into (5) however four currently on/due to start Maternity leave. Currently exploring ability to backfill with alt. role e.g. PA/JCF |
| 8      | Ensure 24/7 availability of stroke or emergency department nurses who are capable of administering a swallow assessment and can do so, ideally within 2 hours of admission.   | In Progress           | Emergency Department Therapies  |            | 47.00%  | Engagement with ED ongoing   Training to be provided early Oct 2023   |
| 11     | Embed the Stroke Association Carers Support Pathway (SACS). RNOH/GIRFT observed that the pathway has not been fully embedded in all units, with significant gaps in the commissioning of life after stroke pathways.  | In Progress           | Therapies CNRS                  |            |   | Requires completion of rehabilitation reconfiguration then contact Naheed Ashraf  |
| 12     | Embed the National Stroke Service Model in ABUHB <a href="https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf">https://www.england.nhs.uk/wp-content/uploads/2021/05/national-stroke-service-model-integrated-stroke-delivery-networks-may-2021.pdf</a>  | In Progress           | Stroke Directorate              |            |   | Action will be completed as part of the Rehabilitation Reconfiguration  |
| 13     | Ensure 7 day access to neuro-physiotherapy and that there is adequate provision to deliver 45 minutes of therapy a day for all eligible patients.   | In Progress           | Therapies CNRS                  |            | 33.60%  | The latest guidance has moved away from the 45 minutes of Therapy and now suggests 3 hours of combined motor recovery rehabilitation per day.   |
| 14     | The HASU and peripheral rehabilitation units to review workforce and capability for 7/7 therapy working to improve access to physiotherapy, occupational therapy and SLT, embracing a capability framework of competency [Stroke Educational Framework <a href="https://stroke-education.org.uk/">https://stroke-education.org.uk/</a> ].   | In Progress           | Therapies                       |            |   | The current Therapies commissioned staffing for stroke across all professions is 51% below minimum National Standards.  |
| 15     | Deliver adequate psychological and emotional support for stroke survivors and their families. This may take the form of a commissioned neuropsychology service that supports a matched/stepped psychological model of care approach .   | In Progress           | Therapies CNRS Psychology       |            |   | Initial plans being worked up   |
| 16     | ABUHB to ensure continence plans are delivered and that the documentation and reporting of data is robust. There should be a weekly 'compliance' meeting to provide assurance.  | In Progress           | Stroke Directorate              |            | Provisional 100% compliance (require data corroboration)            | Update Sept. 2023: Requested datasource from Peggy Edwards Nursing metric and datasource requested  |
| 2      | Commission an ESD pathway process flow map, it is only after full mapping of a needs-based ESD pathway or Integrated Community Stroke Service Model (ICSSM stroke-integrated-community-service-february-2022.pdf (england.nhs.uk)) that an accurate calculation of the requirement of community bed needs is possible. This, we expect will support a move to having only two stroke specific rehabilitation units, one in the North and one in the South of ABUHB.   | Not Started           | Therapies                       |            |   | Requires completion of rehabilitation reconfiguration: Nov 2023   |
| 9      | ABUHB to put a cohort of doctors, therapists and third sector representatives together through the Welsh Leadership Academy Programme.  | Not Started           | ABUHB Corporate                 |            |   | Seeking clarification about which course to enrol on.   |
| 10     | Embed the integrated community stroke service model (ICSS) to ensure patients receive longer term support: stroke-integrated-community-service-february-2022.pdf (england.nhs.uk).  | Not Started           | Therapies CNRS                  |            |   |   |
| 19     | Ensure this evidence-based bundle of care (nurse and therapist <24hrs, all relevant therapists <72 hrs, rehab goals agreed < 5days) is more consistently delivered. Improve documentation of MDT goal setting in case notes. Recommendations to ensure improved access to therapy reviews are highlight above, but it must be noted that achieving this bundle is difficult if all therapy teams work a 5 day rota.   | Not Started           | Therapies                       |            | <a href="#">Link to Metrics</a>                                     | Requires completion of rehabilitation reconfiguration & then more resource/funding. Therapies to take this forward  |
| 20     | Standardise post discharge reviews using the GM-SAT six-month post stroke review tool .   | Not Started           | Stroke Directorate              |            |   | Update Sept 2023: Start from November 2023 when B7 CNS in post Unable to start until CNS workforce is stabilised. Est. Dec 2023   |



Quality Measures Summary

Show 72 Hours Pathway

Show Post 72 Hours Pathway

Show Post 72 Hours Pathway Non Routine

ReportingMonth  
 Oct 2023  
 MONTHS -  
 2022  
 JUN JUL AUG SEP OCT NOV DEC 2023  
 JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC  
 < >

Selected Reporting Period  
Oct-23

Note: If post 72 hr pathway is showing below please be aware that the rolling 3 month period is already show when one month is selected. If several months selected e.g. three months in the slicer then some measures will be 6 months (you may be double counting patients)

| Acute Stroke Quality Improvement Measures Performance  | Aneurin Bevan | Betsi Cadwaladr |            |                |       | Cardiff & Vale | Cwm Taf Morgannwg |          | Hywel Dda |               |           |           | Swansea Bay | All Wales |
|--|---------------|-----------------|------------|----------------|-------|----------------|-------------------|----------|-----------|---------------|-----------|-----------|-------------|-----------|
|  | The Grange    | Bangor          | Glan Clwyd | Wrexham Maelor | UHW   | Prince Charles | Princess of Wales | Bronllys | Glangwili | Prince Philip | Withybush | Morriston |             |           |
| Percentage of stroke patients given thrombolysis (all stroke types)  | 22.7%         | 11.8%           | 11.1%      | 16.1%          | 16.1% | 15.4%          | 30.8%             | 8.3%     | 14.8%     | 22.2%         | 22.2%     | 7.1%      | 15.9%       |           |
| Thrombolysed patients DTN <= 45 mins   | 10.0%         | 0.0%            | 0.0%       | 0.0%           | 33.3% | 12.5%          | 0.0%              | 0.0%     | 0.0%      | 0.0%          | 0.0%      | 0.0%      | 8.3%        |           |
| Percentage of patients scanned within 1 hour of clock start  | 43.2%         | 50.0%           | 55.6%      | 54.8%          | 53.6% | 44.2%          | 57.7%             | 58.3%    | 77.8%     | 100.0%        | 88.9%     | 23.8%     | 51.9%       |           |
| Percentage of patients directly admitted to a stroke unit within 4 hours of clock start                            | 7.1%          | 50.0%           | 29.4%      | 7.7%           | 60.0% | 21.7%          | 11.5%             | 63.6%    | 9.5%      | 100.0%        | 50.0%     | 33.3%     | 31.4%       |           |
| Percentage of applicable patients who were given a swallow screen within 4 hour of clock start                     | 46.3%         | 74.1%           | 71.0%      | 73.1%          | 71.4% | 88.2%          | 73.9%             | 71.4%    | 92.0%     | 100.0%        | 50.0%     | 83.3%     | 74.6%       |           |
| Percentage of Unique stroke patients given thrombectomy (all stroke types)   | 2.3%          | 3.0%            | 0.0%       | 3.3%           | 3.6%  | 8.0%           | 0.0%              | 0.0%     | 0.0%      | 0.0%          | 0.0%      | 0.0%      | 2.4%        |           |
| Percentage of patients assessed by stroke specialist consultant physician within 24 hours of clock start           | 86.4%         | 61.8%           | 61.1%      | 64.5%          | 83.9% | 50.0%          | 73.1%             | 83.3%    | 100.0%    | 88.9%         | 77.8%     | 92.9%     | 75.1%       |           |
| Assessed by one of OT, PT, SALT within 24 hours  | 47.7%         | 82.4%           | 86.1%      | 83.9%          | 87.5% | 44.2%          | 73.1%             | 83.3%    | 63.0%     | 55.6%         | 88.9%     | 92.9%     | 73.0%       |           |
| Percentage of applicable patients who were given a formal swallow screen assessment within 72 hours of clock start | 83.8%         | 66.7%           | 75.0%      | 85.7%          | 85.0% | 32.0%          | 75.0%             | 75.0%    | 80.0%     |               | 66.7%     | 100.0%    | 73.4%       |           |

| Acute Stroke Quality Improvement Measures Values   | Aneurin Bevan | Betsi Cadwaladr |            |                |     | Cardiff & Vale | Cwm Taf Morgannwg |          | Hywel Dda |               |           |           | Swansea Bay | All Wales |
|--|---------------|-----------------|------------|----------------|-----|----------------|-------------------|----------|-----------|---------------|-----------|-----------|-------------|-----------|
|  | The Grange    | Bangor          | Glan Clwyd | Wrexham Maelor | UHW | Prince Charles | Princess of Wales | Bronllys | Glangwili | Prince Philip | Withybush | Morriston |             |           |
| Number of stroke patients given thrombolysis (all stroke types)  | 10            | 4               | 4          | 5              | 9   | 8              | 8                 | 1        | 4         | 2             | 2         | 3         | 60          |           |
| Total number of stroke patients (all stroke types)   | 44            | 34              | 36         | 31             | 56  | 52             | 26                | 12       | 27        | 9             | 9         | 42        | 378         |           |
| Number Thrombolysed patients DTN <= 45 mins  | 1             | 0               | 0          | 0              | 3   | 1              | 0                 | 0        | 0         | 0             | 0         | 0         | 5           |           |
| Total number of Thrombolysed patients  | 10            | 4               | 4          | 5              | 9   | 8              | 8                 | 1        | 4         | 2             | 2         | 3         | 60          |           |
| Number of patients scanned within 1 hour of clock start  | 19            | 17              | 20         | 17             | 30  | 23             | 15                | 7        | 21        | 9             | 8         | 10        | 196         |           |
| Total number of stroke patients (all stroke types)   | 44            | 34              | 36         | 31             | 56  | 52             | 26                | 12       | 27        | 9             | 9         | 42        | 378         |           |
| Number of patients directly admitted to a stroke unit within 4 hours of clock start                            | 3             | 15              | 10         | 2              | 30  | 10             | 3                 | 7        | 2         | 8             | 4         | 14        | 108         |           |
| Total number of patients applicable for direct admission to the stroke unit                                    | 42            | 30              | 34         | 26             | 50  | 46             | 26                | 11       | 21        | 8             | 8         | 42        | 344         |           |
| Number of applicable patients who were given a swallow screen within 4 hour of clock start                     | 19            | 20              | 22         | 19             | 40  | 45             | 17                | 5        | 23        | 7             | 3         | 35        | 255         |           |
| Total number of applicable patients who required a swallow screen  | 41            | 27              | 31         | 26             | 56  | 51             | 23                | 7        | 25        | 7             | 6         | 42        | 342         |           |
| Number of Unique stroke patients given Thrombectomy (all stroke patients)                                      | 1             | 1               | 0          | 1              | 2   | 4              | 0                 | 0        | 0         | 0             | 0         | 0         | 9           |           |
| Total number of Unique stroke patients (all stroke types)  | 44            | 33              | 36         | 30             | 55  | 50             | 26                | 12       | 27        | 9             | 9         | 42        | 373         |           |
| Number of patients assessed by stroke specialist consultant physician within 24 hours of clock start           | 38            | 21              | 22         | 20             | 47  | 26             | 19                | 10       | 27        | 8             | 7         | 39        | 284         |           |
| Total of patients requiring a stroke specialist consultant physician   | 44            | 34              | 36         | 31             | 56  | 52             | 26                | 12       | 27        | 9             | 9         | 42        | 378         |           |
| Number assessed by one of OT, PT, SALT within 24 hours   | 21            | 28              | 31         | 26             | 49  | 23             | 19                | 10       | 17        | 5             | 8         | 39        | 276         |           |
| Total number of patients that require being seen by one of OT, PT, SALT  | 44            | 34              | 36         | 31             | 56  | 52             | 26                | 12       | 27        | 9             | 9         | 42        | 378         |           |
| Number of applicable patients who were given a formal swallow screen assessment within 72 hours of clock start | 31            | 6               | 9          | 12             | 17  | 8              | 3                 | 3        | 16        | 0             | 2         | 6         | 113         |           |
| Total Number of patients that require a formal swallow screen assessment                                       | 37            | 9               | 12         | 14             | 20  | 25             | 4                 | 4        | 20        | 0             | 3         | 6         | 154         |           |



Quality Measures Summary

Performance Trends

Scanning

Thrombolysis

Thrombectomy

Stroke Unit & Specialist Assessment

Therapies & Discharge Standards



Routine?

1

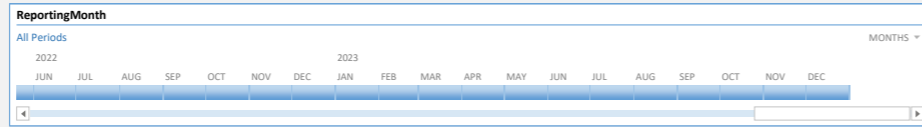
Health...  
Cardiff & ...

Hospital

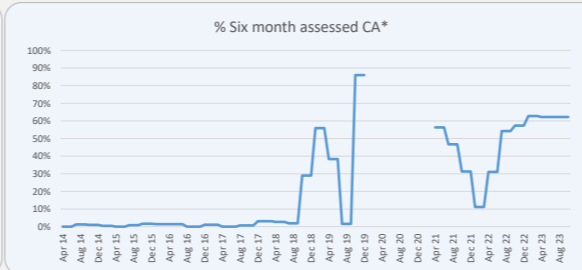
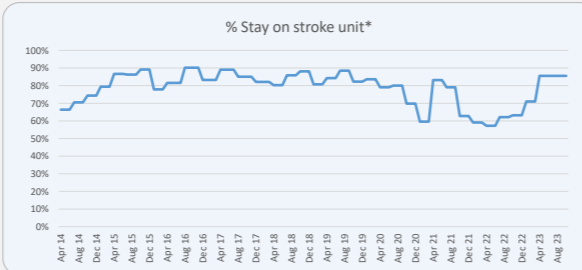
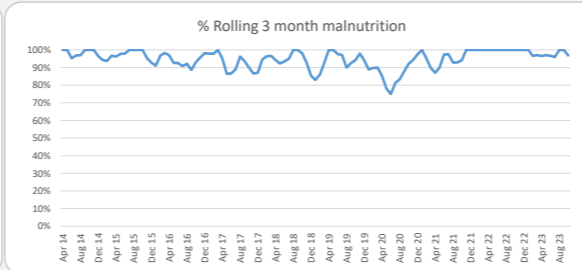
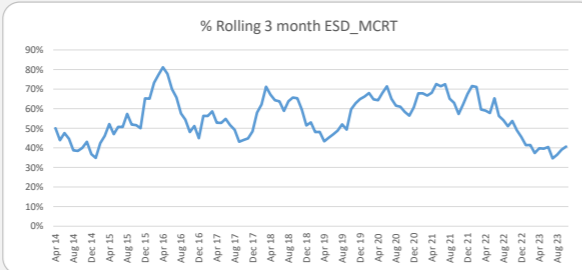
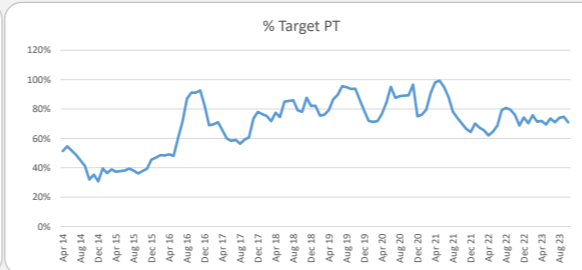
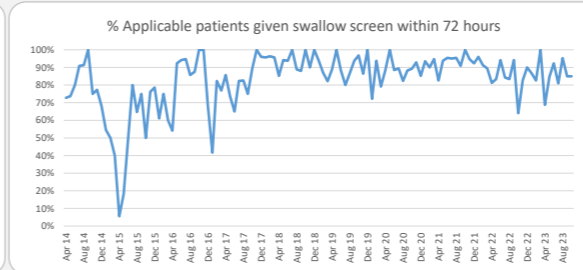
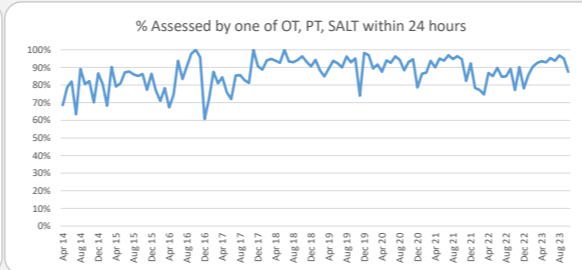
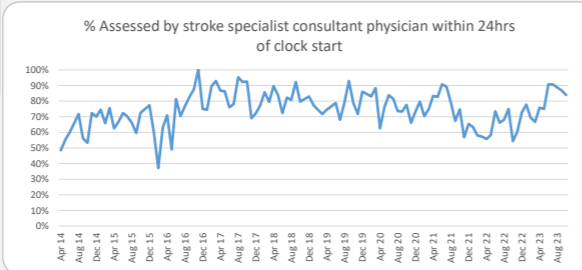
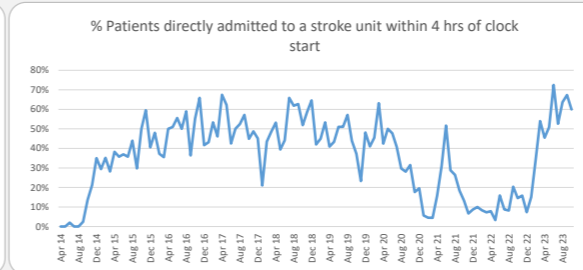
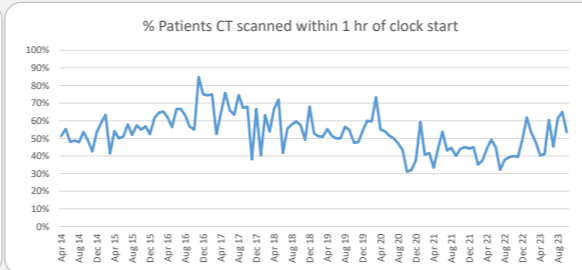
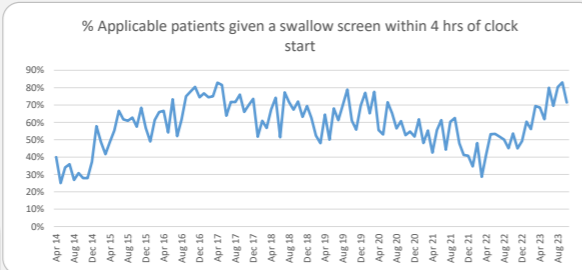
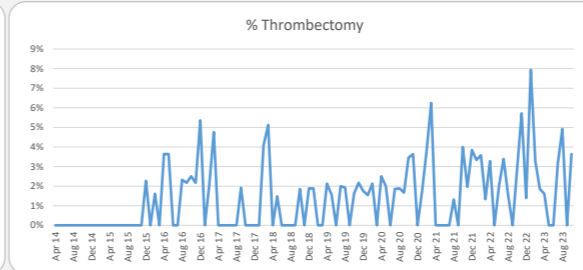
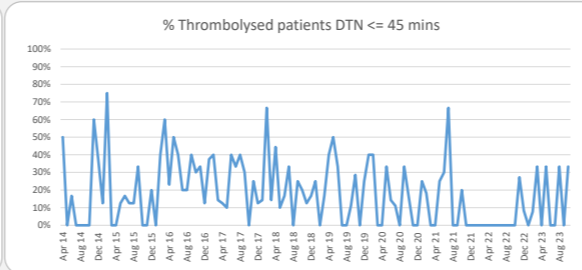
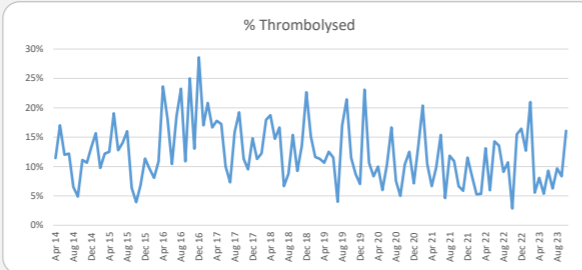
- Princess...
- Royal Gl...
- Royal G...
- Singleton
- St Woolos
- The Gra...
- UHW
- UHW NR
- West Re...
- Withybu...
- Wrexha...
- Ysbvtv C...
- Ystrad F...

Note that scales are different on each graph

\*Shaded graphs from SSNAP source



Currently Selected: - Both Routine & Non-Routine - All Health Boards - UHW - Apr-14 to Oct-23



\*Shaded graphs from SSNAP source



Quality Measures Summary

Performance Trends

Scanning

Thrombolysis

Thrombectomy

Stroke Unit & Specialist Assessment

Therapies & Discharge Standards



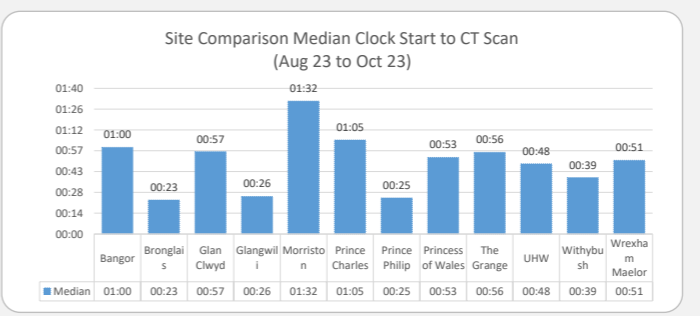
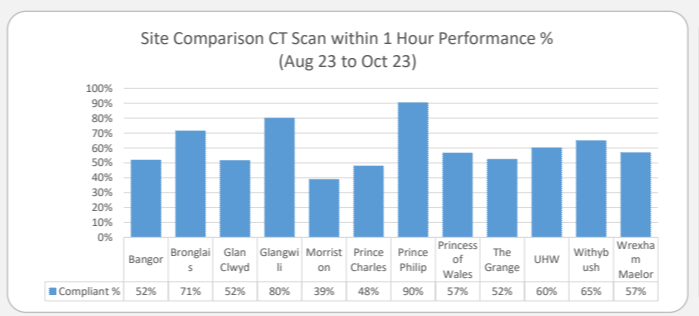
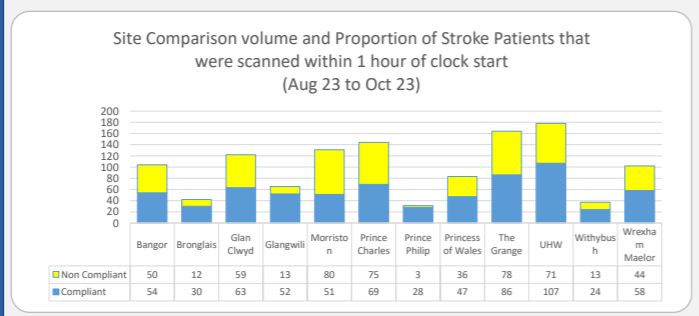
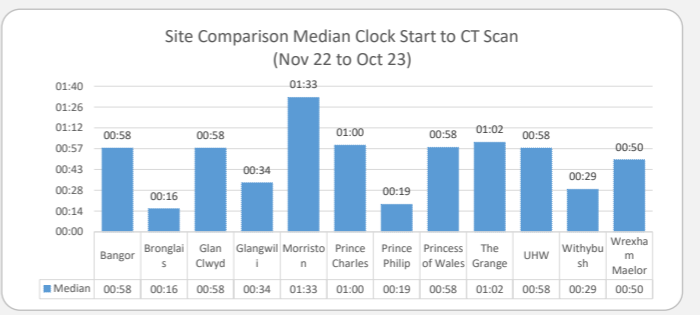
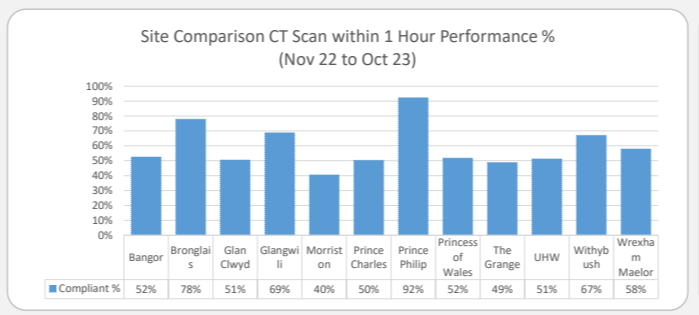
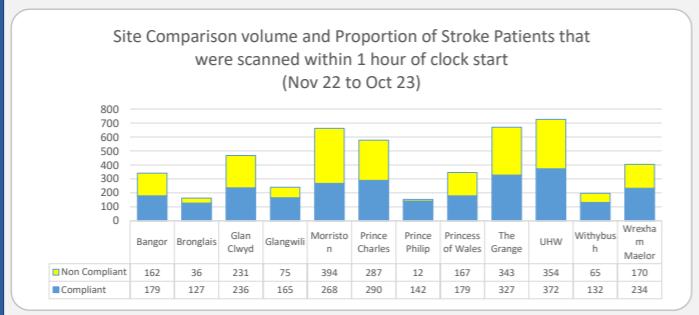
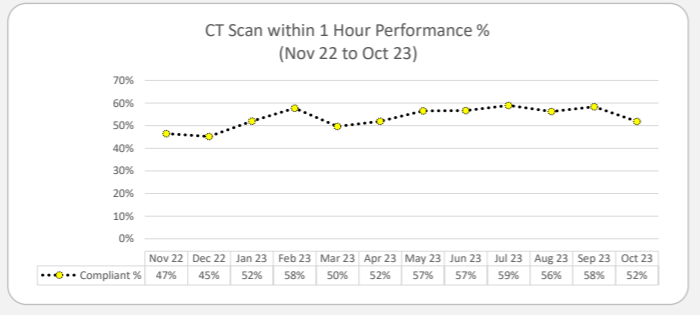
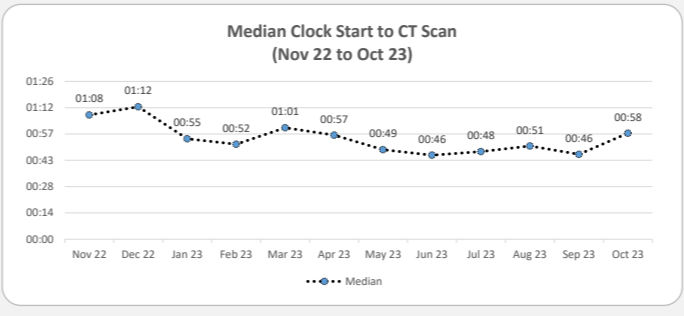
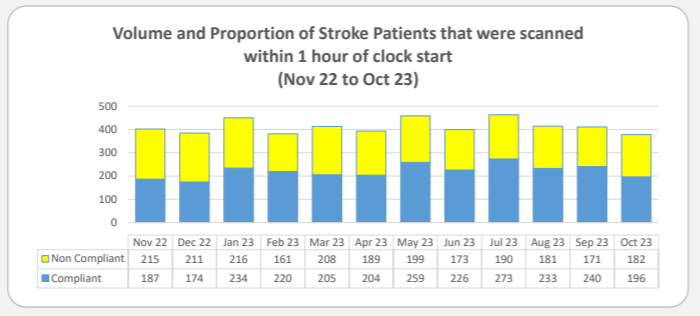
- HealthB...**
- Aneurin Be...
  - BCU
  - Cardiff & Vale
  - Cwm Taf M...
  - Hywel Dda
  - Swansea Bay

- Hospital**
- Bangor
  - Bronglais
  - Glan Clwyd
  - Glangwili
  - Morrison
  - Prince Ch...
  - Prince Phi...
  - Princess o...
  - The Grange
  - UHW
  - Withybush
  - Wrexham...

Scanning for the Latest Reporting Period October 2023

|                       |                           |                                      |             |                          |
|-----------------------|---------------------------|--------------------------------------|-------------|--------------------------|
| Total Stroke Patients | Seen within 1 Hour for CT | CT Scan Within 1 Hours non compliant | 1 hour CT % | Median Clock Start to CT |
| 378                   | 196                       | 182                                  | 52%         | 00:58                    |

Currently Selected: - All Health Boards - All Hospital Sites





Quality Measures Summary

Performance Trends

Scanning

Thrombolysis

Thrombectomy

Stroke Unit & Specialist Assessment

Therapies & Discharge Standards



- HealthB...**
- Aneurin Be...
  - BCU
  - Cardiff & Vale
  - Cwm Taf M...
  - Hywel Dda
  - Swansea Bay

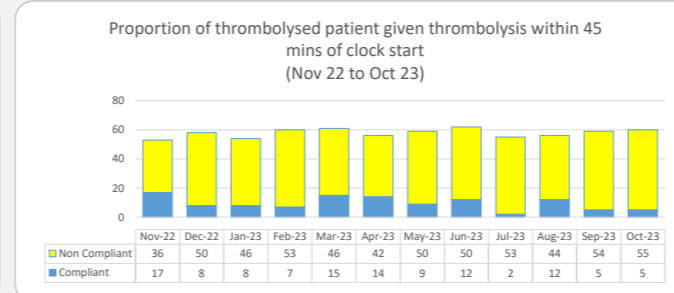
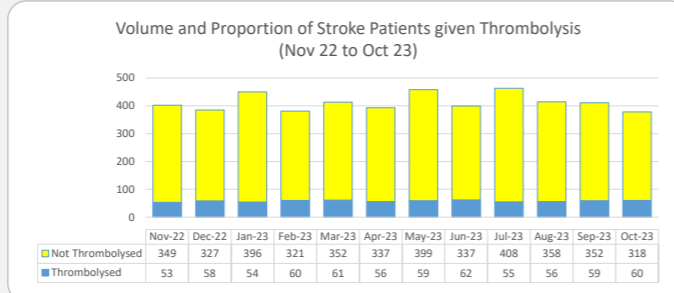
- Hospital**
- Bangor
  - Bronglais
  - Glan Clwyd
  - Glangwili
  - Morrison
  - Prince Ch...
  - Prince Phi...
  - Princess o...
  - The Grange
  - UHW
  - Withybush
  - Wrexham...

Thrombolysis for the Latest Reporting Period October 2023

|                       |                    |                 |                        |              |
|-----------------------|--------------------|-----------------|------------------------|--------------|
| Total Stroke Patients | Total Thrombolysed | Seen DTN 45mins | Minimum Wait CS to TPA | LQ CS to TPA |
| 378                   | 60                 | 5               | 00:32                  | 01:00        |
|                       | Median CS to TPA   | UQ CS to TPA    | Maximum Wait CS to TPA |              |
|                       | 01:20              | 01:59           | 06:43                  |              |

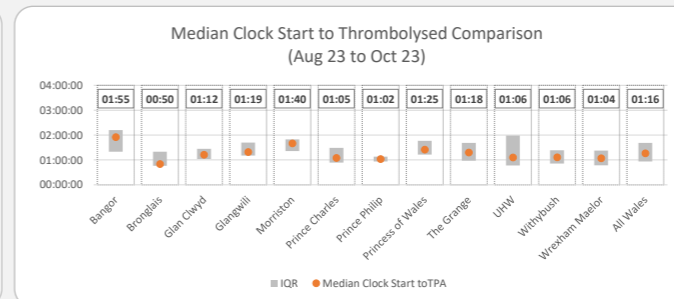
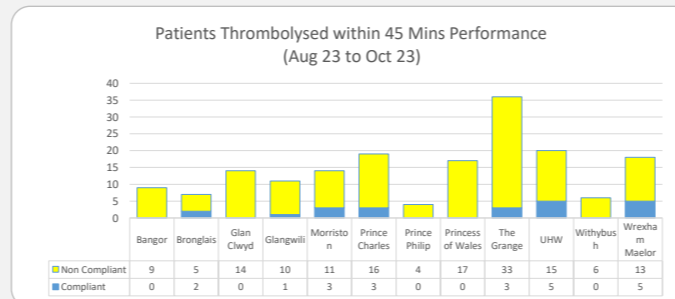
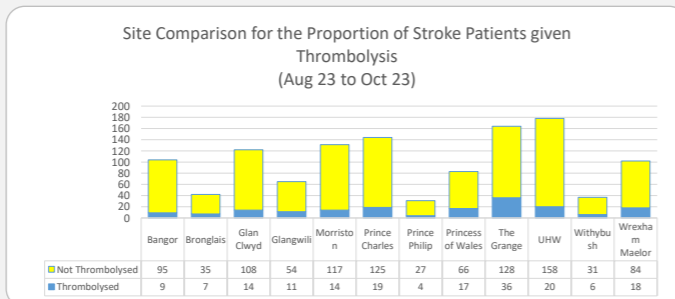
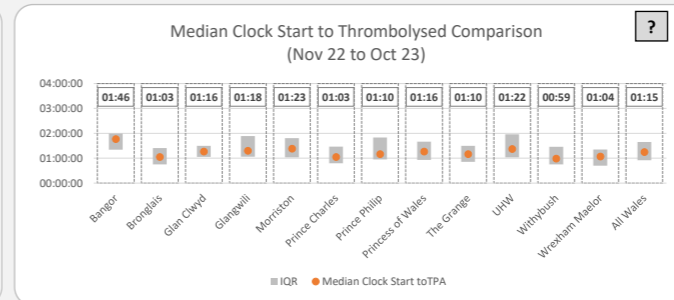
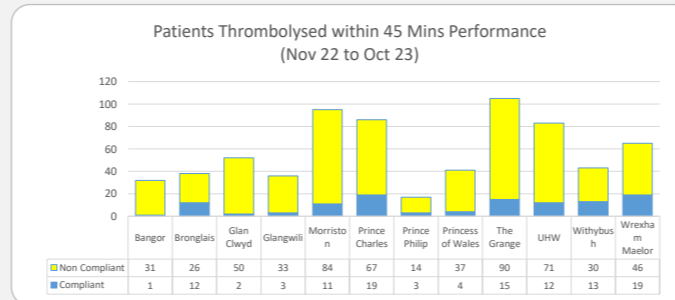
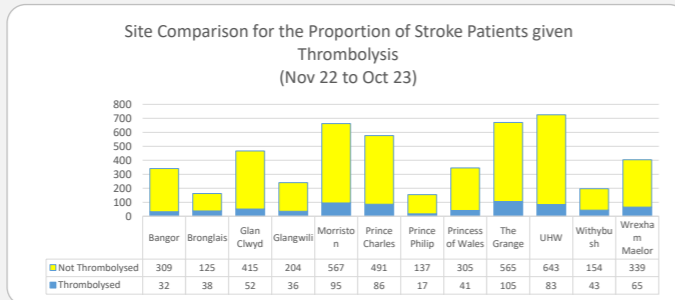
Currently Selected - All Health Boards - All Hospital Sites

Show Thrombolysed Values Show Thrombolysed %



Hide Table

| Time Intervals (hh:mm)                   |       |
|--|-------|
| Minimum Wait Clock Start to Thrombolysis | 00:10 |
| LQ Clock Start to Thrombolysis           | 00:56 |
| Median Clock Start to Thrombolysis       | 01:16 |
| UQ Clock Start to Thrombolysis           | 01:41 |
| Maximum Wait Clock Start to Thombolysis  | 07:01 |







Quality Measures Summary

Performance Trends

Scanning

Thrombolysis

Thrombectomy

Stroke Unit & Specialist Assessment

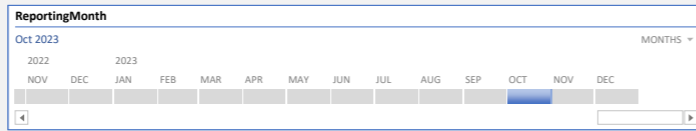
Therapies & Discharge Standards



Health...  
Cardiff & ...

- Hospital**
- Glangwili
  - Morrison
  - Nevill Hall
  - Prince C...
  - Prince P...
  - Princess ...
  - Royal Gl...
  - Royal G...
  - The Gra...
  - UHW
  - Withybush
  - Wrexha...

Thrombectomy for the Selected Reporting Period: Oct-23

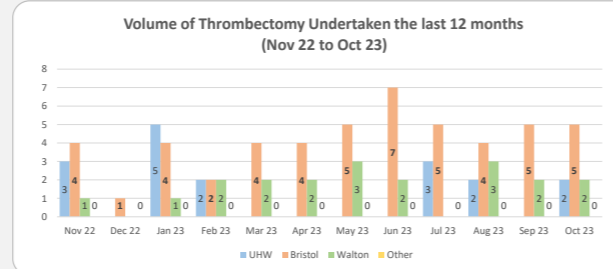
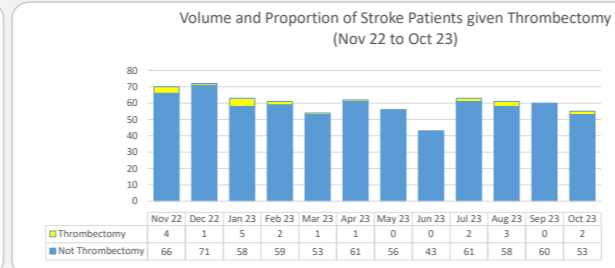
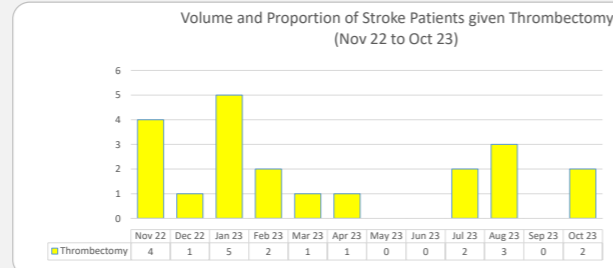


|                                    |    |                                   |   |                                |   |
|------------------------------------|----|-----------------------------------|---|--------------------------------|---|
| Total Unique Stroke Patients       | 55 | Total Thrombectomy                | 2 | Thrombectomy Undertaken at UHW | 1 |
| Thrombectomy Undertaken at Bristol | 1  | Thrombectomy Undertaken at Walton | 0 | Thrombectomy Undertaken Other  | 0 |

Thrombectomy allocated as "Other" are usually those that have no transfer from teamcode allocated to them. We are unaware of the treatment site the thrombectomy has been undertaken.

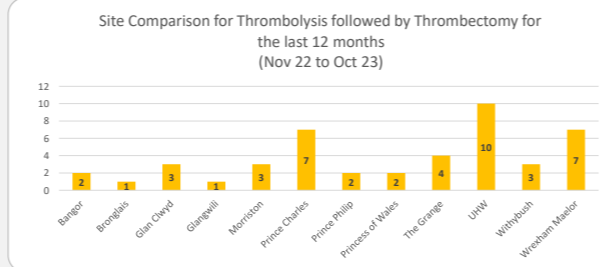
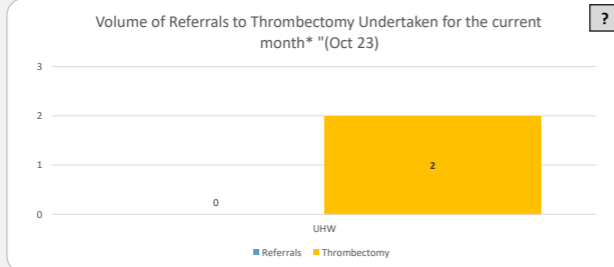
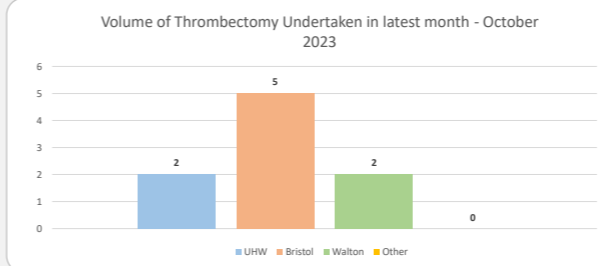
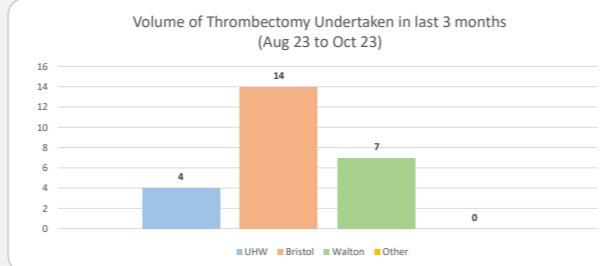
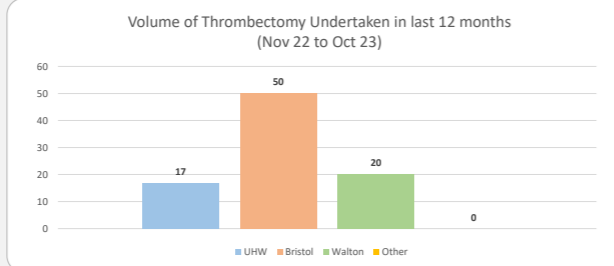
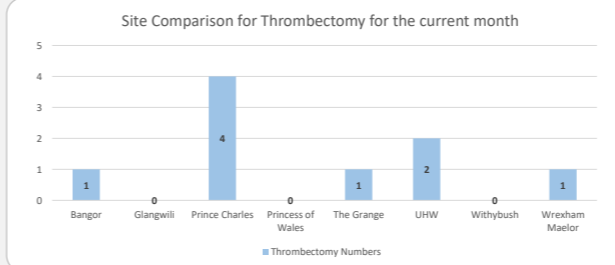
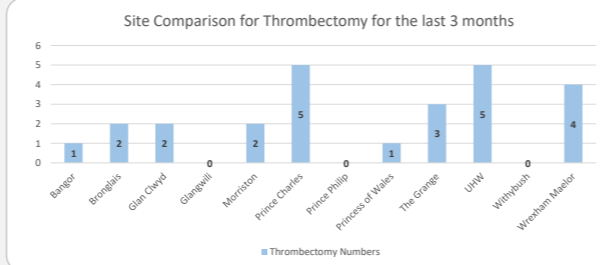
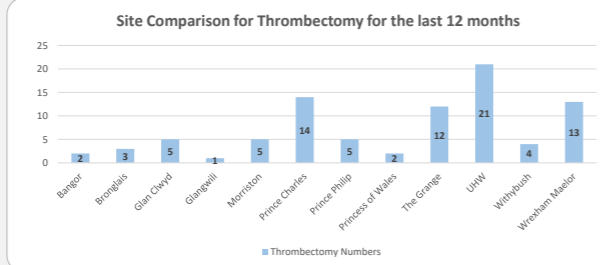
Currently Selected - All Health Boards - UHW

Show Thrombectomy %



Please Note: Not all charts change with health board or hospital slicer selected

Show Tertiary Sites



Change Chart to last 3 Months

Heal...  
Aneur...  
BCU  
Cardif...  
Cwm T...  
Hwyl...  
Swansea

Hosp...  
Bangor  
Bron...  
Glan...  
Morri...  
Prince...  
Prince...  
The G...  
UHW  
Withv...  
Wrex

Stroke Unit for the Latest Reporting Period October 2023

|                                  |     |  |     |                                       |     |  |     |  |       |
|----------------------------------|-----|--|-----|---------------------------------------|-----|--|-----|--|-------|
| Total Applicable Stroke Patients | 344 | Direct Admission to Stroke Unit Within 4 hrs Patient Volumes | 108 | Non Compliant to Stroke Unit Within 4 | 236 | Direct Admission to Stroke Unit Within 4 | 31% | Median Clock Start to Stroke Unit Arrival* | 07:24 |
|----------------------------------|-----|--|-----|---------------------------------------|-----|--|-----|--|-------|

Specialist Assessment - October 2023

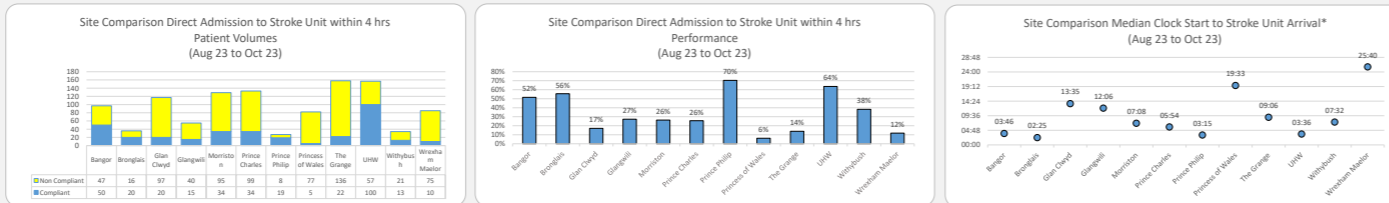
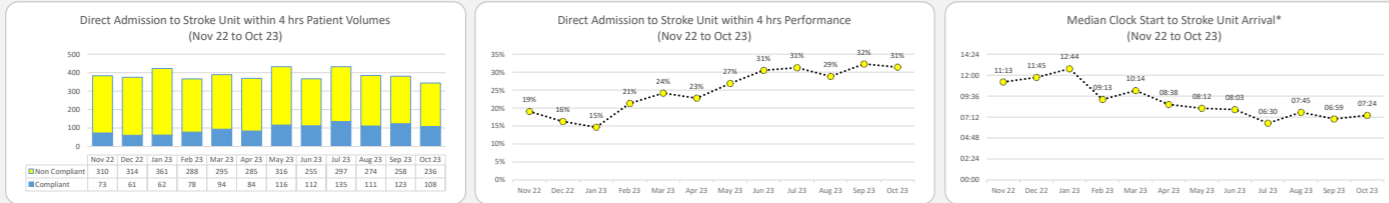
|  |     |   |     |                                  |     |   |     |  |     |
|--|-----|---|-----|----------------------------------|-----|---|-----|--|-----|
| Stroke Consultant Assessment within 24 | 108 | Assessed by one of PT, OT or SaLT within 24 hrs*    | 276 | Swallow Screening within 4 hrs   | 255 | Formal Swallow Assessment within 72       | 113 | Stroke Consultant Assessment within 24 hrs % | 75% |
|  |     | Assessed by one of PT, OT or SaLT within 24 hrs %** | 73% | Swallow Screening within 4 hrs % | 75% | Formal Swallow Assessment within 72 hrs % | 73% |  |     |

\*Patients with a first ward of admission on Intensive Therapy Unit (ITU) / Coronary Care Unit (CCU) / High Dependency Unit (HDU), those patients receiving intra-arterial intervention, and those patients who were not admitted at any time are all excluded from this measure.

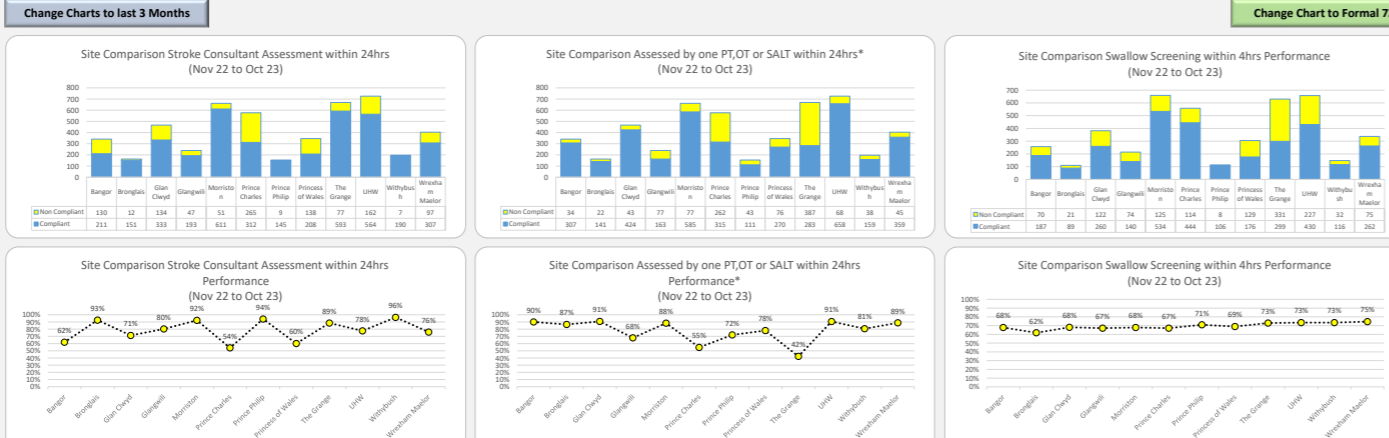
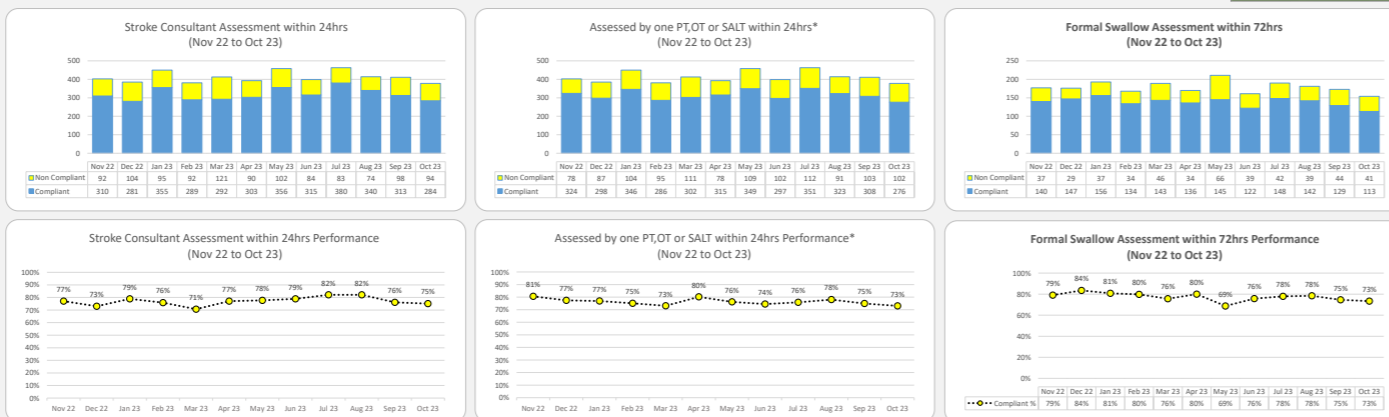
\*\* This is not an RCP SSNAP specific measure hence no value for comparison other than the All Wales Position

Currently Selected - All Health Boards - All Hospital Sites

Stroke Unit



Specialist Assessment

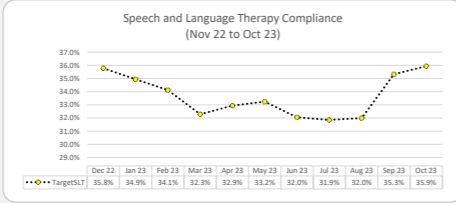
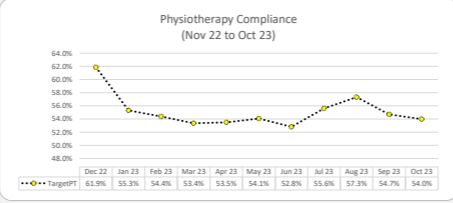
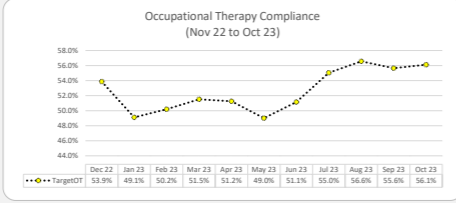




Heal... Aneur... BCU... Cardif... Cwm... Hwael... Powys

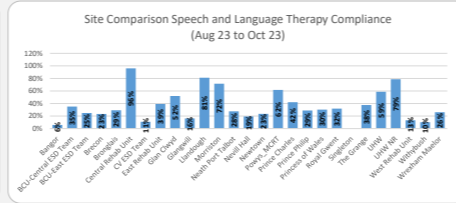
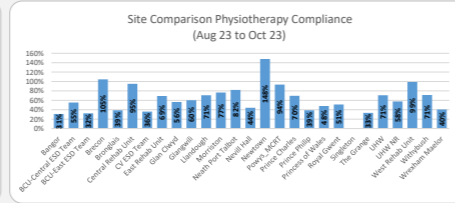
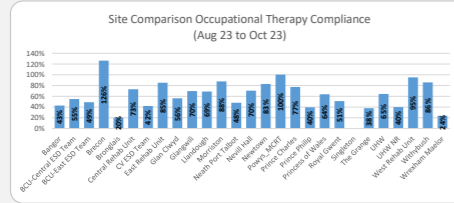
Hosp... Bangor... BCU-C... BCU-F... Brecon... Bron... Centr... CVES... East R... Glan... Island... Morri

Compliance (%) against the Therapy Target (Rolling 3 month)

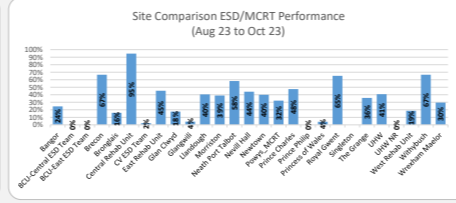
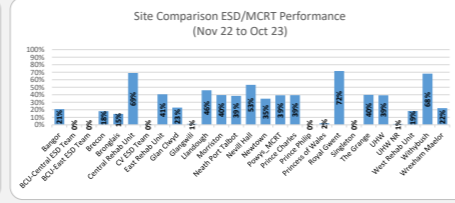
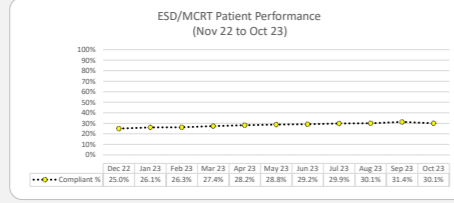
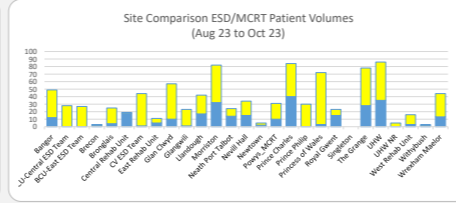
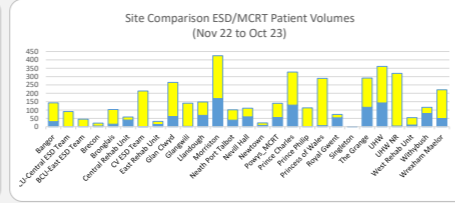
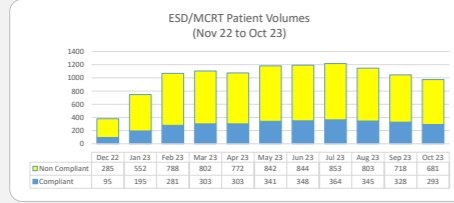
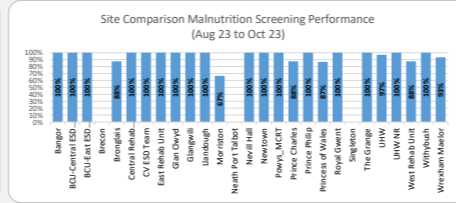
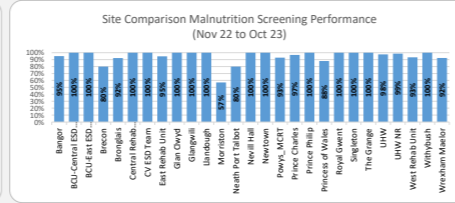
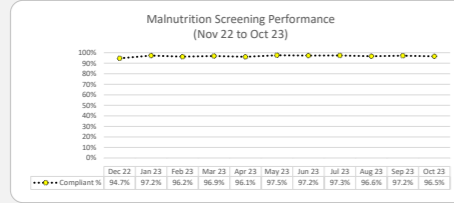
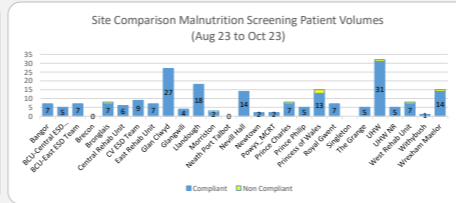
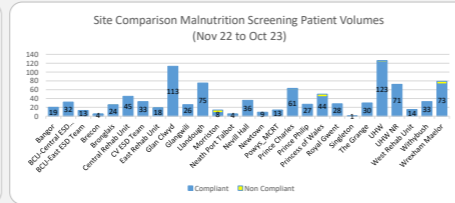
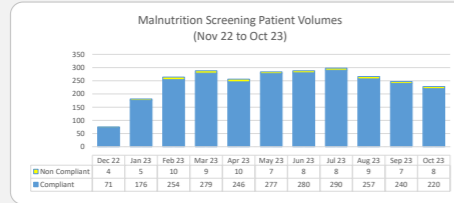


Currently Selected - All Health Boards - All Hospital Sites

Change Charts to last 12 Months



Discharge Standards



# Improvement plan

## HIW - National Review of Patient Flow - a journey through the stroke pathway

The table below includes any other improvements identified during the review where we require the service to complete an improvement plan telling us about the actions, they are taking to address these areas.

| Recommendation 1  |  |                              |
|---|--|------------------------------|
| Health boards should engage with each other, to learn from the good patient education practices taking place across Wales. This could help the shared learning with themselves and with GP practices in their localities, to educate patients of the risks for a stroke, to help reduce the number of strokes across Wales.                                       |  |                              |
| Health Board Measures/Evidence  | Responsible Officer                          | Timescale                    |
| <p><b>There are extensive ongoing discussions between stroke services and programme managers / planners, both through formal governance arrangements such as the national network and through a range of informal channels and collaborations.</b></p> <p><b><u>Actions</u></b><br/> Engagement with the Stroke Network<br/> Appointment of Programme Manager</p> | <p>Peter Carr / Rhys Monk<br/> Rhys Monk</p> | <p>Ongoing<br/> 3 Months</p> |
| Recommendation 2  |  |                              |
| Public Health Wales should consider the development and promotion of a national campaign to raise stroke awareness and its prevention in Wales alongside its Act FAST campaign. This should include raising awareness of stroke prevention within black and minority ethnic communities and the impact of health inequalities and socio-economic deprivation.     |  |                              |

| Health Board Action(s)   | Responsible Officer        | Timescale |
|--|----------------------------|-----------|
| Action for Public Health Wales   |                            |           |
| <b>Recommendation 3</b>  |                            |           |
| Health boards and PHW should work closely with Black, and minority ethnic communities and people affected by socio-economic deprivation, to understand the specific issues they face with their increased risk of stroke and in accessing preventative care and ensure ongoing engagement with them to support better health outcomes. |                            |           |
| Health Board Action(s)   | Responsible Officer        | Timescale |
| To be addressed as part of the IMTP / annual plan development process  |                            |           |
| <b>Recommendation 4</b>  |                            |           |
| Welsh Government, health boards and WAST must work collaboratively, to consider whether the Immediate Release Directions are effective or need improvements, given the high number of declined Immediate Release Directions occurring across Wales.  |                            |           |
| Health Board Action(s)   | Responsible Officer        | Timescale |
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas   | <b>Flow &amp; Ops Team</b> |           |
| <b>Recommendation 5</b>  |                            |           |

Health boards must communicate with each other to establish the good practices taking in place in some hospitals for the robust management of patient flow. This includes the implementation of effective action plans to manage daily discharges, which remain active throughout the day, and in planning for subsequent days.

| Health Board Action(s)   | Responsible Officer        | Timescale |
|--|----------------------------|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas | <b>Flow &amp; Ops Team</b> |           |

### Recommendation 6

Health boards must review and consider timelier processes of prescribing take home medication and obtaining this promptly from pharmacy to minimise discharge delays. This should include planning well in advance of the scheduled time for discharge (such as the day before).

| Health Board Action(s)   | Responsible officer | Timescale |
|--|---------------------|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas | <b>Pharmacy</b>     |           |

### Recommendation 7

Health boards should consider the benefits of dedicated ‘discharge phlebotomy slots’ for managing the necessary blood tests, to assist with effective and timelier discharge.

| Health Board Action(s)   | Responsible officer | Timescale |
|--|---------------------|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas | <b>Pharmacy</b>     |           |

### Recommendation 8

| Health boards must consider the benefits of Improvement Cymru's Real Time Demand Capacity methodology, and whether this would have a positive impact to implement (or to pilot) within all hospitals to help manage timelier patient flow.   |                     |           |
|--|---------------------|-----------|
| Health Board Action(s)   | Responsible officer | Timescale |
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas   | Flow & Ops Team     |           |
| <b>Recommendation 9</b>  |                     |           |
| Health boards should reflect on their patient flow processes and consider whether improvements can be made with predictive methodology for demand in each of their hospital sites, such as with medical and surgical admissions.   |                     |           |
| Health Board Action(s)   | Responsible officer | Timescale |
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas   | Flow & Ops Team     |           |
| <b>Recommendation 10</b>   |                     |           |
| Health boards should consider whether a daily senior nursing/ clinical oversight for each directorate could be implemented to facilitate clinical issues with flow. This may help ensure staff are making timely progress to discharge patients, challenge medical staff to undertake key tasks where necessary, and help expedite any outstanding clinical patient needs. In addition, to commence planning for patient discharge on subsequent days. |                     |           |
| Health Board Action(s)   | Responsible officer | Timescale |
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas   | Flow & Ops Team     |           |



**Recommendation 11**

Welsh Government should consider strengthening its promotion of the *Help Us to Help You* campaign, to ensure people are appropriately educated and understand how to access healthcare in the right place, first time, by guiding them towards the most appropriate care service.

| Health Board Action(s)      | Responsible officer | Timescale |
|-----------------------------|---------------------|-----------|
| Action for Welsh Government |                     |           |

**Recommendation 12**

Health boards and WAST should engage with people to better understand the barriers to them accessing, or choosing, from the range of healthcare services available in Wales. Once the barriers are understood, this in turn, could be used to influence service design.

| Health Board Action(s)  | Responsible officer | Timescale |
|---|---------------------|-----------|
| To be addressed as part of the IMTP / annual plan development process |                     |           |

**Recommendation 13**

WAST must ensure that all relevant staff are fully aware of the WAST stroke pathway to minimise risks to patient safety.

| Health Board Action(s) | Responsible officer | Timescale |
|------------------------|---------------------|-----------|
| Action for WAST        |                     |           |

**Recommendation 14**

Welsh Government should consider how it can support WAST to develop and implement improvements with its service delivery model, such as increasing the number of advanced paramedic practitioners across Wales, to help reduce the pressure on EDs and improve flow through healthcare systems.

| Health Board Action(s) | Responsible officer | Timescale |
|------------------------|---------------------|-----------|
|------------------------|---------------------|-----------|

|                             |  |  |
|-----------------------------|--|--|
| Action for Welsh Government |  |  |
|-----------------------------|--|--|

### Recommendation 15

WAST should consider the benefits of training its paramedic staff in the use of the ROSIER stroke assessment tool, to enable staff to differentiate patients with stroke and stroke mimics, such as TIA.

| Health Board Action(s) | Responsible officer | Timescale |
|------------------------|---------------------|-----------|
|------------------------|---------------------|-----------|

|                 |  |  |
|-----------------|--|--|
| Action for WAST |  |  |
|-----------------|--|--|

### Recommendation 16

Health boards should seek assurance that their MIUs and ED departments ensure all reception staff have received up to date Act FAST training, and they are competent with this. In addition, that appropriate escalation process is in place if a receptionist is or is not sure a patient may be suffering with a stroke.

| Health Board Action(s) | Responsible officer | Timescale |
|------------------------|---------------------|-----------|
|------------------------|---------------------|-----------|

|  |         |  |
|--|---------|--|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas | ED Team |  |
|--|---------|--|

### Recommendation 17

WAST and all health boards must work collaboratively to identify a consistent approach to ensure handover of stroke patients is made within the Welsh Government 15-minute target. This is to ensure that time critical investigations and treatment are undertaken promptly.

| Health Board Action(s)   | Responsible officer        | Timescale |
|--|----------------------------|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas | Stroke, ED & Flow/Ops Team |           |

**Recommendation 18**

Welsh Government should work collaboratively with WAST, health boards and social care providers to evaluate and strengthen the current processes in place to improve flow through health and care systems, with a concerted focus on the analysis of flow, the bottlenecks impeding flow and the issues with achieving timely discharge.

| Health Board Action(s)   | Responsible officer | Timescale |
|--|---------------------|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas |                     |           |

**Recommendation 19**

Health boards must ensure that ED staff undertake the triage of patients within the 15-minute target time. Where this has not been possible, it should be clearly documented 'why not' within the patient's clinical record.

| Health Board Action(s) | Responsible officer | Timescale |
|------------------------|---------------------|-----------|
|                        |                     |           |

|  |                         |           |
|--|-------------------------|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas   | ED Team                 |           |
| <b>Recommendation 20</b>   |                         |           |
| Health boards must ensure that medical staff who carry the bleep for stroke alerts recognise the urgency of both thrombolysis and non-thrombolysis stroke calls. A patient may still be symptomatic whilst out of the thrombolysis window but may still be within the thrombectomy time frame. This is particularly important if a referral tertiary centre is relatively close to the ED. |                         |           |
| Health Board Action(s)   | Responsible officer     | Timescale |
| ABUHB have updated the Stroke Thrombolysis/Thrombectomy pathway in Sept. 2023 and adjusted processes in relation to image transfer to facilitate 08:00 - 22:00 referral for Thrombectomy to Southmead Hospital.  | Yaqoob Bhat             | Ongoing   |
| <b>Recommendation 21</b>   |                         |           |
| Health boards should review the provision of the CNS or ANP stroke specialist service at each acute site and consider how they can maximise their availability throughout the stroke service.  |                         |           |
| Health Board Action(s)   | Responsible officer     | Timescale |
| Recruitment working towards 24/7 CNS service as per GIRFT recommendation. Some challenges with significant amount of maternity leave but workforce should stabilise in Q3 2024/25  | Rhys Monk & Lynsey Hook | 12 Months |
| <b>Recommendation 22</b>   |                         |           |
| Health boards should ensure that EDs track and monitor all patients arriving at hospital with a suspected stroke (by ambulance and self-presenting), to drive improvement on assessment times, so people can commence on the stroke pathway in a timely manner.  |                         |           |

| Health Board Action(s)  | Responsible officer        | Timescale |
|---|----------------------------|-----------|
| <b>This is a core function of the clinical nurse specialist role referenced in 21 above</b>   | ED Team/Stroke directorate | 12 months |
| <b>Recommendation 23</b>  |                            |           |
| Health boards must ensure that all relevant staff within EDs are trained and are competent to use the ROSIER assessment tool. In addition, that staff are consistently using a validated tool, such as ROSIER, to enable prompt differentiation with strokes or stroke mimics, such as TIA. |                            |           |
| Health Board Action(s)  | Responsible officer        | Timescale |
| <b>This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas</b>   | ED Team                    |           |
| <b>Recommendation 24</b>  |                            |           |
| Health boards must ensure that ED staff fully and clearly complete the clinical diagnostic assessment tool for stroke.  |                            |           |
| Health Board Action(s)  | Responsible officer        | Timescale |
| <b>This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas</b>   | ED Team                    |           |
| <b>Recommendation 25</b>  |                            |           |
| All health boards should consider the prompt implementation of Artificial Intelligence for stroke imaging following the completion of the all-Wales procurement which was completed in December 2021.   |                            |           |

| Health Board Action(s)  | Responsible officer                    | Timescale |
|---|--|-----------|
| Preparatory works complete (AI assurance/networking etc.) awaiting funding decision   | Rhys Monk                              | 3 Months  |
| <b>Recommendation 26</b>  |  |           |
| Health boards must ensure that the reason for delayed brain imaging is monitored and analysed for possible stroke patients to ensure scans are completed in a timely manner in line with NICE guidance.   |  |           |
| Health Board Action(s)  | Responsible officer                    | Timescale |
| Regular review of SSNAP data to identify trends/exceptions in weekly SSNAP meetings   | Rhys Monk                              | 3 Months  |
| <b>Recommendation 27</b>  |  |           |
| Health boards and WAST must ensure that all staff associated with potential stroke patients are aware of the updated guidance for thrombolysis treatment window of between 4.5 and nine hours, as highlighted within the <i>National Clinical Guideline for Stroke</i> updated in April 2023. |  |           |
| Health Board Action(s)  | Responsible officer                    | Timescale |
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas  | Workforce/Training/Practice educators? |           |

**Recommendation 28**

Health boards must ensure that sufficient staff in EDs across Wales are awarded time to train and are assessed as competent to administer thrombolysis treatment.

| Health Board Action(s)  | Responsible officer | Timescale |
|---|---------------------|-----------|
| This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review | ED Team             |           |

**Recommendation 29**

Health boards must ensure that all possible stroke patients who are clinically appropriate for thrombolysis, receive treatment in a timely manner.

| Health Board Action(s)   | Responsible officer     | Timescale |
|--|-------------------------|-----------|
| Refresh of Stroke/ED pathway and recruitment of additional CNS to move to a 24/7 front-end service model.<br>Note Thrombolysis rate improvements over the past 12 months and increase in SSNAP rating to C | Yaqoob Bhat & Rhys Monk | Ongoing   |

**Recommendation 30**

Welsh Government must work with the Thrombectomy Wales Oversight Group, the National Clinical Lead for Stroke, and health boards, to consider how timely and equitable access to thrombectomy treatment for stroke can be made, for all relevant people across Wales.

| Health Board Action(s) | Responsible officer | Timescale |
|------------------------|---------------------|-----------|
|------------------------|---------------------|-----------|



|  |                                    |           |
|--|------------------------------------|-----------|
| Action for Welsh Government  |                                    |           |
| <b>Recommendation 31</b>   |                                    |           |
| Health boards must ensure clinicians consider the option of thrombectomy treatment where appropriate, and the decision either way (with rationale), should be clearly recorded within the patient's clinical records.  |                                    |           |
| Health Board Action(s)   | Responsible officer                | Timescale |
| Currently under discussion within the service  | Yaqoob Bhat<br>(Clinical Director) | Ongoing   |
| <b>Recommendation 32</b>   |                                    |           |
| WAST must consider its current response times for patients awaiting interhospital transfers for urgent thrombectomy treatment which are classified as 'Red'. This is to ensure a thrombectomy can be completed within the six-hour timescale from the onset of symptoms. |                                    |           |
| Health Board Action(s)   | Responsible officer                | Timescale |
| Action for WAST  |                                    |           |
| <b>Recommendation 33</b>   |                                    |           |
| Health boards must explore the options available to improve the process for prioritising stroke patient admissions to acute stroke wards within the four-hour target, to help maximise their clinical outcome.   |                                    |           |
| Health Board Action(s)   | Responsible officer                | Timescale |

|  |                                 |                  |
|--|---------------------------------|------------------|
| This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review  | Flow/Ops team<br>Stroke service |                  |
| <b>Recommendation 34</b>   |                                 |                  |
| Ringfenced stroke beds are frequently used for non-stroke patients, which may impact on a new stroke admission to ED. Therefore, health boards must explore how a ringfenced stroke bed can be maintained, to help ensure the best outcome for a stroke patient following their arrival at ED. |                                 |                  |
| <b>Health Board Action(s)</b>  | <b>Responsible officer</b>      | <b>Timescale</b> |
| This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review  | Flow/Ops team                   |                  |
| <b>Recommendation 35</b>   |                                 |                  |
| Health boards should consider both the benefits and potential implementation of Early Supported Discharge to patients' physical and mental wellbeing, and to the hospitals, with earlier discharge therefore improving flow through the stroke pathway.  |                                 |                  |
| <b>Health Board Action(s)</b>  | <b>Responsible officer</b>      | <b>Timescale</b> |
| This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review<br><br>ESD rates in ABUHB are currently approx. 60% compliant, representing a significant improvement since Oct 2022 when rates were 20%   | Adele Griffiths                 | 12 Months        |
| <b>Recommendation 36</b>   |                                 |                  |

Health boards must review their therapies staffing models to ensure there are sufficient resources and staff in place to adequately manage the rehabilitation and recovery of stroke patients in line with NICE guidance.

| Health Board Action(s)   | Responsible officer | Timescale |
|--|---------------------|-----------|
| This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review, but represents a major challenge in the current financial climate | Therapies           |           |

**Recommendation 37**

Health boards must consider the need for psychological support for people with stroke, and that adequately trained staff can provide this support to help effectively manage patient recovery.

| Health Board Action(s)   | Responsible officer | Timescale |
|--|---------------------|-----------|
| This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review, but represents a major challenge in the current financial climate | Therapies           |           |

**Recommendation 38**

Health boards must consider introducing the provision of sufficient seven-day therapies services to comply with NICE guidance, to help improve patient flow by supporting a seven-day discharge for patients, and to help meet targets as highlighted within SSNAP.

| Health Board Action(s) | Responsible officer | Timescale |
|------------------------|---------------------|-----------|
|------------------------|---------------------|-----------|

|   |  |                  |
|---|--|------------------|
| <p>This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review. It is proposed to centralise stroke rehabilitation services, but represents a major challenge in the current in line with GIRFT recommendations, subject to operational deliverability and full public engagement</p> | <p>Medicine Division<br/>Therapies Directorate</p> | <p>12 months</p> |
| <p><b>Recommendation 39</b></p>   |  |                  |
| <p>Health boards must ensure that stroke rehabilitation environments are appropriate and are adequate to meet the needs of patients.</p>  |  |                  |
| <p>Health Board Action(s)</p>   | <p>Responsible officer</p>                         | <p>Timescale</p> |
| <p>Stroke reconfiguration to centralise resources (as above)<br/>Rehabilitation bays agreed to be protected from breaches in all cases</p>  | <p>Therapies<br/>Flow &amp; Ops Team</p>           |                  |
| <p><b>Recommendation 40</b></p>   |  |                  |
| <p>Health boards must review their board rounds within stroke wards to consider their efficiency and effectiveness so that any actions identified and resolved in a timely manner to facilitate a timely patient discharge.</p>   |  |                  |
| <p>Health Board Action(s)</p>   | <p>Responsible officer</p>                         | <p>Timescale</p> |
| <p>This is currently being progressed as part of the service response to the recommendations set out in the recently commissioned GIRFT service review<br/><br/>Review of Ward Round Processes to be taken forward</p>  | <p>Rhys Monk</p>                                   | <p>6 Months</p>  |
| <p><b>Recommendation 41</b></p>   |  |                  |

Health boards should ensure that staff are utilising the SAFER Patient Flow principles, to promote safe and timely discharge and help improve patient flow.

| Health Board Action(s)   | Responsible officer | Timescale |
|--|---------------------|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas | Flow & Ops Team     |           |

**Recommendation 42**

Health boards should work collaboratively with local authorities and social care providers to improve the discharge processes in place. This includes the need for improved communication processes, improving the information provided for a robust referral into social care, and the sharing of and compliance with health board discharge policies.

| Health Board Action(s)   | Responsible officer                        | Timescale |
|--|--|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas | Flow & Ops Team<br>Discharge Co-ordinators |           |

**Recommendation 43**

Health Boards must work collaboratively with social worker teams to consider and understand the processes in place for social worker assessments and allocation to patients. The reasons for delayed assessment and allocation must also be considered to make improvements in this area.

| Health Board Action(s) | Responsible officer | Timescale |
|------------------------|---------------------|-----------|
|------------------------|---------------------|-----------|

|  |  |                  |
|--|--|------------------|
| <p>This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas</p>  | <p>Flow &amp; Ops Team<br/>Discharge Co-ordinators</p> |                  |
| <p><b>Recommendation 44</b></p>  |  |                  |
| <p>Welsh Government must consider the process in place for social work teams and their role in assessment and allocation to patients in hospital, and whether the services across Wales are appropriately funded and managed to support the discharge process from hospital to improve patient flow.</p> |  |                  |
| <p>Health Board Action(s)</p>  | <p>Responsible officer</p>                             | <p>Timescale</p> |
| <p><b>Action for Welsh Government</b></p>  |  |                  |
| <p><b>Recommendation 45</b></p>  |  |                  |
| <p>Health boards must work collaboratively with social workers and social care providers to ensure that delays in arranging or holding Best Interest Meetings are minimised, to ensure timely and effective hospital discharge for patients to improve flow.</p>   |  |                  |
| <p>Health Board Action(s)</p>  | <p>Responsible officer</p>                             | <p>Timescale</p> |
| <p>This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas</p>  | <p>Flow &amp; Ops Team<br/>Discharge Co-ordinators</p> |                  |
| <p><b>Recommendation 46</b></p>  |  |                  |
| <p>Health boards must develop and strengthen Home First services across Wales to benefit the people who need this across Wales, and to help manage the issues with patient flow through health and social care systems.</p>  |  |                  |

| Health Board Action(s)   | Responsible officer                        | Timescale |
|--|--|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas | Flow & Ops Team<br>Discharge Co-ordinators |           |
| <b>Recommendation 47</b>   |  |           |
| Welsh Government, health boards and local authorities must work collaboratively to consider the options of improving the accessibility to care in the community, such as domiciliary care.       |  |           |
| Health Board Action(s)   | Responsible officer                        | Timescale |
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas | Flow & Ops Team<br>Discharge Co-ordinators |           |
| <b>Recommendation 48</b>   |  |           |
| Health boards must consider their discharge lounge services and whether they are utilised efficiently and effectively to support timely discharge to improve patient flow.                       |  |           |
| Health Board Action(s)   | Responsible officer                        | Timescale |
| Review of appropriateness of discharge lounge against SSNAP metric of % time spent in Stroke pathway: Currently under active discussion in the service   | Rhys Monk                                  | 12 Months |
| <b>Recommendation 49</b>   |  |           |
| Health board must identify the hospital sites that do not have a discharge lounge service and should consider the benefits of implementing this service on improving patient flow.               |  |           |



| Health Board Action(s)   | Responsible officer | Timescale |
|--|---------------------|-----------|
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas   | Flow & Ops Team     |           |
| <b>Recommendation 50</b>   |                     |           |
| Health boards must assure themselves that ward staff are promptly declaring a fully completed patient discharge within the electronic patient systems once they have left the ward. This is to enable patient flow managers to see that a bed as become available, to help manage timely patient flow. |                     |           |
| Health Board Action(s)   | Responsible officer | Timescale |
| This forms part of the core tasks being progressed within the wider national six goals urgent care programme, ABUHB stroke GIRFT action plan and weekly operational patient flow meeting agendas   | Stroke Nursing      |           |

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

### Service representative

**Name (print): Peter Carr**

**Job role: Executive Director of Therapies & Health Science**

**Date: 12<sup>th</sup> October 2023**

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

|  |   |
|--|---|
| <b>DYDDIAD Y CYFARFOD:<br/>DATE OF MEETING:</b>      | 21 December 2023  |
| <b>CYFARFOD O:<br/>MEETING OF:</b>                   | Finance and Performance Committee   |
| <b>TEITL YR ADRODDIAD:<br/>TITLE OF REPORT:</b>      | Finance Performance Report – October 2023 (2023/24 Month 7) & November 2023 early brief |
| <b>CYFARWYDDWR<br/>ARWEINIOL:<br/>LEAD DIRECTOR:</b> | Rob Holcombe - Director of Finance, Procurement & VBHC                                  |
| <b>SWYDDOG ADRODD:<br/>REPORTING OFFICER:</b>        | Suzanne Jones – Interim Assistant Director of Finance                                   |

**Pwrpas yr Adroddiad  
Purpose of the Report**

Er Sicrwydd/For Assurance

This report sets out the following:

- The financial performance at the end of October 2023 and the forecast position against the statutory revenue and capital resource limits,
- The savings position for 2023/24,
- The revenue reserve position on the 31<sup>st</sup> of October 2023,
- The Health Board’s underlying financial position,
- The Capital position, and
- The month 7 MMR enclosed in appendices.




**An early brief for the November 2023 position is provided while a full report is developed to be issued to the full Board**

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

This report sets out the financial performance of Aneurin Bevan University Health Board, at the 31<sup>st</sup> October 2023 (month 7).

The 2023/24 financial performance is measured by comparing actual expenditure with the budgets as delegated and approved by the Board and CEO. The Health Board has statutory financial duties and other financial targets which must be met. The table below summarises these and the Health Board's performance against them.

| Oct-23<br>Performance against key financial targets 2023/24<br>+Adverse / ( ) Favourable   |                  |                         |                         |  |  |
|--|------------------|-------------------------|-------------------------|--|--|
| Target   | Unit             | Current Month           | Year to Date            | Movement   | Year-end Forecast                        |
| <b>Revenue financial target</b><br>To secure that the HB's expenditure does not exceed the aggregate of its funding in each financial year. <i>This confirms the YTD and forecast variance.</i>                                | £'000            | (40,283)                | 41,864                  |   | <b>57,627</b>                            |
| <b>Capital financial target</b><br>To ensure net Capital Spend does not exceed the Capital Resource Limit. <i>This confirms the current month and YTD expenditure levels along with the % this is of total forecast spend.</i> | £'000<br>£52,541 | 4,278<br>8.1%           | 27,369<br>52.1%         |   | <b>0</b>                                 |
| <b>Public Sector Payment Policy</b><br>To pay a minimum of <b>95%</b> of all non NHS creditors within 30 days of receipt of goods / invoice (by Number)  | %                | 97.0%                   | 97.1%                   |  | <b>&gt;95%</b>                           |
| <b>Performance against requirements 23/24</b>  |                  | <b>20/21</b>            | <b>21/22</b>            | <b>22/23</b>   | <b>3 Year Aggregate (20/21 to 22/23)</b> |
| Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Revenue   | x                | (245)                   | (249)                   | 36,842   | 36,348                                   |
| Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period - Capital   | ✓                | (13)                    | (50)                    | (43)   | (106)                                    |
| Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers  | x                |                         |                         |  |  |
| <b>Underlying Financial Position (Brought Forward ULP)</b>   |                  | <b>20/21</b>            | <b>21/22</b>            | <b>22/23</b>   | <b>23/24</b>                             |
| This represents the recurrent expenditure commitments and the recurrent income assumptions that underpin the financial position of the HB moving into future years.  |                  | <b>£16.261m Deficit</b> | <b>£20.914m Deficit</b> | <b>£89.6m Deficit</b>  | <b>£81.2m Deficit</b>                    |

The ABUHB month 7 year to date budget performance identifies an adverse variance of **£41.864m**.

In month the Health Board has received an allocation from Welsh Government of £89m (£9m anticipated), this funding has improved the month 6 position from a £145m deficit to a £57m deficit.

Welsh Government correspondence received on the 20<sup>th</sup> October, (referred to in the circulated Board briefing paper), where this allocation is explained, describes the expectation of ABUHB to achieve a control total of £13m deficit for 2023/24. The current forecast variance is above the pro-rata control total by £44m.

During the last few months the Board, Executives, budget holders and staff have engaged in a rigorous and thorough review of the opportunities to improve the financial forecast for 2023/24. This review included identifying further opportunities to make savings and avoid costs. This process involved a multi-professional clinical group performing an impact assessment of proposals with consideration of what is an acceptable patient risk. During the mid-year review process further rigour and ideas were considered & identified a further stretch target for savings delivery and a likely forecast deficit of a £145m deficit, reported for month 6.

At this point the WG target and revised control total for ABUHB of £13m deficit is not considered achievable without significant service impact and risks, however, the Health Board will continue to review and re-examine all savings options and further opportunities.

The revised Health Board forecast of £57m is c.£44m greater compared with the control total of £13m. The reasons driving the overall forecast are as follows:-

- **Annual Plan deficit £112.848m**
- WG Funding – (£88.4m) (f)
- **Annual plan deficit off-set by WG funding - £24.4m**
- IMTP unachieved savings variance £9.4m
- CHC growth and price pressures & Prescribing price growth - £18m
- Covid legacy service costs - £7.4m
- Medical and Nursing workforce operational pressures - £19m
- Off-set by reserves supporting the financial position and other benefits e.g. energy – (£11.6m) (f)
- Further Executive scrutiny and updated mitigation plans (£9m) (f)
- **Total forecast as at month 7 - £57.6m**

Work will continue to mitigate this position for this year and for future years. When considering this, the Health Board feels a **range of best case £52m to worst case £62m** is reflective of the remaining opportunities and risks. The best case incorporates opportunities that were not supported by the Clinical Advisory Group but are being revisited due to the financial position. The worst case takes account of a risk to certain Board allocations and assumptions, the worsening of variable pay agency, and prescribing price growth.

The forecast of £57m deficit, is in line with the CEO accountability letter forwarded to the Director General for NHS Wales on 16<sup>th</sup> October 2023 less the assumed funding stated in the WG letter dated 20<sup>th</sup> October 2023.

**The revised forecast position is still subject to delivery risk since it relies on savings achievement and other mitigating actions across a wide range of services, some of which remain 'Amber' and need more detailed**

**implementation plans. These actions remain a key standing item on Executive Committee meetings as well as the focus of the ABUHB Value and Sustainability group.**

### Cefndir / Background

Key points to note for month 7 include:

- A reported year to date position of **£41.9m deficit**. The March IMTP planned profile variance of **£68.8m deficit**, to note this is not comparable due to funding.
- The reported forecast has been revised to a **£57.6m deficit**, given WG funding confirmed of £78.9m and anticipated funding of £9.5m, however, there remain risks to achievement given the level of savings and actions required.
- Income –includes funding for the 2023/24 A4C pay award (£26.5m), anticipated income for the 2023/24 medical pay award (£6.4m) and estimated revenue charges related to Capital accounting.
- Pay Spend (excluding the notional pension adjustment from March 2023) – has increased compared to month 6 by c.£4m. The main reasons are:
  - Back-dated medical pay award of £3.8m
  - Substantive enhancement increase of £0.2m
  - WLI, additional sessions increase of £0.2m
  - Reduction in bank / agency usage of £0.2m
- Non-Pay Spend (excluding capital adjustments) - has increased by c.£4.4m, due to increased dental contract costs, drugs/vaccines costs, funded RIF and 6 goals scheme costs and EASC.
- Savings – overall forecast achievement is £42.1m, against the IMTP savings plan of £51.5m
  - Year to date achievement of £18.4m against year-to-date plan of £28.4m.
  - All additional schemes likely to be achieved have been included which in some cases have replaced original IMTP savings schemes which are no longer expected to be achieved. All opportunities from the executive led exercise are included in the forecast, delivery of these new schemes will be reported as part of established savings reporting arrangements.

As at Month 07, ABUHB is reporting a deficit of **£41.9m** with a revised forecast deficit of **£57.6m**.

There remain risks associated with maintaining this forecast position, particularly the full receipt of all anticipated income, identification and achievement of mitigation savings plans, prescribing cost growth, CHC cost growth and workforce pressures. Further detail is provided in this report however, the risk lies between a **£52m** and **£62m** deficit.

As at month 7 the reported capital position is break-even with a balanced forecast, however there is currently a deficit risk of £0.2m which is expected to be managed by year end.

### Asesiad / Assessment

- **Revenue Performance**

The month 7 position is reported as a **£41.9m deficit**, the planned year end deficit agreed by the Board as part of the Annual Plan was £112.8m. This has now been revised to a forecast deficit position of **£57.6m**. This is derived from the month 6 forecast of £145.7m deficit as agreed by the Board on the 11<sup>th</sup> October less funding assumed of £88.4m following WG correspondence on the 20<sup>th</sup> October.

A summary of the financial performance is provided in the following table, by delegated area. The month 7 year to date position has reflected a pro-rata 7/12ths of the new WG allocation funding, hence showing a significant improvement compared with the prior month 6.

| Summary Reported position - October 2023 (M07)               | Full Year Budget<br>£000s | YTD Reported Variance<br>£000s | Prior month reported variance<br>£000s | Movement from prior month<br>£000s |
|--|---------------------------|--------------------------------|--|------------------------------------|
| <b>Operational Divisions:-</b>                               |                           |                                |  |                                    |
| Primary Care and Community                                   | 285,668                   | 800                            | 1,356                                  | (556)                              |
| Prescribing  | 111,133                   | 6,373                          | 5,796                                  | 577                                |
| Community CHC & FNC  | 73,677                    | (620)                          | (78)                                   | (541)                              |
| Mental Health  | 127,700                   | 8,495                          | 7,447                                  | 1,048                              |
| <b>Total Primary Care, Community and Mental Health</b>       | <b>598,177</b>            | <b>15,048</b>                  | <b>14,520</b>                          | <b>527</b>                         |
| Scheduled Care   | 197,181                   | 5,841                          | 4,982                                  | 859                                |
| Clinical Support Services                                    | 62,572                    | (977)                          | (816)                                  | (161)                              |
| Medicine   | 148,725                   | 10,394                         | 8,877                                  | 1,517                              |
| Urgent Care  | 35,024                    | 3,041                          | 2,781                                  | 260                                |
| Family & Therapies   | 132,869                   | 1,860                          | 1,639                                  | 222                                |
| Estates and Facilities                                       | 87,170                    | 3,961                          | 2,944                                  | 1,017                              |
| Director of Operations                                       | 8,283                     | 441                            | 307                                    | 134                                |
| <b>Total Director of Operations</b>                          | <b>671,823</b>            | <b>24,560</b>                  | <b>20,713</b>                          | <b>3,847</b>                       |
| <b>Total Operational Divisions (Chief Operating Officer)</b> | <b>1,270,000</b>          | <b>39,608</b>                  | <b>35,233</b>                          | <b>4,374</b>                       |
| Corporate Divisions  | 121,923                   | (2,418)                        | (2,807)                                | 389                                |
| Specialist Services  | 183,299                   | (1,692)                        | (1,450)                                | (242)                              |
| External Contracts   | 88,576                    | (157)                          | (149)                                  | (8)                                |
| Capital Charges  | 54,118                    | 347                            | 321                                    | 27                                 |
| <b>Total Delegated Position</b>                              | <b>1,717,915</b>          | <b>35,688</b>                  | <b>31,147</b>                          | <b>4,541</b>                       |
| Total Reserves   | 6,572                     | 6,176                          | 50,999                                 | (44,823)                           |
| Total Income   | (1,724,488)               | (0)                            | (0)                                    | (0)                                |
| <b>Total Reported Position</b>                               | <b>0</b>                  | <b>41,864</b>                  | <b>82,146</b>                          | <b>(40,283)</b>                    |

### Summary of key operational pressures for Month 7

- During October 2023, pay expenditure (excluding the effect of the notional pension adjustment from March 2023) increased by c.£4m compared with September.
  - Backdated 2023/24 medical pay award costs (£3.8m) were incurred in-month.
  - Enhancement costs were higher (£0.2m) which is an expected result of the payroll profiles,
  - Other WLI, additional sessional costs increased by c.£0.2m compared with September,
  - Overall variable pay costs remain significant (£7.4m in month 7, YTD value £57.6m) but decreased by £0.2m compared with September. The cessation of flexible reward payments continues to reduce the overall variable pay monthly average and in addition registered nursing agency costs decreased by £0.2m compared with September,
  - HCSW costs in estates and facilities remain high linked to the continuation of enhanced cleaning standards and other Covid legacy related costs.



- Non-Pay Spend (excluding capital adjustments) - has increased by c.£4.4m. Key movements from month 6 include;
  - Dental contract costs increased by £1.4m this is a result of the clawback reducing the spend in September,
  - RIF funded scheme and 6 goals increased costs (£1.1m increase) matched by budget,
  - Homecare drug and vaccine increases linked to timing of prescriptions, pharmacy system and school vaccinations. (£1.3m increase)
  - EASC, WHSSC, Out of Area Treatment, IPTR, and other costs (c.£0.6m increase).
  
- Demand pressures for elective and urgent care across all services, including primary care, mental health, acute and community hospitals remains above the pre pandemic levels. There are 281 inpatients who are fit for discharge as at the end of October; approximately 26% of the blocked bed days are health related, 45% are social care and package of care related with the remaining 29% relating to other reasons e.g. patient/family related, nursing homes, etc.
  
- The estimated cost for the year of continued blocked bed days for all reasons is c.£21.3m using a £200 cost per bed day. The challenges in terms of demand and flow across the UHB drive surge bed capacity requirements which result in high cost temporary staff demand and overspends across the UHB. The delays need to reduce to avoid the requirement for this capacity and to achieve a safe and sustainable aligned service, workforce and financial plan for the UHB. There is an invigorated focus on optimising appropriate bed capacity to support financial sustainability for 2023/24 and the future, through the discharge and bed reduction saving programme.
  
- For October other issues include:-
  - Prescribing spend remains significant at £9.8m in-month (£71.2m year to date). The August PAR average cost per item was 1p lower than July. The 2023/24 forecast PAR price per item has reduced from £7.53 to £7.52 due to a reduction in NCSO concessions from October.
  - CHC cost and growth pressures in Mental Health and Learning Disabilities (Mental Health year to date deficit variance of c.£4.4m, forecast £6.4m deficit),
  - An additional 4 out of county paediatric CHC packages (23 as at October, 6 of which are classified as high value), total year to date expenditure on external packages is currently £1.3m,
  - On-going use of variable pay above budget within mental health wards for acuity as well as sickness and vacancy cover, (nursing variable pay within the Division of £4.6m year to date with over 40% linked to enhanced care,)

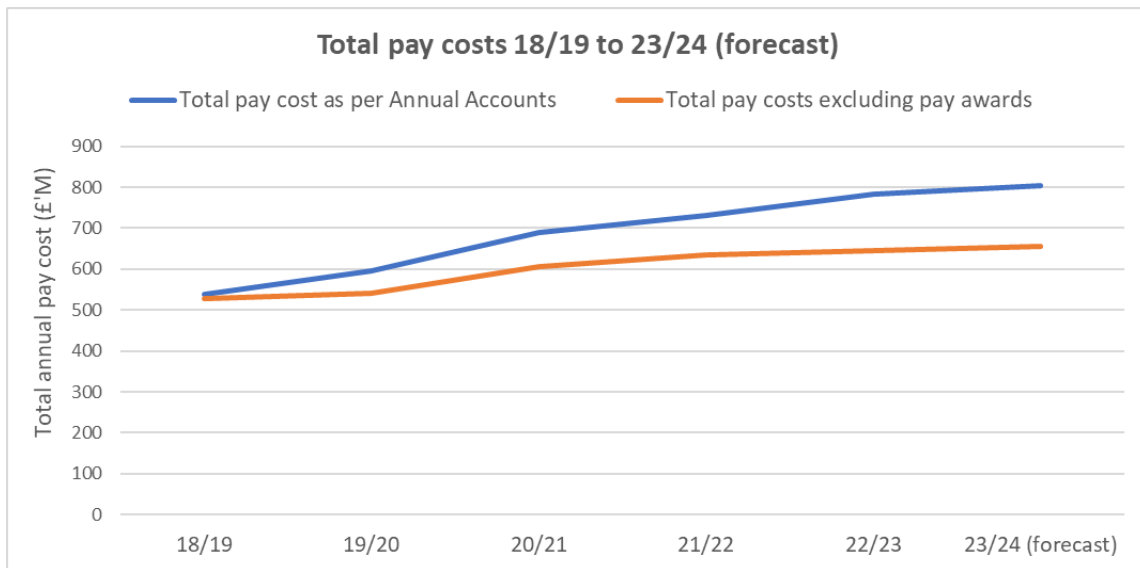
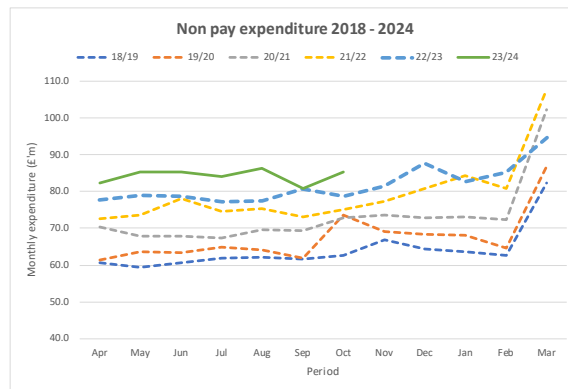
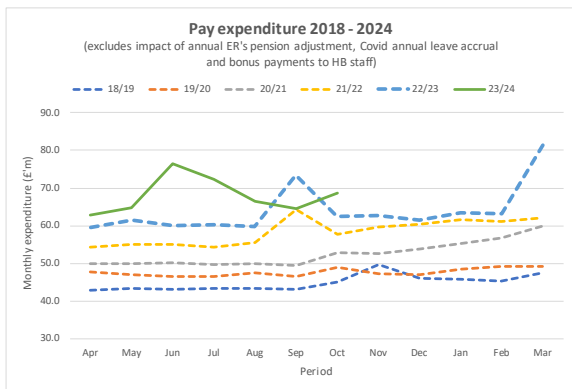
- Enhanced cleaning, additional security and other Covid-19 legacy costs (£4.4m expenditure for year to date), and
- Increased non-pay costs across a number of areas including homecare drugs, respiratory equipment, diabetes pumps/consumables and hearing aids. Diabetes pumps and associated consumable costs are now forecast to be c.£1.6m above funded levels across both adult and paediatric services.
- Additional income from HEIW for training grade post changes for the year 2023/24 hence the back-dated element provides an in-month benefit.

Key areas of focus for mitigating actions for the Health Board remain:

- System level working & redesign – reducing DTOCs and additional bed capacity requirements
- Elective care, Theatre and operational efficiency improvement,
- Urgent care pathways re-design,
- Demand and flow management,
- Workforce efficiency, reducing variable pay in particular agency and medical temporary pay costs,
- Driving Medicines management opportunities,
- Review of CHC pathways within Mental Health and Complex Care,
- Review of savings plans, current investments made and service options across Divisions,
- Other actions to improve the financial position e.g. review of income and non-pay expenditure.
- Consideration of longer term benefits of prevention services
- Optimising Digital solutions.
- Recruitment to vacant posts will go through a weekly scrutiny panel process to enable recruitment to progress
- There will be a freeze on all agency and consultancy for administrative work
- Internal conferences not to be held at external venues
- IT equipment will be subject to IT department approval and refurbished or reallocated equipment will be used as the first call for requests for kit.
- A freeze on purchasing all office equipment and furniture

### **Expenditure run-rates**

Pay and Non-Pay expenditure run-rates for the last four financial years are shown below, along with a chart showing annual total pay and the impact of pay awards;



The expenditure run-rates need to reduce substantially in the remaining five months of the financial year in order to meet the revised forecast for the Health Board.

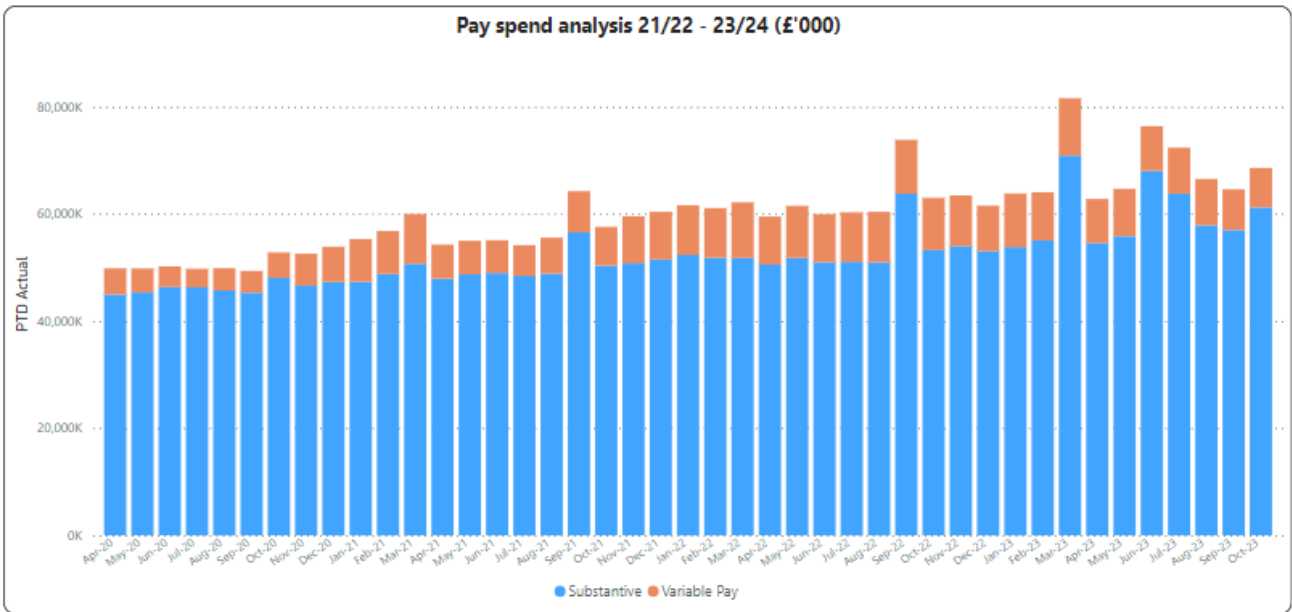
The run rate drives an overspend of £6m per month - this needs to move to an average of £3.2m per month for months 8 to 12 to achieve the forecast £57m, this is a £2.8m reduction per month.

## Workforce

The Health Board spent £68.6m on workforce in month 7 23/24, an increase of £4m compared with month 6 (22/23 monthly average of £64.1m) driven by the backdated medical pay award. A monthly average year to date for 23/24 of £68m per month.

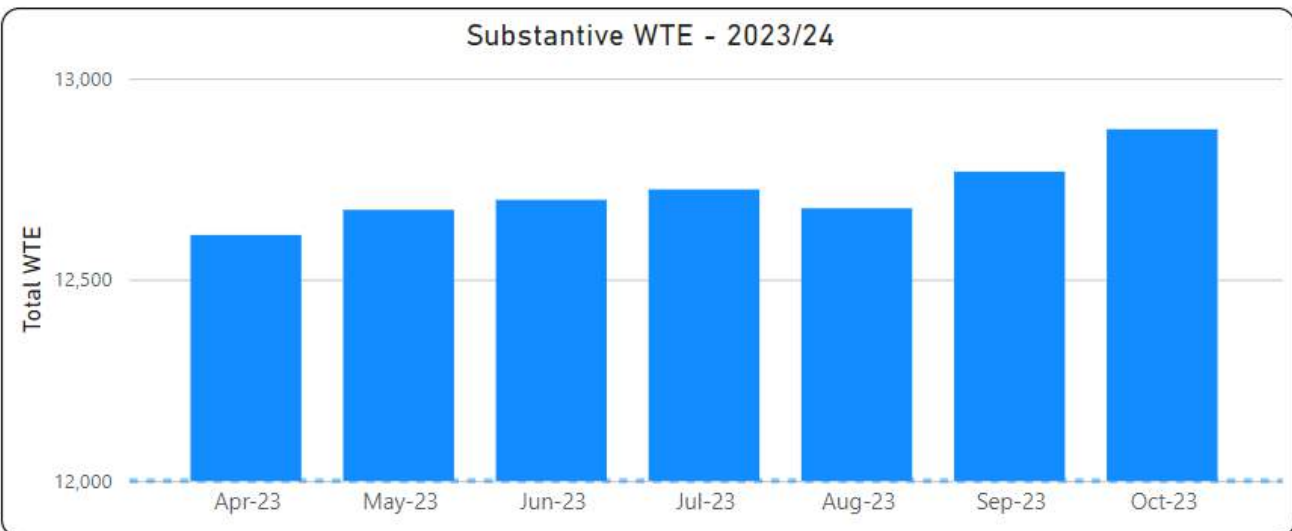
Workforce expenditure is shown below differentiating between substantive and variable pay<sup>1</sup>:

<sup>1</sup> To enable useful comparisons and trends all references to 22/23 pay expenditure exclude the month 12 expenditure for additional employer pension contributions (6.3%/£27.5m).



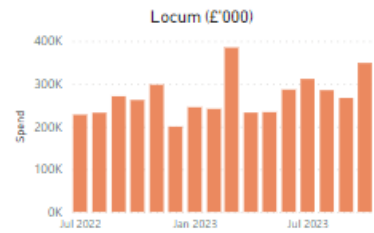
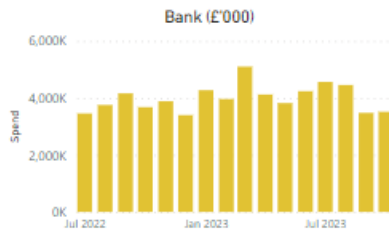
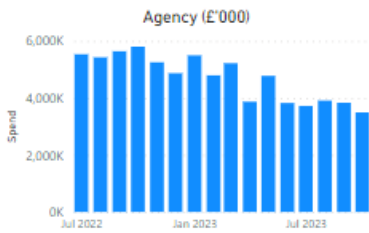
### Substantive staff

Substantive pay was £61.2m in October, costs increased by £4.2m compared with September due to the backdated medical pay award of c.£3.8m. A higher number of enhancements were paid in October (c.£0.2m) as well as increased additional consultant sessional/WLI costs (£0.2m). Month 7 includes 12,873 wte employed, an increase of 105 wte over the prior month.



### Variable pay

Variable pay (agency, bank and locum) was £7.4m in October. The monthly average variable pay is currently running at £8.2m for 2023/24 (£9.2m average 22/23). Vacancy cover along with sickness and enhanced care continue to drive a financial pressure as well as pressure on staff. Mental Health, in particular, remains an area with a sustained increase in acuity which subsequently impacts variable pay. Nursing agency expenditure decreased in-month alongside continued reduced bank costs. Costs relating to vacancy cover have decreased which is likely to be linked to the increase in substantive staff in October shown above.



## Bank staff

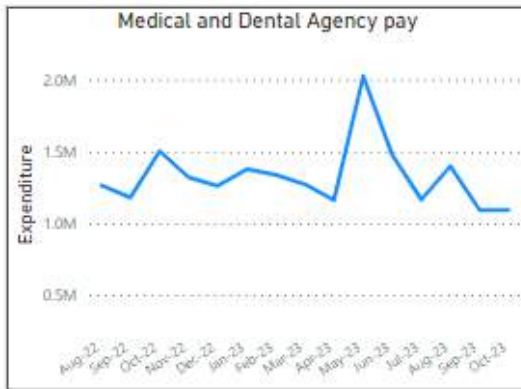


In-month spend of £3.5m, a similar level compared with September, but reduced compared to the average spend April-August (£4.2m per month).

- **Flexible rewards ceased end of August 23. Flexible rewards costs were £0.6m in August, with no new costs incurred in September or October (£2.7m year to date).**
- Continued pressures in Medicine wards, GUH Acute Medicine and GUH ED but generally reduced usage.
- Enhanced care / observation shifts particularly linked to Mental Health.
- Continued expenditure in Critical Care, General Surgery and Trauma & Orthopaedics for operational pressures / elective activity.
- £0.27m expenditure within medicine wards in YYF.
- Average bank spend in 2022/23 of £3.8m per month

## Agency


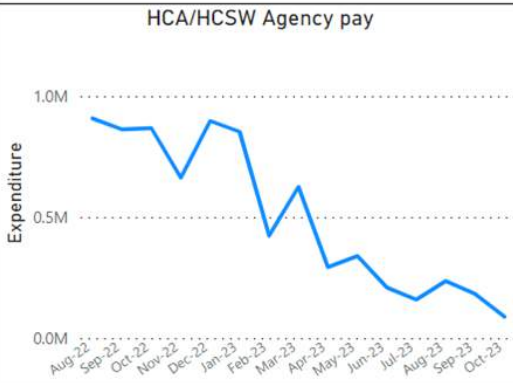
Total agency spend in October was £3.5m compared with £3.8m in September.



- In-month spend of £1.1m, a similar level compared with September.
  - Decreased expenditure in Managed Practices, specialist Mental Health and Community Hospitals linked to review of previous shifts worked in 2023/24.
  - Continued pressures in Medicine wards, pathology and GUH ED to cover operational pressures.
  - COTE expenditure (c.£0.2m) for operational pressures.
  - Trauma & Orthopaedics costs (c.£0.17m) for junior rota (vacancies) and orthogeriatric cover that was implemented post GUH.
- Medical agency spend averaged c.£1.3m per month in 2022/23.



- In-month spend of £1.6m decrease of £0.2m compared with September. Average spend per month, year to date, is £1.5m per month.
- Reasons for use of registered nurse agency include:
    - Vacancy cover
    - Additional service demand,
    - Enhanced care and increased acuity of patients across all sites, and
    - On-going sickness and international recruitment costs,
  - On-going significant costs in GUH Emergency Department (c.£0.2m) and medicine wards (c.£0.7m) linked to enhanced care, sickness pressures as well as vacancy cover. Mental Health agency costs increased by c.£0.2m in-month linked to enhanced care cover.
  - Registered Nursing agency spend averaged c.£1.8m per month in 2022/23.

|  |  |
|--|--|
|   | <ul style="list-style-type: none"> <li>• In month spend of £0.49m on Estates &amp; Ancillary agency, a similar level compared with September.</li> <li>• Reasons for use of agency include: <ul style="list-style-type: none"> <li>○ Meeting enhanced cleaning standards,</li> <li>○ Other additional surge capacity,</li> <li>○ Sickness,</li> <li>○ Vacancies and</li> <li>○ Supporting National Covid-19 programmes (Mass Vaccination).</li> </ul> </li> <li>• Estates and Ancillary agency spend averaged c.£0.65m per month 2022/23.</li> </ul>   |
|  | <ul style="list-style-type: none"> <li>• In month spend of £89k on HCSW agency, this has significantly reduced from £0.88m average spend per month in 2022/23.</li> <li>• Areas where spend remains are: <ul style="list-style-type: none"> <li>○ F&amp;T £10k in CAMHS / complex needs</li> <li>○ MH&amp;LD £39k including: £9.6k in LD, specifically LGH Ty Lyfant unit, £21.6k in Adult MH services including 5k in Talygarn I/P and 14k in the Psychiatric ICU unit, and £8k in Older Adult MH across 4 wards</li> <li>○ PCCS £27k across the wards including: 4k in County, £7k in YAB, £8k in STW, £3k in Cas Gwent &amp; £5k in Monnow Vale Trefynwy ward.</li> <li>○ Medicine £11k across the wards including: £6k NHH, £2.6k GUH &amp; £2.6k RGH</li> </ul> </li> </ul> |

**Registered Nurse Agency**

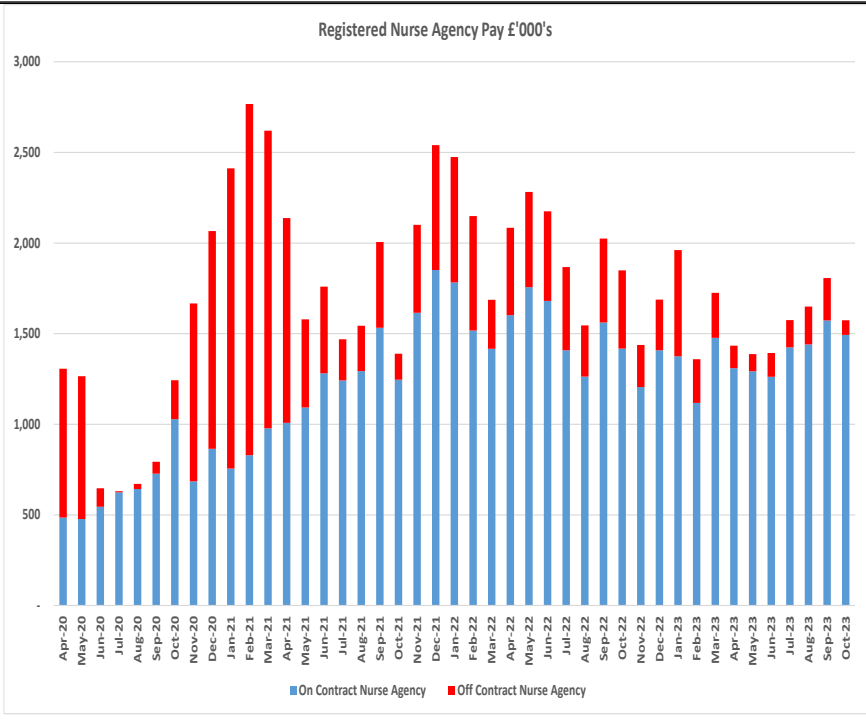
Health Board spend in October 2023 is £1.6m which is a decrease of £0.23m compared with September. The effect of the removal of the flexi rewards for Bank staff may now be reduced but this needs to be monitored. The increase in substantive wte suggests that a combination of these various actions have reduced in-month expenditure. It is forecast that decreases in bed capacity should continue to directly reduce agency costs.

Current indications are that 23/24 agency costs could be circa £18.5m.

Registered nurse agency spend totalled £22m in 2022/23, £22.8m in 2021/22, £18.1m in 2020/21 and £10.2m in 2019/20.

The use of “off-contract” agency i.e. not via a supplier on an approved procurement framework usually incurs higher rates of pay, is decreasing but remains a pressure.





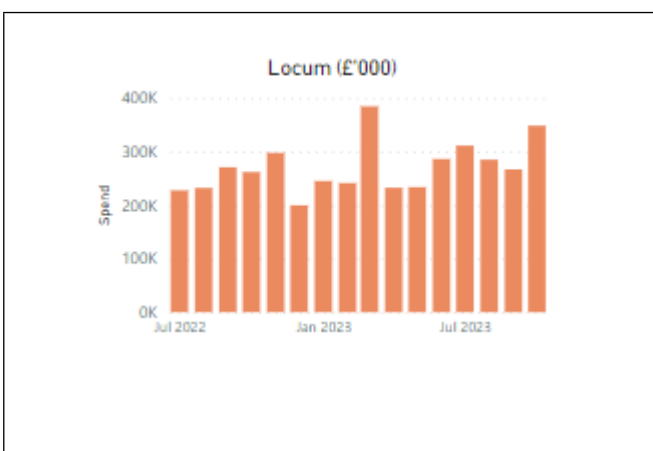
The Health Board spent £0.1m on **“off” contract** RN agency in October. These costs reflect the on-going vacancy cover as well as smaller usage for other operational pressures such as:

- Enhanced care,
- Additional capacity,
- Nursing vacancies,
- Patient safety, and
- Increased sickness and cover for staff in isolation.

### Implications of Nursing Shift 'Fill Rate'

It should be noted that there remain high levels of unfilled shifts. Whilst filling these shifts may improve workforce and service provision, there would be an increased cost. In October there were approximately 200 unfilled registered nursing shifts and 450 unfilled HCSW shifts, which could in total result in a further c.£0.25m if these shifts were filled.

### Medical locum staff



- Total locums spend of £0.3m, a £0.1m increase compared with September.
  - Medical pay award costs of c.£0.06m
  - Radiology, COTE, AMU NHH, and GUH ED are the specialties with the greatest in-month expenditure.
  - Expenditure incurred in relation to vacancies, elective recovery alongside other operational pressures.

## Enhanced Care

Enhanced Care, also known as 'specialling', can be provided for a variety of reasons ranging from the provision of assistance to help a patient mobilise or avoid falls through to one-to-one patient monitoring. Enhanced care is designed to ensure an appropriate level of safety and supervision for patients with additional care needs.

The following graph highlights the hours attributed to enhanced care for the period September 2021 to October 2023 using bank and agency registered nurses and health care support workers. The trend suggests that targeted actions may be having a positive impact on enhanced care usage. This reduction needs to be considered in conjunction with trends for other reasons for variable pay usage.

### Enhanced Care bank and agency calculated costs and hours booked.



The level of the provision of enhanced care for patients within the Medicine Division for April to October 2023 shows a decrease in September significantly within YYF as well a decrease within RGH.

| <b>Enhanced Care by Hospital Site as a percentage of total bed capacity</b> | <b>M1</b>  | <b>M2</b>  | <b>M3</b>  | <b>M4</b>  | <b>M5</b>  | <b>M6</b>  | <b>M7</b>  |
|---|------------|------------|------------|------------|------------|------------|------------|
| <b>RGH</b>  |            |            |            |            |            |            |            |
| Total no of Medicine beds   | 192        | 192        | 192        | 192        | 192        | 192        | 192        |
| Monthly average enh care patients   | 46         | 38         | 32         | 31         | 42         | 37         | 22         |
| %age of beds in receipt of enh care   | 24%        | 20%        | 17%        | 16%        | 22%        | 19%        | 12%        |
| <b>NHH</b>  |            |            |            |            |            |            |            |
| Total no of Medicine beds   | 164        | 164        | 164        | 164        | 164        | 164        | 164        |
| monthly average enh care patients   | 17         | 17         | 23         | 23         | 24         | 25         | 23.2       |
| %age of beds in receipt of enh care   | 10%        | 10%        | 14%        | 14%        | 15%        | 15%        | 14%        |
| <b>GUH</b>  |            |            |            |            |            |            |            |
| Total no of Medicine beds   | 91         | 91         | 91         | 91         | 91         | 91         | 91         |
| monthly average enh care patients   | 14         | 12         | 12         | 11         | 10         | 9          | 11.87      |
| %age of beds in receipt of enh care   | 15%        | 13%        | 13%        | 12%        | 11%        | 10%        | 13%        |
| <b>YYF</b>  |            |            |            |            |            |            |            |
| Total no of Medicine beds   | 148        | 148        | 148        | 148        | 148        | 148        | 148        |
| monthly average enh care patients   | 33         | 35         | 30         | 27         | 28         | 18         | 14         |
| %age of beds in receipt of enh care   | 22%        | 23%        | 20%        | 18%        | 19%        | 12%        | 9%         |
| <b>Total</b>  |            |            |            |            |            |            |            |
| <b>Total no of beds</b>   | <b>595</b> | <b>595</b> | <b>595</b> | <b>595</b> | <b>595</b> | <b>595</b> | <b>595</b> |
| <b>Total monthly average enh care patients</b>                              | <b>110</b> | <b>102</b> | <b>97</b>  | <b>92</b>  | <b>104</b> | <b>89</b>  | <b>71</b>  |
|   | <b>18%</b> | <b>17%</b> | <b>16%</b> | <b>15%</b> | <b>17%</b> | <b>15%</b> | <b>12%</b> |

### **Nursing vacancy cover**

The graph below presents the bank and agency hours and costs relating to those shifts booked to cover vacancies. The graph highlights that in October 2023 variable pay relating to vacancies remains significant and is c.£2.5m of 'notional calculated' expenditure.

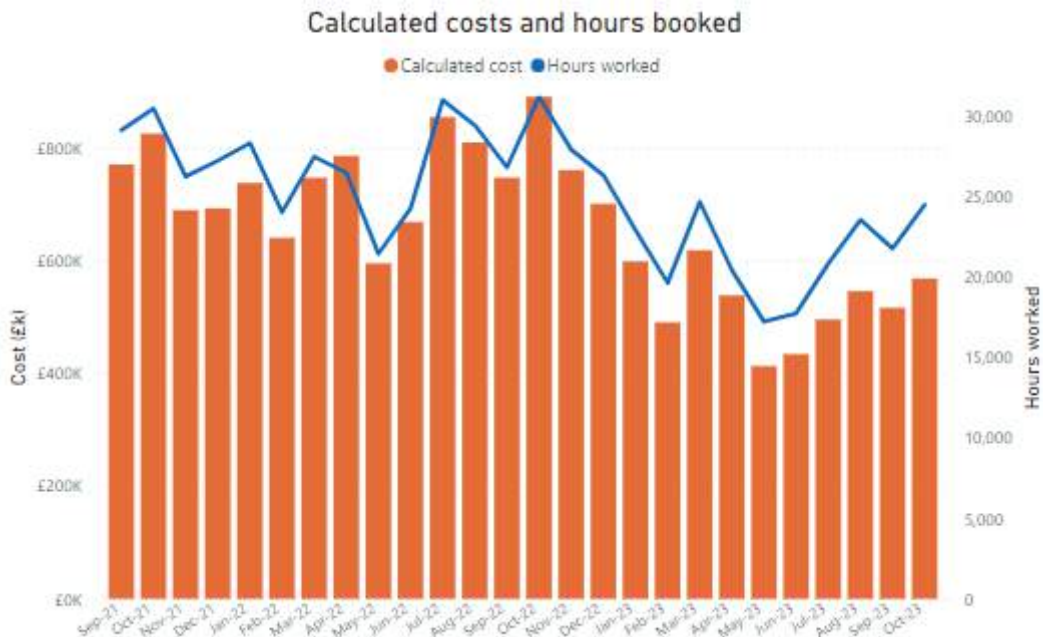
**Calculated bank and agency costs / hours booked to cover shifts resulting from vacancies.**



**Nursing sickness cover**

The graph below presents the bank and agency hours and costs relating to those shifts booked to cover sickness as input onto the e-roster system. The graph highlights that in October 2023 variable pay relating to sickness is significant (c.£0.6m) of 'notional calculated' expenditure.

**Calculated bank and agency costs / hours booked to cover shifts resulting from sickness.**

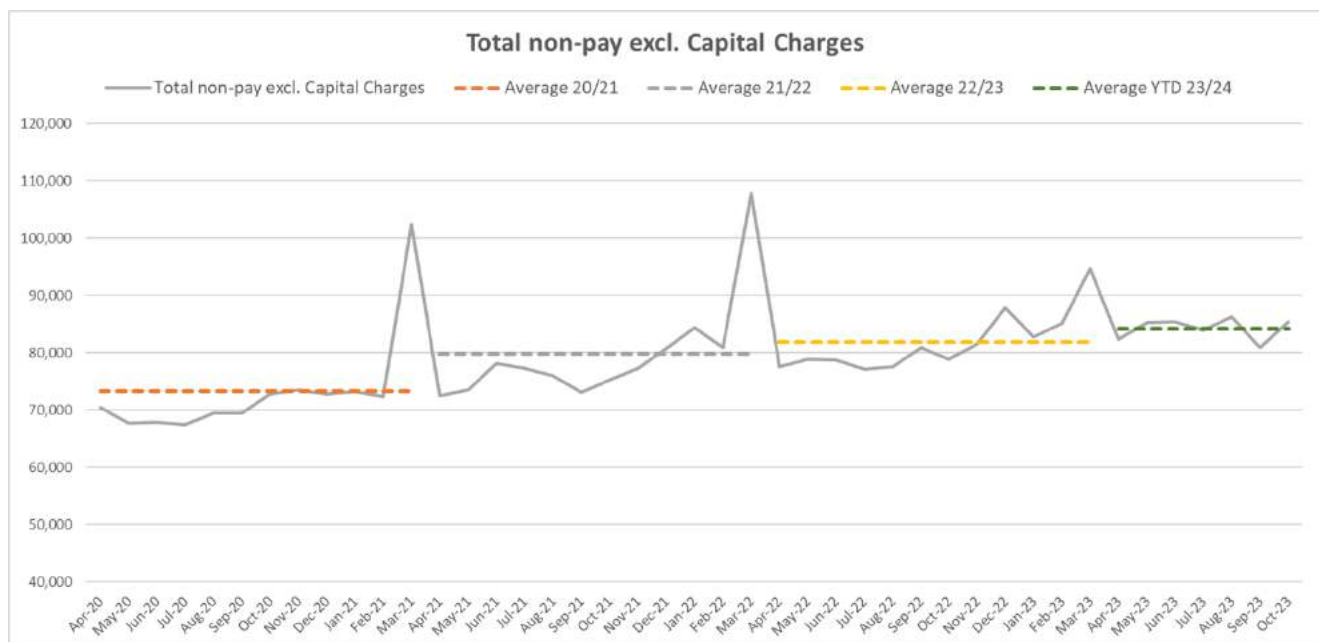


## Non-Pay

Spend (excluding capital) was £85.4m in October, which is a £4.4m increase when compared with September. Key reasons include:-

- Dental contract costs increased by £1.4m, note contract underperformance was recovered in September accounts,
- EASC and WHSSC increased by c.£0.3m in line with funding received,
- RIF funded scheme and 6 goals increased costs (£1.1m increase) matched by budget,
- Homecare drug and vaccine increases linked to timing of prescriptions, pharmacy system and school vaccinations. (£1.3m increase)
- Out of Area Treatment, IPTR and other costs (c.£0.3m increase).

The graph below presents non-pay expenditure since April 2020 (it should be noted that the peaks are year-end adjustments and Month 12 items):-



## Energy

Energy costs remain a volatile cost pressure, additional non-recurrent funding received in 2022/23 was c.£13.7m with total expenditure of c.£22.2m. 2023/24 forecasts will continue to be updated in line with the latest data and advice received from NWSSP and internally for those energy costs outside of this arrangement, an updated national contract forecast was not available for month 7 so the forecast remains based on month 6 intelligence.

Forecast expenditure for 2023/24 as at month 7 is £18.1m, compared with c.£29m IMTP estimates and the baseline 2022/23 costs of £22.2m.

| Element                          | 2022/23 costs (baseline) £'000 | 2023/24 forecast (£'000) | Variance (£'000) |
|----------------------------------|--------------------------------|--------------------------|------------------|
| Total Shared Service Energy Cost | 20,620                         | 16,659                   | (3,961)          |
| Total Other Energy costs         | 571                            | 849                      | 278              |
| NWSSP (Greenvale Laundry)        | 992                            | 628                      | (364)            |
| <b>Total</b>                     | <b>22,183</b>                  | <b>18,137</b>            | <b>(4,046)</b>   |

Note 2022/23 experienced a significant energy cost increase over 21/22 of £13.7m.

### CHC

- CHC Mental Health – the patient numbers at the end of October were 426 at a cost of £4.5m (419 patients at a cost of £4.4m in September).
- CHC Adult / Complex Care - 553 total active placements on 31<sup>st</sup> of October at a cost of £4.8m in-month (increase of 1 from previous month). There was a decrease of 6 D2A patients and a decrease of 1 placement on the 'Step Closer to Home' pathway in October. The table below summarises the current position (patients and forecast costs):

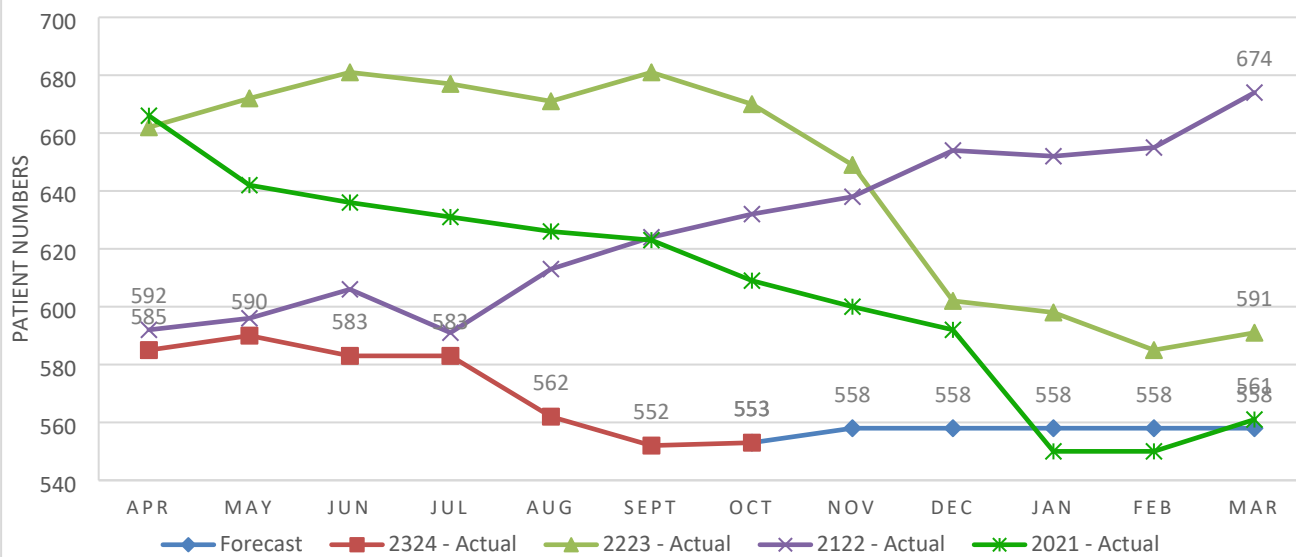
| Activity            | Oct 2023 | Sept 2023 | Movement |
|---------------------|----------|-----------|----------|
| D2A                 | 10       | 16        | -6       |
| Step Closer to Home | 6        | 7         | -1       |
| All Other CHC       | 537      | 529       | +8       |
| Total               | 553      | 552       | +1       |

| £'000               | M07 Forecast | M06 Forecast | M05 Forecast |
|---------------------|--------------|--------------|--------------|
| D2A                 | 1,948        | 2,273        | 2,541        |
| Step closer to home | 532          | 524          | 563          |
| All other CHC       | 40,991       | 41,101       | 41,542       |
| Total               | 43,472       | 43,897       | 44,646       |

- FNC - currently 1,063 active placements, which is an increase of 40 from the number of placements in September (expenditure of £0.94m in October).

Adult Complex Care CHC activity over the last four financial years is summarised in the chart below: -

## CHC ACTIVITY (INCL DTA/ SCTH)



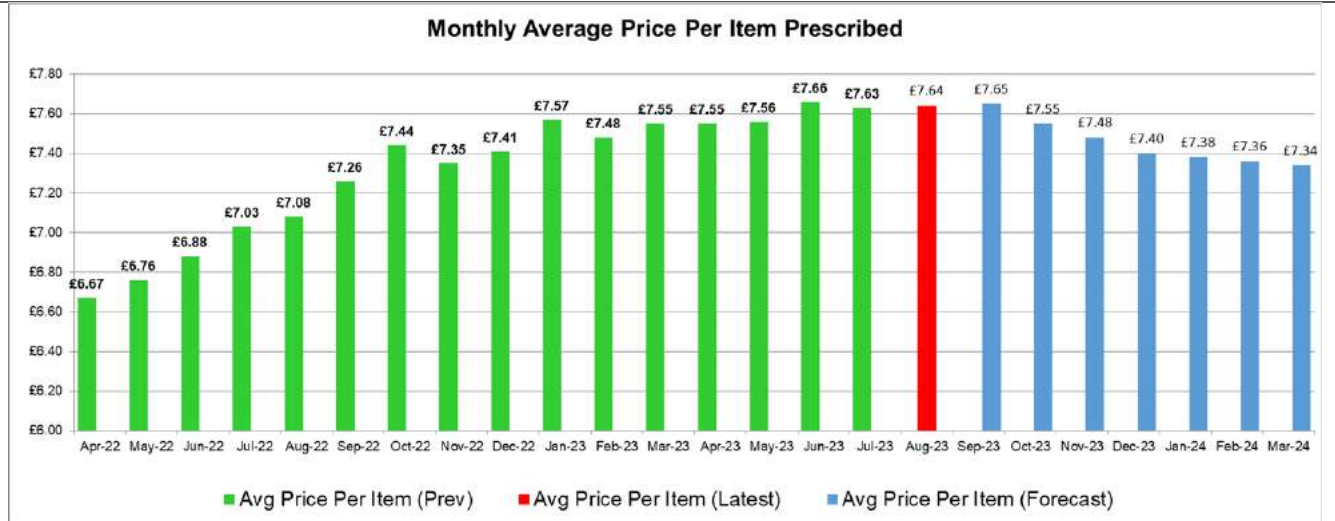
- CHC Paediatric – currently 23 Out of County patients (2023/24 year to date cost of £1.3m) and 15 internal packages (12 patients). There are 6 external and 4 internal high cost packages which continue to be a cost pressure against budget levels.

### Prescribing

- Primary Care prescribing – the expenditure year to date is £71.2m. The October 2023 costs are based on August PAR data: -
  - Item growth rate for 2023/24 of 0.8% (forecast volume of items based on the number of prescriptions for 23/24 is c.16.8m)
  - IMTP average cost per item was £7.20.
  - Average actual cost per item for 2022/23 was £7.21.
  - Average cost per item price forecast for 2023/24 (April-March) is £7.52. This has decreased slightly in month 7 by £0.01 due to a reduction in NCSO concessions from October.
  - A revised home oxygen contract and drug rebates have improved the forecast position by c.£0.2m.

The graphs below show the monthly average price per item and item growth: -



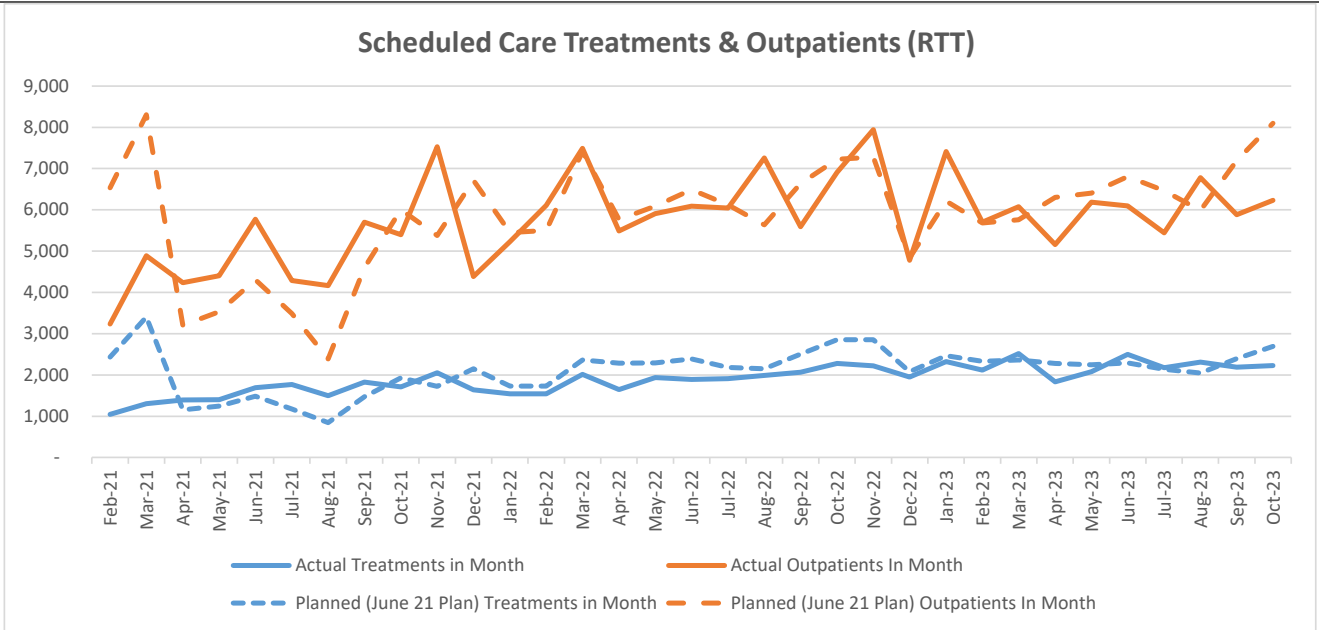


## Scheduled Care treatments and outpatients

Elective Treatments for October '23 was 2,226 (September '23 was 2,187). Elective Activity in October has increased by 39 treatments compared with September (2% increase). The number of in month treatments are 464 below plan for October, resulting in a cumulative deficit against plan of 772 treatments.

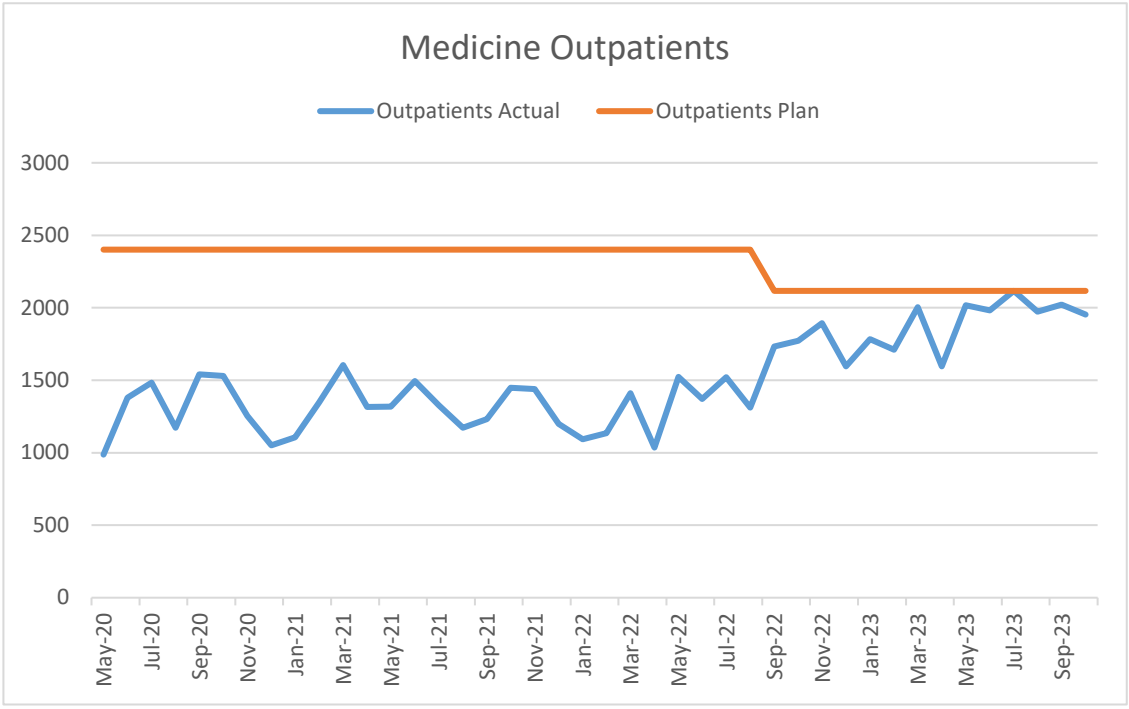
Outpatient activity for October '23 was 6,229 (September '23 was 5,885). Outpatient activity has increased in comparison with the level achieved in September (increase of 344 attendances, 6%) but remains significantly below the planned levels on a year to date basis (5,473 cases).

There remain significant efficiency opportunities in the delivery of elective care which need to be progressed as part of the Planned Care programme. The graph below presents performance compared to plan.



**Medicine Outpatient Activity**

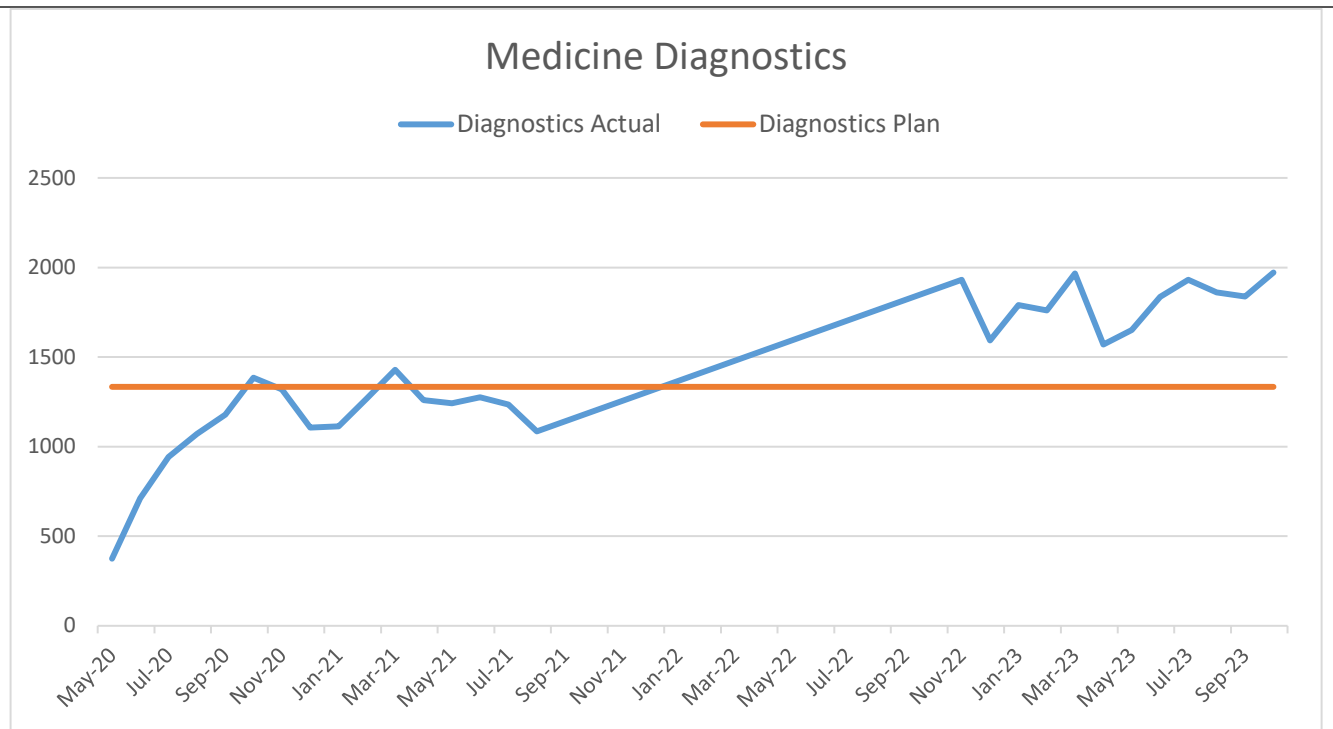
Medicine Outpatient activity for October '23 was 1,954 attendances (September '23 was 2,023 attendances) the activity is presented below:



**Medicine Diagnostics (Endoscopy) Activity**

Medicine endoscopy activity for October '23 was 1,937 procedures which is 639 cases more than plan (September '23 activity was 1,838). Additional services have been commissioned.

The activity undertaken since May '20 is shown below.



## Divisional analysis

Summaries of the Divisional forecast positions are included in the appendices. These include expenditure and budget profiles along with a list of savings schemes and their current progress.

The table below identifies operational divisional forecasts at month 7, these forecasts will be updated once clarity on bed reduction plans are applied to divisions at ward level.

| Summary Reported position - October 2023 (M07) | Annual Year Budget £000s | Full-year forecast at M07 £000s | Full-year forecast at M06 £000s | Movement £000s |
|--|--------------------------|---------------------------------|---------------------------------|----------------|
| <b>Operational Divisions:-</b>                 |                          |                                 |                                 |                |
| Primary Care and Community                     | 285,668                  | 2,701                           | 3,459                           | (757)          |
| Prescribing                                    | 111,133                  | 10,253                          | 10,461                          | (208)          |
| Community CHC & FNC                            | 73,677                   | (3,549)                         | (2,732)                         | (817)          |
| Mental Health                                  | 127,700                  | 12,681                          | 12,914                          | (233)          |
| Scheduled Care                                 | 197,181                  | 8,980                           | 8,574                           | 406            |
| Clinical Support Services                      | 62,572                   | (512)                           | (432)                           | (80)           |
| Medicine                                       | 148,725                  | 16,264                          | 16,918                          | (653)          |
| Urgent Care                                    | 35,024                   | 5,053                           | 5,138                           | (85)           |
| Family & Therapies                             | 132,869                  | 3,058                           | 2,703                           | 356            |
| Estates and Facilities                         | 87,170                   | 6,138                           | 5,988                           | 150            |

In line with the ABUHB performance escalation framework, Divisions with a forecast overspend attended escalation 'special budgetary financial review' meetings to establish further plans to achieve an improved financial forecast, ensure control and governance procedures are maintained and identify any areas requiring support.

Divisional forecast movement summaries are as follows (f=favourable, a=adverse):-

- Primary Care and Community £0.757m (f) – due to COTE funding (£0.6m) received from Medicine and reduced GMS fees.
- Prescribing £0.208m (f) – due to revised home oxygen contracts and additional drug rebates.
- Community CHC & FNC £0.818m (f) – reduced forecast numbers for the Discharge to Assess and CHC pathways. Additional RIF funding of c.£0.3m for Step Closer to Home.
- Mental Health £0.233m (f) – reduced forecast due to HEIW income (c£0.05m) and lower nursing variable pay costs particularly in relation to HCSW agency.
- Scheduled Care £0.406m (a) – increased forecast linked to additional medical agency costs (£0.4m) despite c.£0.3m of HEIW income alongside non-pay implant and hearing aid costs.
- Clinical Support Services £0.08m (f) – reduction due to radiographer vacancies, HEIW income of c.£0.04m and reduced overtime forecast costs.
- Medicine £0.653m (f) – reduction due to RIF funding received for YYF SDEC (£0.6m), Cardiology insourcing (£1.1m) and HEIW income (c.£0.2m) off-set by funding transferred to PCCS (£0.6m) and increased forecast costs for acute drugs (£0.5m) respiratory equipment (£0.2m).
- Urgent Care £0.09m (f) – reduction due to reduced middle grade agency costs in ED, HEIW income of c.£0.05m and increased RTA income.
- Family & Therapies £0.356m (a) – increase due to CHC forecast costs (£0.2m) and increased Diabetes pumps/consumable costs (£0.2m).
- Estates & Facilities £0.15m (a) – increased forecast due to removal of the security savings plan within GUH, in line with the special budgetary review meeting.

### **Covid-19 – 2023/24 Revenue Financial Assessment**

Covid-19 funding of £16.3m (£5.9m received, £10.4m anticipated) is only for specific schemes in 2023/24 which are:

- Nosocomial investigation- £0.753m
- PPE (quarters 1 and 2) - £0.603m
- Health Protection (quarters 1 and 2) - £2.446m
- Immunisation/Mass Vaccination (quarters 1 and 2) - £2.076m

#### Anticipated funding

- *Immunisation (Mass Vaccination) (quarters 3-4) - £6.024m*
- *Surveillance (TTP) (quarters 3-4) - £2.354m*
- *Adferiad (Long Covid) - £1.216m*
- *PPE (quarters 3-4) - £0.797m*

Spend will continue to be reviewed as detailed service delivery plans and models are approved, however, the UHB's financial plan and forecast depends on the receipt and retention of the full levels of funding anticipated.

The Health Board continues to incur additional costs related to Covid-19 for enhanced cleaning standards, security and rental costs. These costs result in an on-going financial pressure for the Health Board.

**The Health Board continues to assume full receipt of all the funding mentioned along with the retention of any slippage.**

### **Revenue Reserves**

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

A number of items in reserves have been re-allocated to specifically indicate that they are supporting the financial position. A summary of all Health Board reserves on 31<sup>st</sup> October, along with details of amounts approved for delegation by the CEO in Month 7 can be found in the appendices.

### **Long Term Agreements (LTA's)**

ABUHB has signed LTA documentation with all organisations apart from Cwm Taf.

ABUHB have fully reflected the Cwm Taf arbitration outcome in the Month 7 reported position. ABUHB were successful in reducing the contract by c.£2m for 2023/24.

Meetings have commenced with CTMUHB to establish a revised LTA contract for 2023-24 and 2024-25.

### **Underlying Financial Position (ULP)**

The Underlying (U/L) forecast position was a brought forward value of £89.6m. The current revised carry forward position into the 2024/25 financial year is assessed to be aligned with the revised 2023/24 £145m forecast deficit reduced by anticipated funding. This forecast will undergo further review during 2023/24 as part of the 2024/25 annual plan process.

The analysis of the c/f underlying deficit is as follows: -

- Forecast 2023/24 deficit - £112.8m
- Non-Recurrent Savings - £11.5m
- FYE Cost Pressures as at IMTP - £5.5m
- Sub-total £129.8m

- Estimated FYE Pressures in 2023/24 (Prescribing, CHC, Covid legacy) - £15.9m
- Sub-Total - £145.7m
- WG recurrent funding – (£64.5m)
- Total recurrent deficit - £81.2m

It is noted that this assumes Health Board savings and mitigating actions for 2023/24 are implemented in line with the plan. Financial sustainability is an on-going priority and focus for the Health Board & will form the basis upon which the 2024/25 Annual Plan is developed.

It should be noted that although the £64.5m allocations are recurrent in principle they are conditional on HB's making progress to delivering the WG target control totals, £13m deficit for ABUHB.

### **Savings delivery**

As part of the IMTP submitted by the Board to Welsh Government, the financial plan for 2023/24 identified an ambitious savings requirement of £51.5m. As at Month 7 the forecast achievement in 23/24 of green and amber schemes is reported as £42.1m. This includes the additional options considered and approved by the Board on the 11<sup>th</sup> October.

Of the expected £42.1m savings delivery, actual savings delivered to October amount to £18.4m.

As part of revised escalation arrangements the Board has established a Value and Sustainability Board in order to progress savings, mitigations delivery, Executive leads have been allocated to the following themes:-

- CHC
- Medicines Management
- Non-pay
- Workforce
- Service reconfiguration
- Prevention
- Digital

The challenge for ABUHB is significant and the reported forecast deficit at month 7 is based on mitigations considered by the Board on the 11<sup>th</sup> October and at previous sessions.

The table below presents the month 7 updated forecast savings profile:

|                        | £m   |         |         |         |         |         |         |
|------------------------|------|---------|---------|---------|---------|---------|---------|
| RAG Rating             | IMTP | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 |
| Green                  | 24.0 | 13.7    | 15.4    | 19.3    | 24.7    | 29.0    | 29.2    |
| Additional Green ideas |      |         |         |         | 3.3     | 5.6     | 6.4     |
| Amber                  | 8.0  | 7.8     | 7.5     | 2.4     | 2.2     | 7.9     | 6.5     |
| Red savings variance   | 19.5 | 30.0    | 28.7    | 29.8    | 21.3    | 9.0     | 9.4     |
| Sub-total              | 51.5 | 51.5    | 51.5    | 51.5    | 51.5    | 51.5    | 51.5    |

The year to date savings delivery is £18.4m.

### Savings Progress as at Year to Date Month 07

- ▣ ABUHB Savings required to be Identified Per IMTP Submission
- ◊ IMTP Savings Identified to WG
- ▨ Savings Plans Forecast Delivering
- Savings Achieved to M07

### Month 7 Forecast Savings Plans

|   | Forecast      | Non Recurrent | Recurrent     | Full year effect of Recurring savings |
|---|---------------|---------------|---------------|---------------------------------------|
| CHC and Funded Nursing Care                       | 6,038         | 580           | 5,458         | 7,305                                 |
| Commissioned Services                             | 5,664         | 3,195         | 2,469         | 2,469                                 |
| Medicines Management (Primary and Secondary Care) | 5,137         | 21            | 5,116         | 6,892                                 |
| Pay   | 13,205        | 1,786         | 11,419        | 12,099                                |
| Non Pay   | 12,014        | 8,398         | 3,616         | 3,915                                 |
| <b>Total</b>                                      | <b>42,057</b> | <b>13,980</b> | <b>28,078</b> | <b>32,681</b>                         |

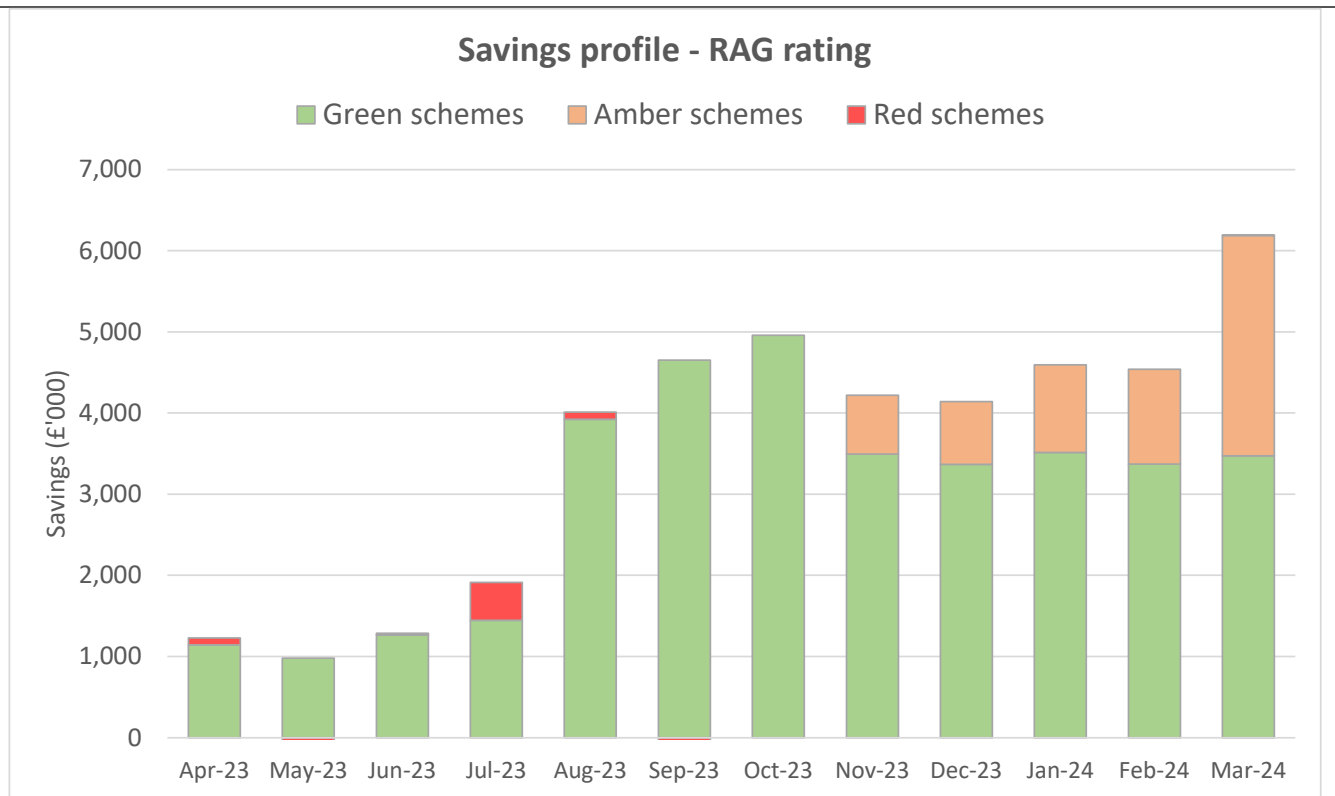
### Month 7 Forecast Savings Plans – Green

| Green Savings schemes                             | Forecast      | Non Recurrent | Recurrent     | Full year effect of Recurring savings |
|---|---------------|---------------|---------------|---------------------------------------|
| CHC and Funded Nursing Care                       | 5,618         | 580           | 5,038         | 6,277                                 |
| Commissioned Services                             | 5,664         | 3,195         | 2,469         | 2,469                                 |
| Medicines Management (Primary and Secondary Care) | 5,137         | 21            | 5,116         | 6,892                                 |
| Pay   | 9,165         | 1,030         | 8,135         | 8,795                                 |
| Non Pay   | 10,005        | 6,807         | 3,198         | 3,307                                 |
| <b>Total</b>                                      | <b>35,588</b> | <b>11,632</b> | <b>23,955</b> | <b>27,740</b>                         |

To achieve the revised forecast the Health Board needs to ensure that savings plans are successfully implemented and that potential risks are offset by mitigation either through additional savings plans or other solutions.

The graph below describes the current profile of green and amber savings (£42.1m), noting that the delivery of other mitigating actions not reflected in the savings graph will be essential to support achievement of the £57.6m deficit target.





### Savings Plans progress to Note

- Within the savings schemes is £2.25m for closure of beds across all sites. Within Community Division there are discussions to move 3 wards from St Woolos to 2 wards in RGH, the plan and timeline for this is not clear and delays could impact the achievement of the savings scheme.
- Despite investment in the support of the inter-site transport management the savings target will not be achieved and in fact spend has increased by £150k in October.
- Medicine reduced Cardiology evening sessions from 4 to 2, however, this is impacting the waiting lists and may need to be reconsidered.
- Urgent Care are reviewing the use of Discharge Lounges, this needs to be considered alongside discharge improvement plans.
- Good progress is now being made with CHC package reviews.

**It is vitally important that all budget holders continue to pursue savings plans to meet the ABUHB financial target and mitigate operational pressures.**

### 2023/24 IMTP revenue plan profile

The in-month variance profile submitted as part of the IMTP for 2023/24 is presented below:

| £m Deficit (Surplus)      | Apr   | May   | Jun  | Jul  | Aug  | Sep  | Oct  | Nov  | Dec  | Jan  | Feb  | Mar  | Forecast year-end position |
|---------------------------|-------|-------|------|------|------|------|------|------|------|------|------|------|----------------------------|
| Revised forecast position | 12.27 | 12.27 | 8.75 | 8.90 | 8.90 | 8.75 | 8.90 | 8.90 | 8.90 | 8.90 | 8.90 | 8.48 | 112.85                     |

The revised profile for 2023/24 with the updated forecast, current savings assessment and updated for new funding, noting the month 7 position is described as follows: -

| £m Deficit (Surplus)      | Apr   | May   | Jun   | Jul   | Aug   | Sep   | Oct     | Nov  | Dec  | Jan  | Feb  | Mar  | Forecast year-end position |
|---------------------------|-------|-------|-------|-------|-------|-------|---------|------|------|------|------|------|----------------------------|
| Revised forecast position | 13.49 | 15.98 | 14.52 | 13.11 | 14.32 | 10.74 | (40.28) | 4.08 | 3.24 | 3.62 | 2.71 | 2.12 | 57.627                     |

The Health Board is reporting a £26.9m favourable variance compared to the Annual Plan for the year to date position, as a result of the new funding received from WG.

### Risks & Opportunities (2023/24)

There are significant challenges to achieving the financial forecast for 2023/24, which include: -

#### Risks:

- Full / part delivery of the savings plans identified,
- Managing variable pay,
- Identifying savings to mitigate any further financial pressures identified outside of the IMTP,
- Full receipt and retention of all anticipated allocations,
- Workforce absence / vacancies, availability of staff for priority areas,
- Delayed transfers of care due to LA service challenges,
- Funding for any wage award and changes in terms and conditions,
- Prescribing growth in items and average cost per item,
- Further CHC fee uplifts above forecast levels and potential challenges/disputes with Councils,
- Establishment increases relating to patient safety & quality issues,
- Covid legacy costs to adhere to specific guidelines, e.g. enhanced cleaning costs, ED screening and testing unit,
- Inflationary impacts including provisions and supplies,
- Additional costs (including national programme/legal/penalty costs) in relation to LINC,

- RISP risk with regards to capital funding letters received exclusive of VAT however the VAT reclaimable is not definitively confirmed,
- WCCIS in relation to the cessation of WG supporting the use of the platform required to run it, ABUHB has invested in staff to undertake work related to phases 2 & 3. If it is decided to cease this work then the costs of these staff will no longer be eligible for Capital funding and will transfer to revenue,
- Health Protection, the HB's Annual plan delivery has always been reliant on slippage relating to HP funding. WG's recent letter stated that this funding would be based on actual costs only, therefore, the slippage is a risk to the delivery of the HB's plan.
- The new funding indicated in WG's letter was apportioned based on Commissioner shares, there is a risk that the HB will be directed to pass some of the funding through to the Providers of ABUHB's LTA services.
- IFRS 16 for PFI schemes. HM treasury has issued guidance related to the accounting / recording of the index linked payments in accordance with IFRS 16 from 2023/24. This could mean additional charges to revenue, this is being taken forward by WG colleagues.
- Specific economic factors/Ukraine conflict issues such as energy costs, supply chain issues and non-pay inflation including travel expense costs, and
- Additional national IMTP programme costs.

### **Opportunities**

- Potential energy cost reduction through new national contract,
- A share of 6 Goals funding slippage, to be confirmed with the All Wales lead,
- VAT rebates (MS Office & Oxygen),
- Velindre NICE cancer drug costs,
- Re-review of 'discounted' savings ideas,
- Driving efficiency opportunities,
- Service reconfiguration, consolidation, centralisation, and
- Maximising the opportunity to change services resulting in improved health outcomes for the population.

### **Capital**

The approved Capital Resource Limit (CRL) as at Month 7 totalled £51.944m. In addition, Charitable funds donations totalling £0.150m and disposals proceeds of £0.427m have been confirmed. The forecast outturn at Month 7, after accounting for anticipated inflation funding of £0.020m in relation to the YYF Breast Unit, is an overspend of £163k. The overspend relates to the fees and enabling works approved in relation to the GUH Emergency Department extension scheme. These

costs will be reimbursed if the business case is approved by Welsh Government (WG). This overspend risk will be managed through the capital programme to ensure financial balance.

The Health Board confirmed the CRL requirements for all All-Wales Capital Programme (AWCP) schemes at the end of October. The revised budget allocations are included in the reported month 7 position and are now fixed. **Any future slippage will need to be managed by the Health Board through brokerage with the Discretionary Capital Programme.**

Additional funding of £3.056m has been received in relation to the GUH remaining works scheme. The additional funding allows the anticipated VAT reclaim amount to be slipped to 2024/25 in line with the expected finalisation of the claim with HMRC.

The Tredegar Health and Well-being Centre scheme is forecasting an overspend of £0.478m in 2023/24 which is being funded by the Discretionary Capital programme (DCP). The total forecast overspend for the scheme is £0.758m with the balance of this amount falling into 2024/25. The handover date for phase one has been delayed to January 2024 due to delayed electricity, water and gas connections. Any additional costs accepted as part of the delay will increase the overspend that is being funded from DCP. A meeting with NWSSP took place in October to discuss the £1.137m ex VAT of unfunded costs in relation to inflation allowances on works and fees, EV charging and other required changes that are intended to be submitted as an additional funding request to WG. Conversely, further risks are identified in relation to five unresolved compensation events which total £2.006m plus VAT (including re-design of the foundations (£0.753m plus VAT), costs associated with the cancellation of the brick supply (£0.644m plus VAT) and the delay associated with the remedial works to the heart floor slab (£0.367m plus VAT)) which are not currently built into the forecast outturn. If these claims are found to be valid, they will significantly increase the reported overspend position.

The works to NHH Satellite Radiotherapy Centre Scheme are progressing. A 10-week delay has been confirmed due to the adverse ground conditions under the now demolished Ante Natal Clinic. This has resulted in a compensation event being awarded to the contractor of £0.468m plus VAT. The revised completion date is now February 2025. The 2023/24 CRL allocation has been reduced in October by £0.975m in line with the contractor's current cash flow forecast. The overall scheme remains within budget.

Works at the YF Breast Centralisation Unit are on schedule to complete by December 2023. The building will then be commissioned by January 2024. The scheme is currently forecasting an overspend against the approved CRL of £0.020m, however, inflation funding is available within the unapproved section of the CRL to offset this amount once it has been confirmed.

WG have agreed a CRL reduction of £0.607m for the Newport East H&WBC scheme because of slippage into 2024/25. The revised outturn is based on the works currently progressing at around 15 weeks behind original programme. There is a

forecast overspend of £0.387m on the project overall which will impact on the 2024/25 DCP unless mitigated by additional funding and / or value engineering savings.

RGH Endoscopy unit was opened on the 6th November. WG have approved for the Health Board to retain the expected VAT savings (£232k) to enable the purchase of additional scope guides and scopes in relation to Bowel Screening patients.

The RGH Blocks 1 & 2 Demolitions and Car Park scheme is forecasting an overspend of £0.106m due to higher than anticipated asbestos removal costs and the requirement to board up the building whilst the scheme is delayed due to nesting birds. The building has now been demolished. A further potential risk in relation to asbestos is being costed by the Facilities Division and will be reported in the Month 8 position. This overspend is being offset by the DCP.

Slippage of £0.196m has been agreed in relation to the EFAB allocations. Slippage on the allocations agreed for the Glan Usk roof replacement and Cordell Centre infrastructure upgrades have been partially offset through the acceleration of the replacement RGH Fire Alarm scheme.

The Outline Business Case for the Mental Health SISU has been submitted to WG for approval. The scrutiny process is on-going. The CRL allocation has been reduced by £ £0.126m in month in line with the underspend achieved against the OBC stage.

Slippage of £0.227m has been agreed against the CAMHS Sanctuary Hub scheme. The Stage 4 design is now complete with the works expected to go to tender mid-November.

The Health Board Discretionary Capital Programme (DCP) funding available for 2023/24 is £7.041m made up of:

- 2023/24 DCP Funding - £9.521m (a reduction of 12% compared to 2021/22)
- Less 30% EFAB contribution - (£0.629m)
- Less 2022/23 AWCP scheme brokerage - (£2.278m)
- NBV of Assets Disposed (E Block disposals) - £0.427m

The opening DCP for 2023/24 was approved at the January 2023 Board meeting. The current forecast spend for approved DCP schemes is £6.588m generating an underspend against DCP of £0.453m. This saving is being used to partially offset overspends on AWCP schemes (mainly Tredegar H&WBC £0.478m and RGH Blocks 1&2 £0.106m). The programme contains two large schemes (GUH ED Extension fees (£0.893m) and Phase one NHH RAAC Urgent Works (£0.250m)) which will be submitted to WG for approval with the intention of being reimbursed in the current financial year. The Business Justification Case for the GUH ED extension was submitted to WG for approval in October.

There are also further significant requirements that are not currently included in the approved DCP funding total including capital works associated with the lease at Ty Gwent (£1.3m), costs associated with phase two remedial works required in relation to RAAC at NHH (costs TBC) and the RGH Pharmacy robot replacement (£710k).

These risks are in addition to the high number of bids submitted by divisions for essential works and end of life IT and equipment replacements.

Potential additional funding sources are available to offset some of the pressures. These include the additional funding bid in relation to Tredegar H&WBC unfunded inflation and costs outside of the FBC approval and the potential reimbursement of fees (previously funded from DCP) in relation to the GUH ED Extension (£1.003m) and RGH Decontamination (£0.114m) schemes. These reimbursements are dependent on the business cases for these schemes being approved within the current financial year.

## **Cash**

The cash balance on the 31<sup>st</sup> of October is £4.502m, which is below the advisory figure set by Welsh Government of £6m.

As part of the mid-year financial review the Board has given approval for the executive to submit a request for the necessary strategic cash support for 2023/24 as a result of the deficit position.

## **Public Sector Payment Policy (PSPP)**

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods in October and cumulatively (97.1% year to date). There has been an increase in the number & value of NHS invoices paid within 30 days this month & cumulatively. We are continuing to work with those departments where invoices are being processed outside of the 30-day payment terms and at the NHS payment rate.

## **Argymhelliad / Recommendation**

### **The Board is asked to note for assurance:**

- The financial performance at the end of October 2023 and forecast position against the statutory revenue and capital resource limits,
- The savings position for 2023/24,
- The revenue reserve position on the 31<sup>st</sup> of October 2023,
- The Health Board's underlying financial position,
- The capital position,
- The month 7 MMR report, and
- The early brief provided for the November 2023 position.

Note the appendices attached providing further information.

Appendices:



F&PC appendix 2

Board%20Finance%20Report%20appendix 2  
MMR 23-24 M7....

**Amcanion: (rhaid cwblhau)**  
**Objectives: (must be completed)**

|   |   |
|---|---|
| Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol:<br>Datix Risk Register Reference and Score:                                    |   |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):  | 7. Staff and Resources<br>Governance, Leadership & Accountability<br>All Health & Care Standards Apply<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br><a href="#">Link to IMTP</a>  | Adults in Gwent live healthily and age well   |
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP  | Finance   |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><br><a href="#">Strategic Equality Objectives 2020-24</a> | Improve the Wellbeing and engagement of our staff<br>Choose an item.<br>Choose an item.<br>Choose an item.                |

**Gwybodaeth Ychwanegol:**  
**Further Information:**

|  |  |
|--|--|
| Ar sail tystiolaeth:<br>Evidence Base: | ABUHB efficiency compendium  |
| Rhestr Termau:<br>Glossary of Terms:   | A&C – Administration & Clerical<br>A&E – Accident & Emergency<br>A4C - Agenda for Change<br>AME – (WG) Annually Managed Expenditure<br>AQF – Annual Quality Framework<br>AWCP – All Wales Capital Programme<br>AP – Accounts Payable<br>AOF – Annual Operating Framework |



ATMP – Advanced Therapeutic Medicinal Products  
 B/F – Brought Forward  
 BH – Bank Holiday  
 C&V – Cardiff and Vale  
 CAMHS – Child & Adolescent Mental Health Services  
 C/F – Carried Forward  
 CHC – Continuing Health Care  
 Commissioned Services – Services purchased external to ABUHB both within and outside Wales  
 COTE – Care of the Elderly  
 CRL – Capital Resource Limit  
 Category M – category of drugs  
 CEO – Chief Executive Officer  
 CEAU – Children’s Emergency Assessment Unit  
 CTM – Cwm Taf Morgannwg  
 D&C – Demand & Capacity  
 DCP – Discretionary Capital Programme  
 DHR – Digital Health Record  
 DNA – Did Not Attend  
 DOSA – Day of Surgery Admission  
 D2A – Discharge to Assess  
 DoLS - Deprivation of Liberty Safeguards  
 DoF – Director(s) of Finance  
 DTOC – Delayed Transfer of Care  
 EASC – Emergency Ambulance Services Committee  
 ED – Emergency Department  
 EDCIMS – Emergency Department Clinical Information Management System  
 eLGH – Enhanced Local general Hospital  
 EFAB – Estates Funding Advisory Board  
 ENT – Ear, Nose and Throat specialty  
 EoY – End of Year  
 ETTF – Enabling Through Technology Fund  
 F&T – Family & Therapies (Division)  
 FBC – Full Business Case  
 FNC – Funded Nursing Care  
 GDS – General Dental Services  
 GMS – General Medical Services  
 GP – General Practitioner  
 GWICES – Gwent Wide Integrated Community Equipment Service  
 GUH – Grange University Hospital  
 GIRFT – Getting it Right First Time  
 HCHS – Health Care & Hospital Services  
 HCSW – Health Care Support Worker

HIV – Human Immunodeficiency Virus  
 HSDU – Hospital Sterilisation and Disinfection Unit  
 H&WBC – Health and Well-Being Centre  
 IMTP – Integrated Medium Term Plan  
 INNU – Interventions not normally undertaken  
 IPTR – Individual Patient Treatment Referral  
 I&E – Income & Expenditure  
 ICF – Integrated Care Fund  
 LoS – Length of Stay  
 LTA – Long Term Agreement  
 LD – Learning Disabilities  
 MH – Mental Health  
 MSK - Musculoskeletal  
 Med – Medicine (Division)  
 MCA – Mental Capacity Act  
 MDT – Multi-disciplinary Team  
 MMR – Welsh Government Monthly Monitoring Return  
 NCA – Non-contractual agreements  
 NCN – Neighbourhood Care Network  
 NCSO – No Cheaper Stock Obtainable  
 NI – National Insurance  
 NICE – National Institute for Clinical Excellence  
 NHH – Neville Hall Hospital  
 NWSSP – NHS Wales Shared Services Partnership  
 ODTC – Optometric Diagnostic and Treatment Centre  
 OD – Organisation Development  
 PAR – Prescribing Audit Report  
 PCN – Primary Care Networks (Primary Care Division)  
 PER – Prescribing Incentive Scheme  
 PICU – Psychiatric Intensive Care Unit  
 PrEP – Pre-exposure prophylaxis  
 PSNC –Pharmaceutical Services Negotiating Committee  
 PSPP – Public Sector Payment Policy  
 PCR – Patient Charges Revenue  
 PPE – Personal Protective Equipment  
 PFI – Private Finance Initiative  
 RGH – Royal Gwent Hospital  
 RN – Registered Nursing  
 RRL – Revenue Resource Limit  
 RTT – Referral to Treatment  
 RPB – Regional Partnership Board  
 RIF – Regional Integration Fund  
 SCCC – Specialist Critical Care Centre

|  |  |
|--|--|
|  | <p>SCH – Scheduled Care Division<br/> SCP – Service Change Plan (reference IMTP)<br/> SLF – Straight Line Forecast<br/> SpR – Specialist Registrar<br/> STW – St.Woolos Hospital<br/> TCS – Transforming Cancer Services (Velindre programme)<br/> T&amp;O – Trauma &amp; Orthopaedics<br/> TAG – Technical Accounting Group<br/> UHB / HB – University Health Board / Health Board<br/> USC – Unscheduled Care (Division)<br/> UC – Urgent Care (Division)<br/> ULP – Underlying Financial Position<br/> VCCC – Velindre Cancer Care Centre<br/> VERS – Voluntary Early Release Scheme<br/> WET AMD – Wet age-related macular degeneration<br/> WG – Welsh Government<br/> WHC – Welsh Health Circular<br/> WHSSC – Welsh Health Specialised Services Committee<br/> WLI – Waiting List Initiative<br/> WLIMS – Welsh Laboratory Information Management System<br/> WRP – Welsh Risk Pool<br/> YAB – Ysbyty Aneurin Bevan<br/> YTD – Year to date<br/> YYF – Ysbyty Ystrad Fawr</p> |
| <p>Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br/> Parties / Committees consulted prior to University Health Board:</p> | <p>Finance &amp; Performance Committee</p>   |

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

**Deddf Llesiant  
Cenedlaethau'r Dyfodol – 5  
ffordd o weithio  
Well Being of Future  
Generations Act – 5 ways  
of working**

<https://futuregenerations.wales/about-us/future-generations-act/>

Long Term - The importance of balancing short-term needs with the needs to safeguard the ability to also meet long-term needs  
Prevention - How acting to prevent problems occurring or getting worse may help public bodies meet their objectives

|   |
|---|
| <b>Aneurin Bevan University Health Board</b>      |
| <b>Finance Report – October (Month 7) 2023/24</b> |
| <b>Appendices</b>                                 |

| <b>Section</b>                            | <b>Page Number(s)</b> |
|---|-----------------------|
| Pay Summary 1                             | 2                     |
| Pay Summary 2 Substantive Pay             | 3                     |
| Pay Summary 3 Variable Pay                | 4                     |
| Non Pay Summary                           | 5                     |
| RTT & Waiting List Initiatives            | 6-7                   |
| Divisional analysis                       | 8-19                  |
| National Covid-19 Funding Assumptions     | 20                    |
| Reserves                                  | 21                    |
| Cash / Public Sector Payment Policy       | 22                    |
| External Contracts – LTA's                | 23                    |
| External Contracts – Specialised Services | 24                    |
| Balance sheet                             | 25                    |
| Health Board Income                       | 26                    |
| Capital Planning & Performance            | 27                    |

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



### Substantive (£'000)

| Pay category                      | Apr-23        | May-23        | Jun-23        | Jul-23        | Aug-23        | Sep-23        | Oct-23        | Change       | %           | Avg 22/23     |
|-----------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|--------------|-------------|---------------|
| ADD PROF SCIENTIFIC AND TECHNICAL | 1,975         | 1,989         | 2,427         | 2,429         | 2,163         | 2,150         | 2,139         | -10          | -0.5%       | 2,027         |
| ADDITIONAL CLINICAL SERVICES      | 7,299         | 7,742         | 10,215        | 9,152         | 8,071         | 7,755         | 7,816         | 61           | 0.8%        | 7,113         |
| ADMINISTRATIVE & CLERICAL         | 9,660         | 9,674         | 12,471        | 11,514        | 10,101        | 9,893         | 10,076        | 183          | 1.9%        | 9,427         |
| ALLIED HEALTH PROFESSIONALS       | 3,773         | 3,817         | 4,803         | 4,508         | 4,000         | 4,009         | 4,035         | 26           | 0.6%        | 3,839         |
| ESTATES AND ANCILLIARY            | 2,735         | 2,875         | 3,777         | 3,342         | 2,974         | 2,875         | 2,868         | -7           | -0.3%       | 2,781         |
| HEALTHCARE SCIENTISTS             | 1,055         | 1,071         | 1,334         | 1,238         | 1,118         | 1,111         | 1,112         | 1            | 0.1%        | 1,039         |
| MEDICAL AND DENTAL                | 12,849        | 12,877        | 13,153        | 13,297        | 13,297        | 13,213        | 16,884        | 3,671        | 27.8%       | 13,085        |
| NURSING AND MIDWIFERY REGISTERED  | 15,206        | 15,802        | 19,843        | 18,278        | 16,143        | 15,996        | 16,281        | 286          | 1.8%        | 15,604        |
| STUDENTS                          | 4             | 4             | 6             | 5             | 4             | 4             | 2             | -3           | -63.6%      | 9             |
| <b>Total</b>                      | <b>54,556</b> | <b>55,849</b> | <b>68,028</b> | <b>63,763</b> | <b>57,871</b> | <b>57,006</b> | <b>61,213</b> | <b>4,207</b> | <b>7.4%</b> | <b>54,923</b> |

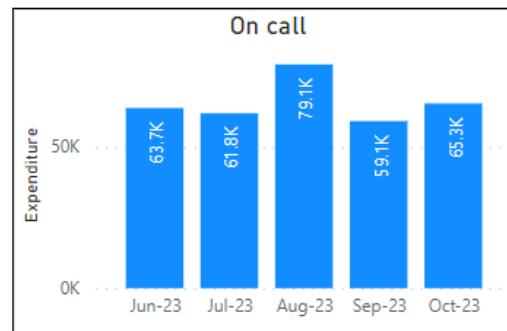
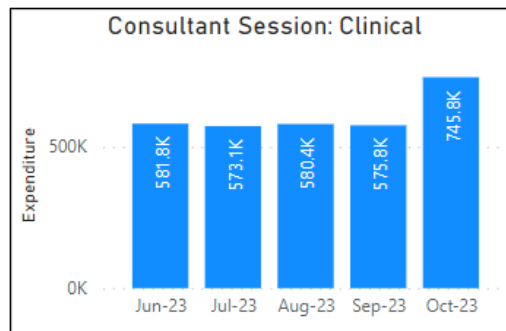
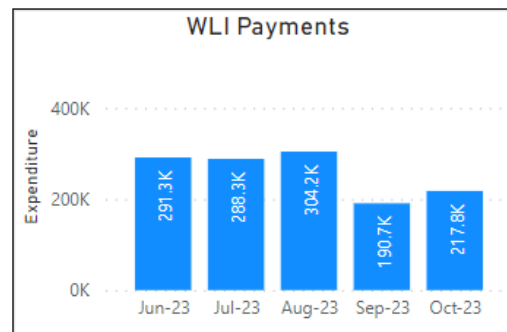
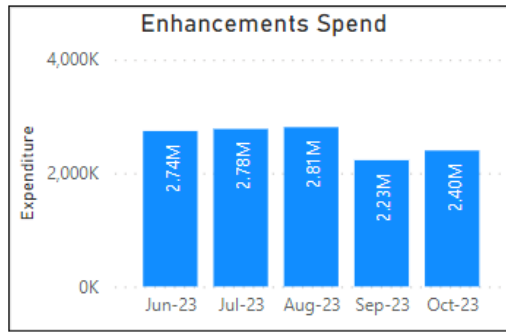
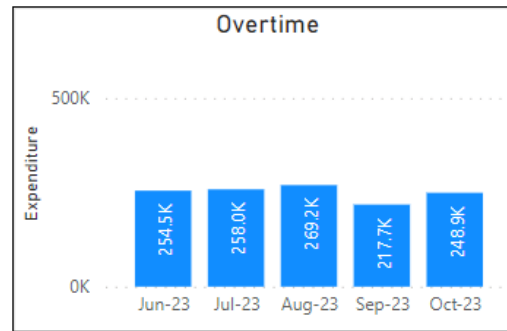
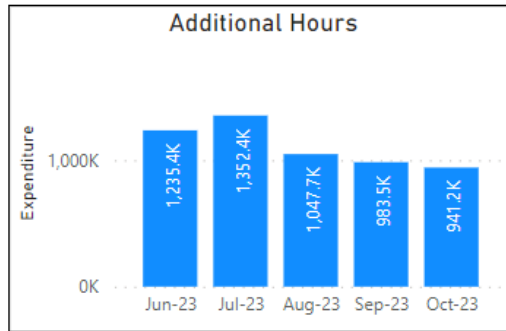
### Variable pay (£'000)

| Pay category | Apr-23       | May-23       | Jun-23       | Jul-23       | Aug-23       | Sep-23       | Oct-23       | Change      | %            | Avg 22/23    |
|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|-------------|--------------|--------------|
| Bank         | 4,125        | 3,823        | 4,242        | 4,568        | 4,460        | 3,480        | 3,519        | -338        | -8.8%        | 5,074        |
| Agency       | 3,873        | 4,781        | 3,827        | 3,724        | 3,913        | 3,835        | 3,497        | 39          | 1.1%         | 3,831        |
| Locum        | 233          | 234          | 286          | 311          | 285          | 267          | 349          | 82          | 30.6%        | 260          |
| <b>Total</b> | <b>8,230</b> | <b>8,838</b> | <b>8,355</b> | <b>8,603</b> | <b>8,658</b> | <b>7,582</b> | <b>7,365</b> | <b>-217</b> | <b>-2.9%</b> | <b>9,165</b> |

### Total pay (£'000)

| Pay category | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Change | %    | Avg 22/23 |
|--------------|--------|--------|--------|--------|--------|--------|--------|--------|------|-----------|
| Pay          | 62,786 | 64,687 | 76,383 | 72,366 | 66,529 | 64,588 | 68,578 | 3,990  | 6.2% | 64,089    |

## Pay Summary (2): Substantive Pay



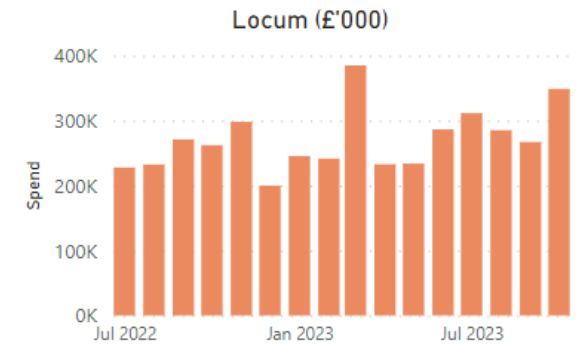
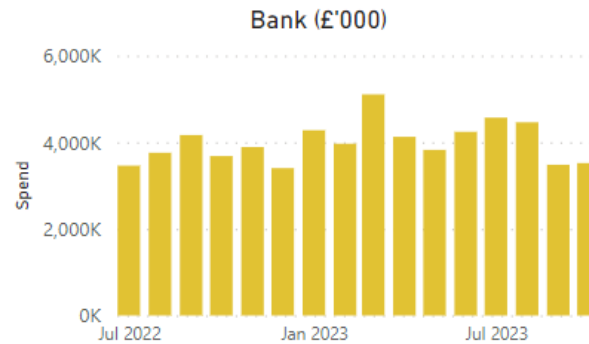
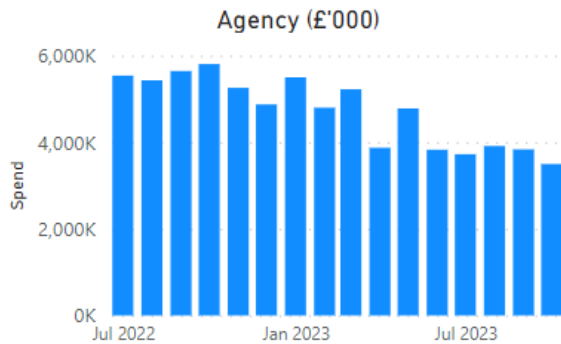
### Analysis type by Division

| Analysis type                             | Jun-23       | Jul-23       | Aug-23       | Sep-23       | Oct-23       | Total         |
|---|--------------|--------------|--------------|--------------|--------------|---------------|
| <b>Enhancements</b>                       |              |              |              |              |              |               |
| Medicine                                  | 493          | 513          | 532          | 410          | 434          | 2,381         |
| Scheduled Care                            | 402          | 415          | 434          | 337          | 366          | 1,954         |
| Estates and Facilities Division           | 371          | 392          | 394          | 346          | 340          | 1,843         |
| Primary Care and Community                | 430          | 386          | 335          | 257          | 324          | 1,732         |
| Family and Therapies                      | 323          | 330          | 352          | 279          | 299          | 1,583         |
| Mental Health and LD                      | 253          | 261          | 266          | 205          | 212          | 1,198         |
| Urgent Care                               | 212          | 213          | 220          | 177          | 186          | 1,008         |
| CHC and FNC                               | 109          | 113          | 119          | 93           | 101          | 535           |
| Clinical Support Services                 | 106          | 113          | 118          | 95           | 99           | 532           |
| Corporate                                 | 43           | 40           | 35           | 27           | 36           | 180           |
| <b>Total</b>                              | <b>2,740</b> | <b>2,776</b> | <b>2,807</b> | <b>2,226</b> | <b>2,396</b> | <b>12,945</b> |
| <b>ADDITIONAL HOURS</b>                   | <b>1,235</b> | <b>1,352</b> | <b>1,048</b> | <b>984</b>   | <b>941</b>   | <b>5,560</b>  |
| <b>CONSULTANTS SESSION: CLINICAL</b>      | <b>582</b>   | <b>573</b>   | <b>580</b>   | <b>576</b>   | <b>746</b>   | <b>3,057</b>  |
| <b>WAITING LIST PAYMENTS: CONSULTANTS</b> |              |              |              |              |              |               |
| Clinical Support Services                 | 157          | 131          | 137          | 104          | 130          | 658           |
| Medicine                                  | 95           | 102          | 92           | 78           | 70           | 436           |
| Scheduled Care                            | 43           | 51           | 77           | 3            | 8            | 182           |
| Family and Therapies                      | -3           | 3            |              | 4            | 6            | 10            |
| Primary Care and Community                |              |              |              | 2            | 3            | 6             |
| <b>Total</b>                              | <b>291</b>   | <b>287</b>   | <b>306</b>   | <b>191</b>   | <b>218</b>   | <b>1,292</b>  |
| <b>Overtime</b>                           | <b>255</b>   | <b>258</b>   | <b>269</b>   | <b>218</b>   | <b>249</b>   | <b>1,248</b>  |
| <b>ON CALL</b>                            | <b>64</b>    | <b>62</b>    | <b>79</b>    | <b>59</b>    | <b>65</b>    | <b>329</b>    |
| <b>Total</b>                              | <b>5,167</b> | <b>5,308</b> | <b>5,089</b> | <b>4,253</b> | <b>4,615</b> | <b>24,432</b> |

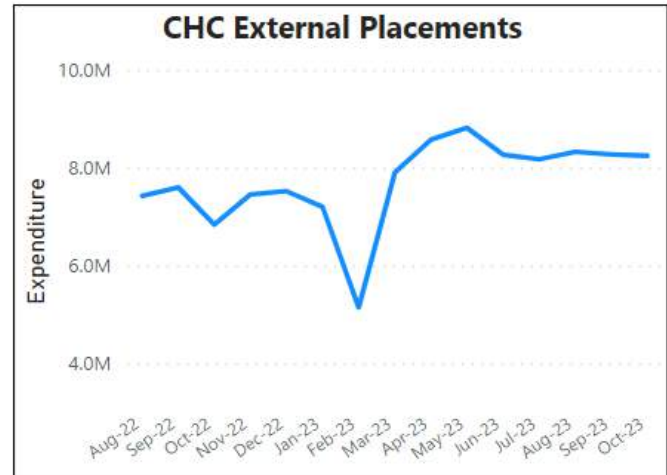
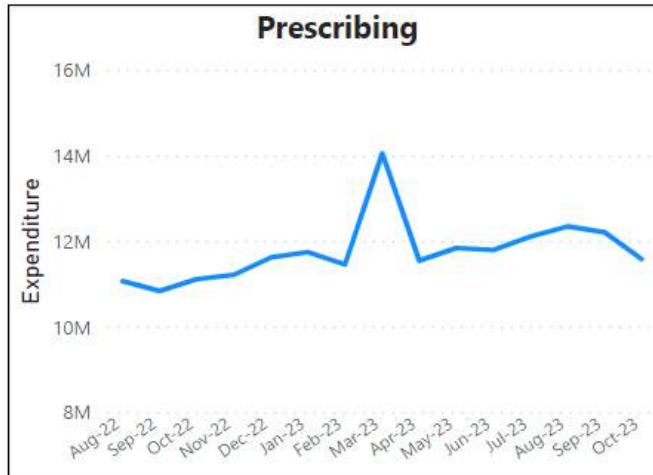
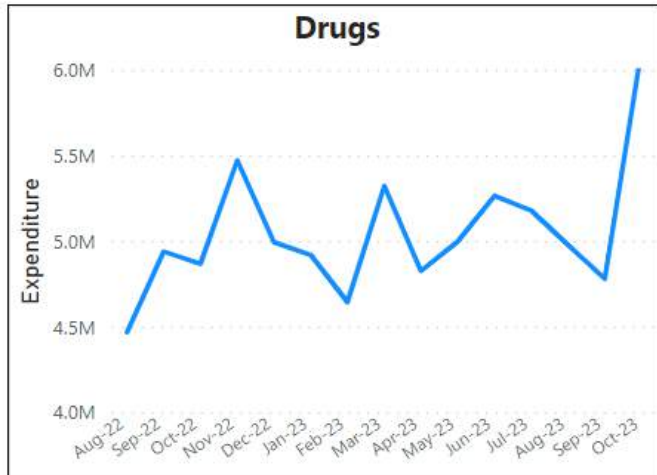
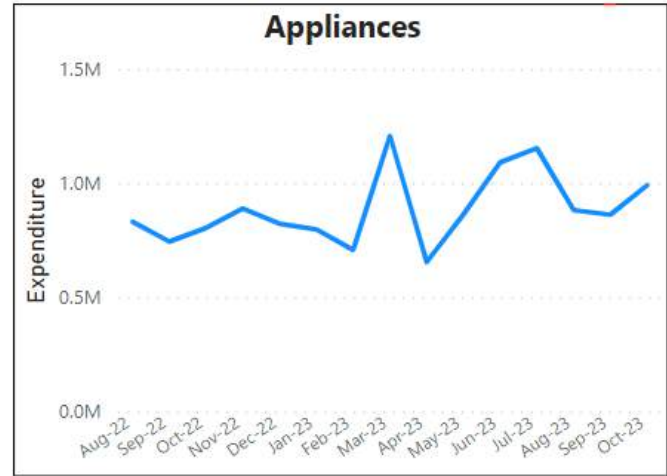
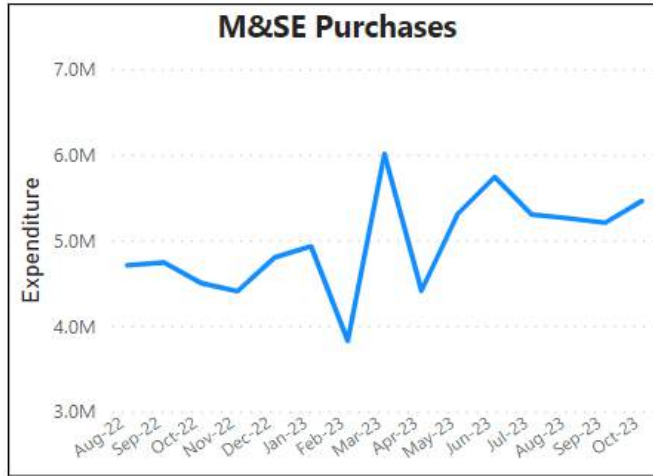
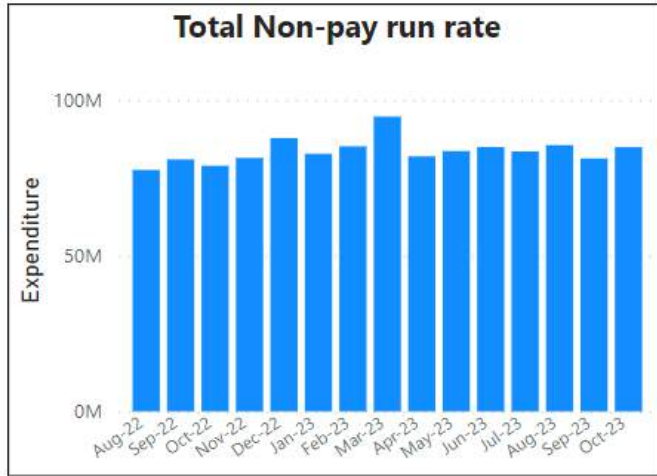


### Pay Summary (3): Variable Pay (£'k)

| Pay category                | Jul-22       | Aug-22       | Sep-22        | Oct-22       | Nov-22       | Dec-22       | Jan-23        | Feb-23       | Mar-23        | Apr-23       | May-23       | Jun-23       | Jul-23       | Aug-23       | Sep-23       | Oct-23       | Change      | %            |  |
|-----------------------------|--------------|--------------|---------------|--------------|--------------|--------------|---------------|--------------|---------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|-------------|--------------|--|
| <b>Agency</b>               |              |              |               |              |              |              |               |              |               |              |              |              |              |              |              |              |             |              |  |
| Admin & Clerical Agency     | 204          | 126          | 118           | 85           | 124          | 152          | 79            | 10           | 147           | 72           | 64           | 77           | 49           | 41           | 39           | 86           | 46          | 117.1%       |  |
| Allied Health Prof Agency   | 155          | 97           | 319           | 187          | 279          | 108          | 232           | 188          | 165           | 171          | 219          | 147          | 196          | 196          | 192          | 123          | -69         | -36.0%       |  |
| Estates & Ancilliary Agency | 663          | 669          | 623           | 635          | 583          | 602          | 639           | 560          | 1,036         | 683          | 675          | 483          | 490          | 341          | 471          | 489          | 18          | 3.9%         |  |
| Medical Agency              | 1,439        | 1,265        | 1,179         | 1,503        | 1,321        | 1,261        | 1,377         | 1,336        | 1,271         | 1,162        | 2,025        | 1,474        | 1,165        | 1,399        | 1,093        | 1,091        | -2          | -0.2%        |  |
| Nurse HCA/HCSW Agency       | 1,122        | 1,080        | 1,092         | 1,135        | 975          | 977          | 980           | 798          | 690           | 293          | 339          | 209          | 160          | 236          | 183          | 89           | -95         | -51.6%       |  |
| Other Agency                | 88           | 146          | 100           | 105          | 116          | 37           | 53            | 64           | 105           | 58           | 70           | 43           | 90           | 49           | 50           | 46           | -4          | -8.6%        |  |
| Registered Nurse Agency     | 1,867        | 2,048        | 2,213         | 2,155        | 1,859        | 1,737        | 2,139         | 1,842        | 1,810         | 1,434        | 1,387        | 1,394        | 1,575        | 1,650        | 1,807        | 1,574        | -233        | -12.9%       |  |
| <b>Total</b>                | <b>5,538</b> | <b>5,430</b> | <b>5,644</b>  | <b>5,806</b> | <b>5,256</b> | <b>4,873</b> | <b>5,500</b>  | <b>4,798</b> | <b>5,224</b>  | <b>3,873</b> | <b>4,781</b> | <b>3,827</b> | <b>3,724</b> | <b>3,913</b> | <b>3,835</b> | <b>3,497</b> | <b>-338</b> | <b>-8.8%</b> |  |
| <b>Bank</b>                 |              |              |               |              |              |              |               |              |               |              |              |              |              |              |              |              |             |              |  |
| Admin & Clerical Bank       | 101          | 105          | 136           | 104          | 108          | 80           | 109           | 88           | 123           | 94           | 86           | 108          | 114          | 92           | 92           | 82           | -9          | -10.2%       |  |
| Estates & Ancilliary Bank   | 181          | 192          | 217           | 169          | 151          | 155          | 156           | 158          | 204           | 138          | 142          | 166          | 216          | 201          | 215          | 216          | 2           | 0.8%         |  |
| Nurse HCA/HCSW Bank         | 1,243        | 1,408        | 1,660         | 1,378        | 1,455        | 1,249        | 1,614         | 1,452        | 1,765         | 1,598        | 1,485        | 1,635        | 1,811        | 1,816        | 1,438        | 1,520        | 82          | 5.7%         |  |
| Other Bank                  | 0            | 0            | 0             | 0            | 0            | 0            | 0             | 0            | 0             | 0            | 0            | 0            | 1            | -1           | 0            | 2            | 2           | -6007.0%     |  |
| Registered Nurse Bank       | 1,934        | 2,052        | 2,154         | 2,031        | 2,175        | 1,918        | 2,397         | 2,268        | 3,014         | 2,295        | 2,110        | 2,332        | 2,425        | 2,352        | 1,736        | 1,699        | -37         | -2.1%        |  |
| <b>Total</b>                | <b>3,460</b> | <b>3,757</b> | <b>4,166</b>  | <b>3,681</b> | <b>3,889</b> | <b>3,402</b> | <b>4,277</b>  | <b>3,966</b> | <b>5,105</b>  | <b>4,125</b> | <b>3,823</b> | <b>4,242</b> | <b>4,568</b> | <b>4,460</b> | <b>3,480</b> | <b>3,519</b> | <b>39</b>   | <b>1.1%</b>  |  |
| <b>Locum</b>                |              |              |               |              |              |              |               |              |               |              |              |              |              |              |              |              |             |              |  |
| Medical Locum               | 228          | 232          | 271           | 262          | 298          | 200          | 245           | 241          | 385           | 233          | 234          | 286          | 311          | 285          | 267          | 349          | 82          | 30.6%        |  |
| <b>Total</b>                | <b>228</b>   | <b>232</b>   | <b>271</b>    | <b>262</b>   | <b>298</b>   | <b>200</b>   | <b>245</b>    | <b>241</b>   | <b>385</b>    | <b>233</b>   | <b>234</b>   | <b>286</b>   | <b>311</b>   | <b>285</b>   | <b>267</b>   | <b>349</b>   | <b>82</b>   | <b>30.6%</b> |  |
| <b>Total</b>                | <b>9,226</b> | <b>9,420</b> | <b>10,082</b> | <b>9,749</b> | <b>9,443</b> | <b>8,475</b> | <b>10,022</b> | <b>9,006</b> | <b>10,713</b> | <b>8,230</b> | <b>8,838</b> | <b>8,355</b> | <b>8,603</b> | <b>8,658</b> | <b>7,582</b> | <b>7,365</b> | <b>-217</b> | <b>-2.9%</b> |  |



**Non-Pay Summary:**



## Referral to Treatment (RTT):

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

- Elective Treatments for October '23 was 2,226 (September '23: 2,187, 2022/23 total: 22,327, 2019/20 total: 28,004)

| Planned Treatments (M07)   |       |          |     |       |       | Actual Treatments (M07)    |       |          |     |       |       | Treatment Variance (M07) |       |          |     |       |       |
|----------------------------|-------|----------|-----|-------|-------|----------------------------|-------|----------|-----|-------|-------|--------------------------|-------|----------|-----|-------|-------|
| Treatment                  | Core  | Backfill | WLI | Other | Total | Treatment                  | Core  | Backfill | WLI | Other | Total | Treatment                | Core  | Backfill | WLI | Other | Total |
| N107-Dermatology           | 261   | 0        |     | 0     | 261   | N107-Dermatology           | 200   | 26       | 0   | 0     | 226   | Derm                     | (61)  | 26       | 0   | 0     | (35)  |
| N147-ENT                   | 156   | 0        |     | 0     | 156   | N147-ENT                   | 134   | 0        | 0   | 0     | 134   | ENT                      | (22)  | 0        | 0   | 0     | (22)  |
| N105-General Surgery       | 308   | 56       |     | 0     | 364   | N105-General Surgery       | 349   | 38       | 0   | 0     | 387   | GS                       | 41    | (18)     | 0   | 0     | 23    |
| N146-Oral Surgery          | 172   | 12       |     | 0     | 184   | N146-Oral Surgery          | 217   | 0        | 0   | 0     | 217   | Max Fax                  | 45    | (12)     | 0   | 0     | 33    |
| N148-Ophthalmology         | 393   | 0        |     | 0     | 393   | N148-Ophthalmology         | 231   | 0        | 0   | 0     | 231   | Ophth                    | (162) | 0        | 0   | 0     | (162) |
| N108-Rheumatology          | 0     | 0        |     | 0     | 0     | N108-Rheumatology          | 0     | 0        | 0   | 0     | 0     | Rheum                    | 0     | 0        | 0   | 0     | 0     |
| N115-Trauma & Orthopaedics | 655   | 138      |     | 0     | 793   | N115-Trauma & Orthopaedics | 500   | 0        | 0   | 0     | 500   | T&O                      | (155) | (138)    | 0   | 0     | (293) |
| N106-Urology               | 539   | 0        |     | 0     | 539   | N106-Urology               | 525   | 6        | 0   | 0     | 531   | Urology                  | (14)  | 6        | 0   | 0     | (8)   |
|                            | 2,484 | 206      | 0   | 0     | 2,690 |                            | 2,156 | 70       | 0   | 0     | 2,226 |                          | (328) | (136)    | 0   | 0     | (464) |

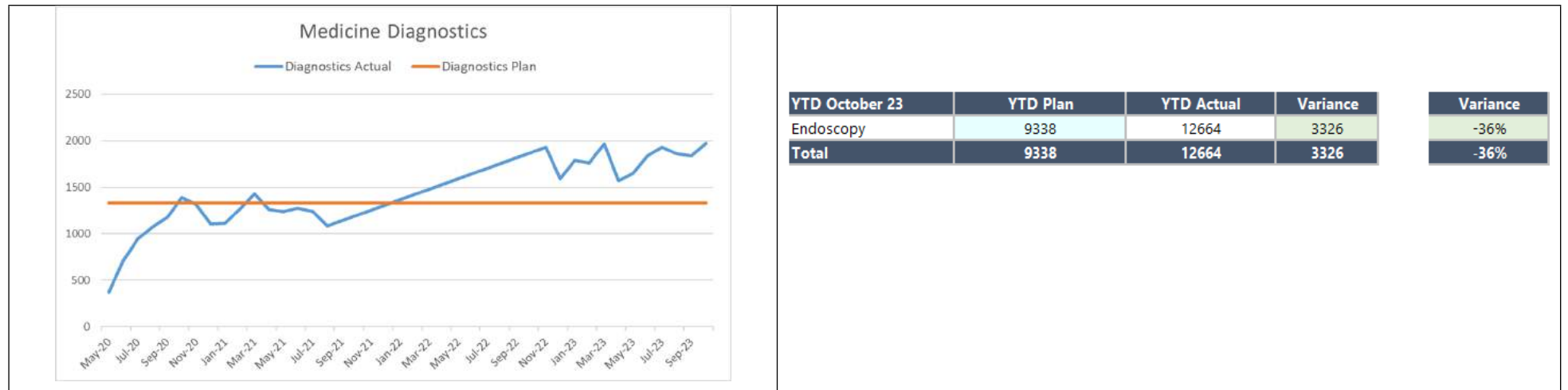
- Outpatient activity for October '23 was 6,229 (September '23: 5,819, 2022/23 total: 65,873, 2019/20 total: 75,707)

| Planned Outpatients (M07)  |       |          |     |       |       | Actual Outpatients (M07)   |       |          |     |       |       | Outpatient Variance (M07) |         |          |     |       |         |
|----------------------------|-------|----------|-----|-------|-------|----------------------------|-------|----------|-----|-------|-------|---------------------------|---------|----------|-----|-------|---------|
| Outpatient                 | Core  | Backfill | WLI | Other | Total | Outpatient                 | Core  | Backfill | WLI | Other | Total | Outpatient                | Core    | Backfill | WLI | Other | Total   |
| N107-Dermatology           | 1,501 | 0        |     | 0     | 1,501 | N107-Dermatology           | 963   | 0        | 0   | 0     | 963   | Derm                      | (538)   | 0        | 0   | 0     | (538)   |
| N147-ENT                   | 716   | 0        |     | 0     | 716   | N147-ENT                   | 573   | 0        | 0   | 0     | 573   | ENT                       | (143)   | 0        | 0   | 0     | (143)   |
| N105-General Surgery       | 1,916 | 0        |     | 0     | 1,916 | N105-General Surgery       | 1,639 | 174      | 21  | 0     | 1,834 | GS                        | (277)   | 174      | 21  | 0     | (82)    |
| N146-Oral Surgery          | 369   | 40       |     | 0     | 409   | N146-Oral Surgery          | 439   | 0        | 3   | 0     | 442   | Max Fax                   | 70      | (40)     | 3   | 0     | 33      |
| N148-Ophthalmology         | 797   | 0        |     | 0     | 797   | N148-Ophthalmology         | 561   | 15       | 0   | 0     | 576   | Ophth                     | (236)   | 15       | 0   | 0     | (221)   |
| N108-Rheumatology          | 194   | 0        |     | 0     | 194   | N108-Rheumatology          | 211   | 0        | 0   | 0     | 211   | Rheum                     | 17      | 0        | 0   | 0     | 17      |
| N115-Trauma & Orthopaedics | 1,722 | 307      |     | 0     | 2,029 | N115-Trauma & Orthopaedics | 1,046 | 66       | 0   | 0     | 1,112 | T&O                       | (676)   | (241)    | 0   | 0     | (917)   |
| N106-Urology               | 518   | 18       |     | 0     | 536   | N106-Urology               | 491   | 0        | 27  | 0     | 518   | Urology                   | (27)    | (18)     | 27  | 0     | (18)    |
|                            | 7,733 | 365      | 0   | 0     | 8,098 |                            | 5,923 | 255      | 51  | 0     | 6,229 |                           | (1,810) | (110)    | 51  | 0     | (1,869) |

**Medicine Outpatients activity for October '23 was 1,954 (September '23: 2,023, 2022/23: 19,258):**

| Oct-23                  |                          |                 |             | Oct-23                  |              |              |              |
|-------------------------|--------------------------|-----------------|-------------|-------------------------|--------------|--------------|--------------|
|                         | Assumed monthly activity | Actual activity | Variance    | YTD Oct-23              | YTD Plan     | YTD Actual   | Variance     |
| Gastroenterology        | 475                      | 373             | -102        | Gastroenterology        | 3325         | 2764         | -561         |
| Cardiology              | 430                      | 466             | 36          | Cardiology              | 3010         | 3023         | 13           |
| Respiratory (inc Sleep) | 455                      | 411             | -44         | Respiratory (inc Sleep) | 3185         | 3275         | 90           |
| Neurology               | 257                      | 341             | 84          | Neurology               | 1799         | 1969         | 170          |
| Endocrinology           | 186                      | 143             | -43         | Endocrinology           | 1302         | 1168         | -134         |
| Geriatric Medicine      | 313                      | 220             | -93         | Geriatric Medicine      | 2191         | 1464         | -727         |
| <b>Total</b>            | <b>2116</b>              | <b>1954</b>     | <b>-162</b> | <b>Total</b>            | <b>14812</b> | <b>13663</b> | <b>-1149</b> |

**Medicine Diagnostics activity for October '23 was 1,973 (September '23: 1,838, 2022/23: 36,246):**

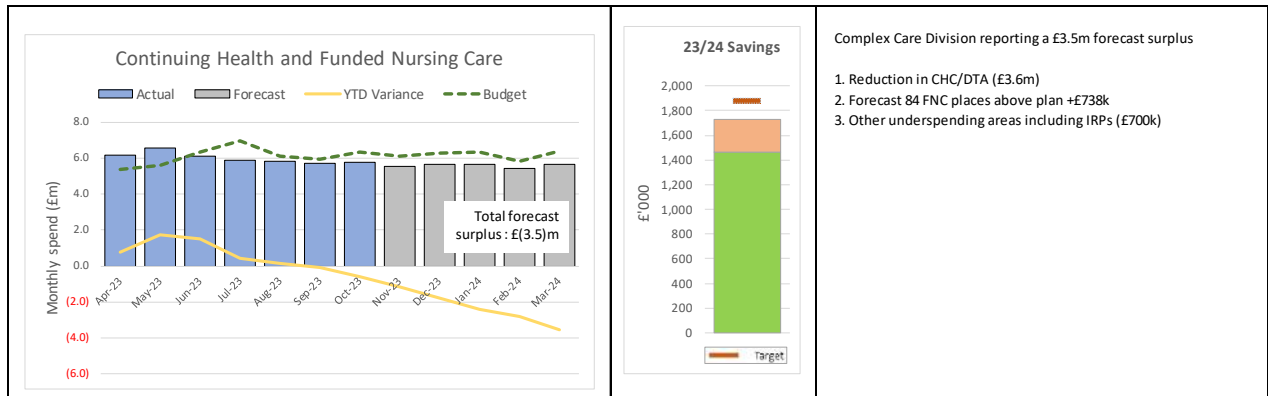


# Divisional analysis – Clinical Support Services



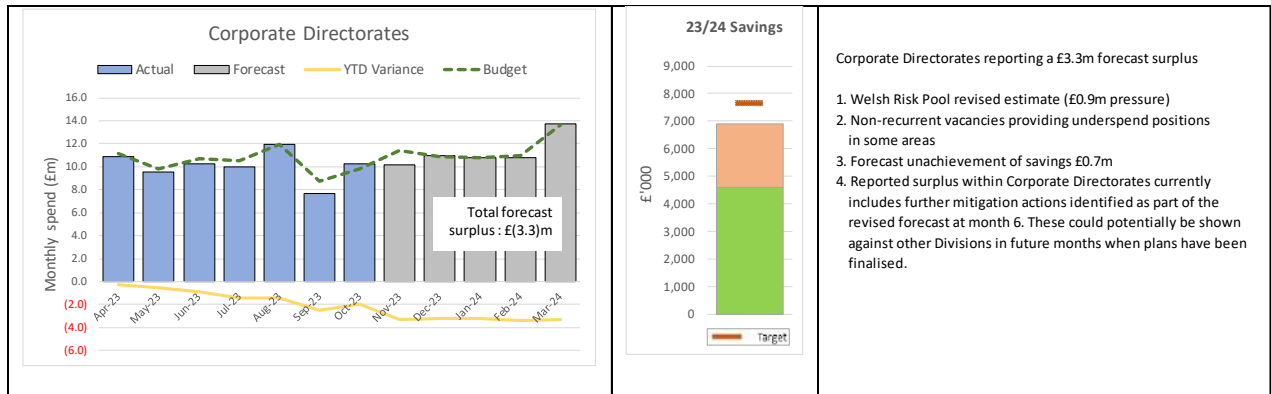
| Division                  | Savings Scheme Number | Scheme / Opportunity  | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            |            | Full year      |                |
|---------------------------|-----------------------|---|------|-----------------------|-------------------|----------------|------------|----------------|----------------|
|                           |                       |   |      |                       |                   | Achieved £'000 | Plan £'000 | Forecast £'000 | Variance £'000 |
| Clinical Support Services | CSS-01                | Generic CIP - Pay   | R    | IMTP                  | Red               | 0              | 190        | 0              | (190)          |
| Clinical Support Services | CSS-02                | Procurement   | R    | IMTP                  | Red               | 0              | 138        | 0              | (138)          |
| Clinical Support Services | CSS-03                | Rostering Efficiencies  | R    | IMTP                  | Red               | 0              | 139        | 0              | (139)          |
| Clinical Support Services | CSS-04                | procurement   | R    | IMTP                  | Red               | 0              | 21         | 0              | (21)           |
| Clinical Support Services | CSS-05                | Generic CIP - Non-Pay   | R    | IMTP                  | Red               | 0              | 105        | 0              | (105)          |
| Radiology                 | CSS-06                | Radiology - IPFR patients via WhSSC                           | R    | In Year               | Green             | 15             | 0          | 50             | 50             |
| Radiology                 | CSS-07                | Radiology - WHSSC other Commissioning Costs                   | R    | In Year               | Red               | 0              | 0          | 0              | 0              |
| Radiology                 | CSS-08                | Radiology - Reduce Dosage of CT IV Contrast                   | R    | In Year               | Green             | 28             | 0          | 50             | 50             |
| Radiology                 | CSS-09                | Radiology - PICC Line - change of supplier / change of consum | R    | In Year               | Green             | 41             | 0          | 70             | 70             |
| Radiology                 | CSS-10                | Radiology - Review Agency Sonographers                        | R    | In Year               | Green             | 15             | 0          | 100            | 100            |
| Radiology                 | CSS-11                | Radiology - Review of overtime CT & MR                        | R    | In Year               | Green             | 15             | 0          | 50             | 50             |
| Radiology                 | CSS-12                | Radiology - Non Pay All Other                                 | R    | In Year               | Green             | 41             | 0          | 81             | 81             |
| Pathology                 | CSS-13                | Pathology - Agency Scientist cost reduction                   | R    | In Year               | Green             | 99             | 0          | 214            | 214            |
| Pathology                 | CSS-14                | Pathology - KPI rebates on MSC's - Siemens and Sysmex         | NR   | In Year               | Green             | 80             | 0          | 80             | 80             |
| Pathology                 | CSS-15                | Pathology - SLA's - Income review                             | R    | In Year               | Green             | 35             | 0          | 60             | 60             |
| Pathology                 | CSS-16                | Pathology - repatriation of tests                             | R    | In Year               | Green             | 12             | 0          | 42             | 42             |
| Pathology                 | CSS-17                | Pathology - DHCW SLA Haemonetics                              | R    | In Year               | Green             | 8              | 0          | 13             | 13             |
| Pathology                 | CSS-18                | Pathology - All Wales Non Pay Procurement scheme              | R    | In Year               | Green             | 14             | 0          | 47             | 47             |
| Radiology                 | CSS2                  | Radiology - Decommission Fluoroscopy Equipt NHH - mainte      | R    | In Year               | Amber             | 0              | 0          | 14             | 14             |
| Radiology                 | CSS3                  | Radiology   | NR   | In Year               | Amber             | 0              | 0          | 75             | 75             |
| Radiology                 | CSS4                  | Radiology - restricted GP access MSK scans                    | R    | In Year               | Green             | 7              | 0          | 40             | 40             |
|                           |                       |   |      |                       |                   | <b>409</b>     | <b>593</b> | <b>986</b>     | <b>393</b>     |

# Divisional analysis – Complex Care



| Division     | Savings Scheme Number | Scheme / Opportunity   | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year    |                |                |
|--------------|-----------------------|--|------|-----------------------|-------------------|----------------|--------------|----------------|----------------|
|              |                       |  |      |                       |                   | Achieved £'000 | Plan £'000   | Forecast £'000 | Variance £'000 |
| Complex Care | CHC-01                | Generic CIP - Pay  | R    | IMTP                  | Red               | 0              | 34           | 0              | (34)           |
| Complex Care | CHC-02                | Rostering Efficiencies   | R    | IMTP                  | Red               | 0              | 305          | 0              | (305)          |
| Complex Care | CHC-03                | Adult CHC Care at home team                                    | R    | IMTP                  | Green             | 47             | 100          | 119            | 19             |
| Complex Care | CHC-04                | Adult CHC high cost packages, 1:1 & chages for hospital visits | R    | IMTP                  | Red               | 0              | 100          | 0              | (100)          |
| Complex Care | CHC-05                | Adult CHC (balance to NP plan (3m target @40% of spend for     | R    | IMTP                  | Red               | 0              | 1,000        | 0              | (1,000)        |
| Complex Care | CHC-06                | procurement  | R    | IMTP                  | Red               | 0              | 56           | 0              | (56)           |
| Complex Care | CHC-07                | Generic CIP - Non-Pay  | R    | IMTP                  | Red               | 0              | 288          | 0              | (288)          |
| Complex Care | CHC-08                | Right Sizing Commitments                                       | R    | In Year               | Green             | 81             | 0            | 500            | 500            |
| Complex Care | CHC-09                | Enhanced care working group and panel                          | R    | In Year               | Green             | 83             | 0            | 265            | 265            |
| Complex Care | CHC-10                | CHC review assessments   | NR   | In Year               | Green             | 21             | 0            | 41             | 41             |
| Complex Care | CHC-11                | Enhanced care cohort model - TBC                               | R    | In Year               | Red               | 0              | 0            | 0              | 0              |
| Complex Care | CHC-12                | CHC placements review  | NR   | In Year               | Green             | 539            | 0            | 539            | 539            |
| Complex Care | CHC1                  | Enhanced care  | R    | In Year               | Amber             | 0              | 0            | 195            | 195            |
| Complex Care | CHC3                  | Hospital admissions  | R    | In Year               | Amber             | 0              | 0            | 34             | 34             |
| Complex Care | CHC4                  | Days after death   | R    | In Year               | Amber             | 0              | 0            | 28             | 28             |
| Complex Care | CHC5                  | Deputyship SLA   | R    | In Year               | Amber             | 0              | 0            | 6              | 6              |
|              |                       |  |      |                       |                   | <b>771</b>     | <b>1,883</b> | <b>1,727</b>   | <b>(156)</b>   |

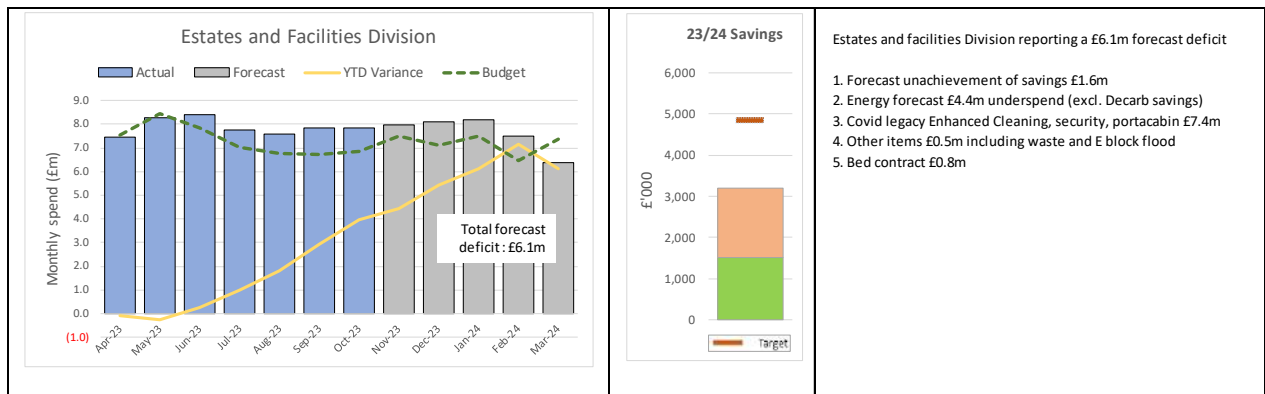
# Divisional analysis – Corporate



| Division                   | Savings Scheme Number | Scheme / Opportunity                    | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            |            | Full year      |                |
|----------------------------|-----------------------|---|------|-----------------------|-------------------|----------------|------------|----------------|----------------|
|                            |                       |   |      |                       |                   | Achieved £'000 | Plan £'000 | Forecast £'000 | Variance £'000 |
| Corporate-ABCI             | CORP-01               | Generic CIP - Non-Pay                   | R    | IMTP                  | Red               | 0              | 4          | 0              | (4)            |
| Corporate-CEO              | CORP-02               | Generic CIP - Pay                       | R    | IMTP                  | Green             | 76             | 0          | 130            | 130            |
| Corporate-CEO              | CORP-03               | Review of RIF expenditure               | NR   | IMTP                  | Red               | 0              | 300        | 0              | (300)          |
| Corporate-CEO              | CORP-04               | Review of Health protection expenditure | NR   | IMTP                  | Red               | 0              | 1,200      | 0              | (1,200)        |
| Corporate-CEO              | CORP-05               | Generic CIP - Non-Pay                   | R    | IMTP                  | Green             | 44             | 415        | 203            | (212)          |
| Corporate-DirFin           | CORP-06               | Generic CIP - Pay                       | R    | IMTP                  | Green             | 96             | 46         | 322            | 276            |
| Corporate-DirFin           | CORP-07               | Generic CIP - Non-Pay                   | R    | IMTP                  | Green             | 2              | 5          | 5              | 0              |
| Corporate-DirNurs          | CORP-08               | Generic CIP - Pay                       | R    | IMTP                  | Red               | 0              | 34         | 0              | (34)           |
| Corporate-DirNurs          | CORP-09               | procurement                             | R    | IMTP                  | Red               | 0              | 1          | 0              | (1)            |
| Corporate-DirNurs          | CORP-10               | Generic CIP - Non-Pay                   | R    | IMTP                  | Red               | 0              | 6          | 0              | (6)            |
| Corporate-DirOps           | CORP-11               | Generic CIP - Pay                       | R    | IMTP                  | Red               | 0              | 61         | 0              | (61)           |
| Corporate-DirOps           | CORP-12               | procurement                             | R    | IMTP                  | Red               | 0              | 2          | 0              | (2)            |
| Corporate-DirOps           | CORP-13               | Generic CIP - Non-Pay                   | R    | IMTP                  | Red               | 0              | 16         | 0              | (16)           |
| Corporate-DirPCMH          | CORP-14               | Generic CIP - Pay                       | R    | IMTP                  | Green             | 44             | 2          | 76             | 74             |
| Corporate-DirPH            | CORP-15               | Generic CIP - Pay                       | R    | IMTP                  | Green             | 17             | 33         | 17             | (16)           |
| Corporate-DirPH            | CORP-16               | Generic CIP - Non-Pay                   | R    | IMTP                  | Green             | 8              | 3          | 38             | 35             |
| Corporate-DirPH            | CORP-17               | Health protection review                | NR   | IMTP                  | Green             | 583            | 1,000      | 1,000          | (0)            |
| Corporate-DirPH            | CORP-18               | procurement                             | R    | IMTP                  | Green             | 2              | 1          | 13             | 12             |
| Corporate-DirPH            | CORP-19               | Health protection review                | NR   | IMTP                  | Green             | 1,630          | 3,000      | 2,279          | (721)          |
| Corporate-DirTher          | CORP-20               | Generic CIP - Pay                       | R    | IMTP                  | Green             | 10             | 6          | 58             | 52             |
| Corporate-DirTher          | CORP-21               | Generic CIP - Non-Pay                   | R    | IMTP                  | Green             | 1              | 2          | 6              | 4              |
| Corporate-DirTher          | CORP-22               | Rostering Efficiencies                  | R    | IMTP                  | Red               | 0              | 47         | 0              | (47)           |
| Corporate-Governance       | CORP-23               | Generic CIP - Pay                       | R    | IMTP                  | Green             | 7              | 7          | 7              | 0              |
| Corporate-Governance       | CORP-24               | Generic CIP - Non-Pay                   | R    | IMTP                  | Red               | 0              | 2          | 0              | (1)            |
| Corporate-Litig            | CORP-25               | Generic CIP - Non-Pay                   | R    | IMTP                  | Red               | 0              | 11         | 0              | (11)           |
| Corporate-Litig            | CORP-26               | procurement                             | R    | IMTP                  | Red               | 0              | 2          | 0              | (2)            |
| Corporate-MedDir           | CORP-27               | Generic CIP - Pay                       | R    | IMTP                  | Green             | 11             | 19         | 19             | 0              |
| Corporate-MedDir           | CORP-28               | Generic CIP - Non-Pay                   | R    | IMTP                  | Green             | 6              | 10         | 10             | 0              |
| Corporate-PlanICT          | CORP-29               | Generic CIP - Pay                       | R    | IMTP                  | Red               | 0              | 77         | 0              | (77)           |
| Corporate-PlanICT          | CORP-30               | procurement                             | R    | IMTP                  | Green             | 66             | 113        | 113            | 0              |
| Corporate-PlanICT          | CORP-31               | Generic CIP - Non-Pay                   | R    | IMTP                  | Red               | 0              | 63         | 0              | (63)           |
| Corporate-WOD              | CORP-32               | Generic CIP - Pay                       | R    | IMTP                  | Green             | 130            | 43         | 222            | 179            |
| Corporate-WOD              | CORP-33               | procurement                             | R    | IMTP                  | Green             | 4              | 6          | 6              | 0              |
| Corporate-WOD              | CORP-34               | Generic CIP - Non-Pay                   | R    | IMTP                  | Green             | 25             | 43         | 43             | (0)            |
| Corporate-DirOps           | CORP-35               | NEPT & INTERSITE                        | R    | IMTP                  | Red               | 0              | 1,000      | 0              | (1,000)        |
| Corporate-Plan             | CORP-36               | Generic CIP - Non-Pay                   | R    | IMTP                  | Green             | 12             | 20         | 20             | 0              |
| Corporate-Plan             | CORP-37               | Generic CIP - Pay                       | R    | IMTP                  | Green             | 14             | 25         | 25             | 0              |
| Corporate-DirOps           | FAC-41                | Reduced Bed Capacity                    | R    | In Year               | Amber             | 0              | 0          | 2,250          | 2,250          |
| Corporate - CAPITAL CHARGE | CAP1                  | Disposal of unused equipment            | NR   | In Year               | Amber             | 0              | 0          | 50             | 50             |
|                            |                       |   |      |                       |                   | 2,788          | 7,623      | 6,912          | (711)          |

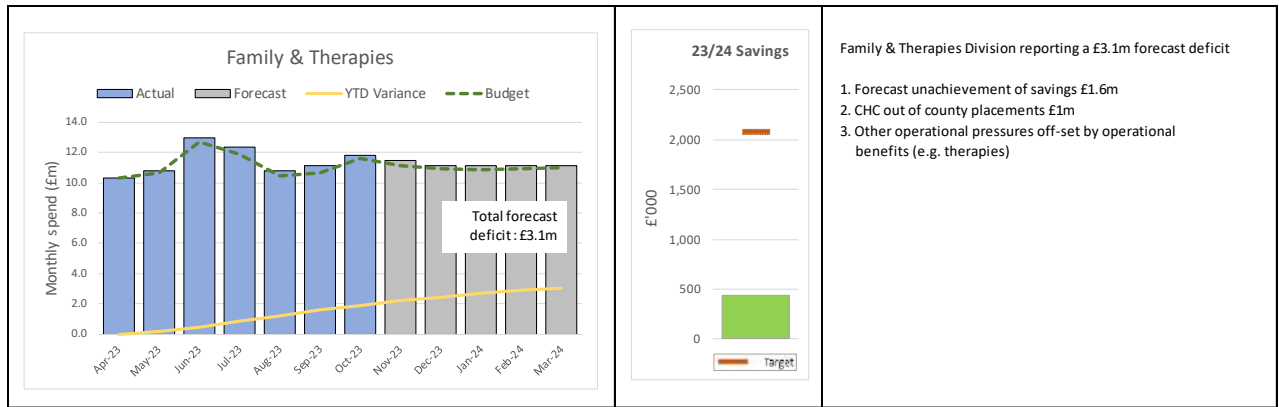


# Divisional analysis – Estates & Facilities



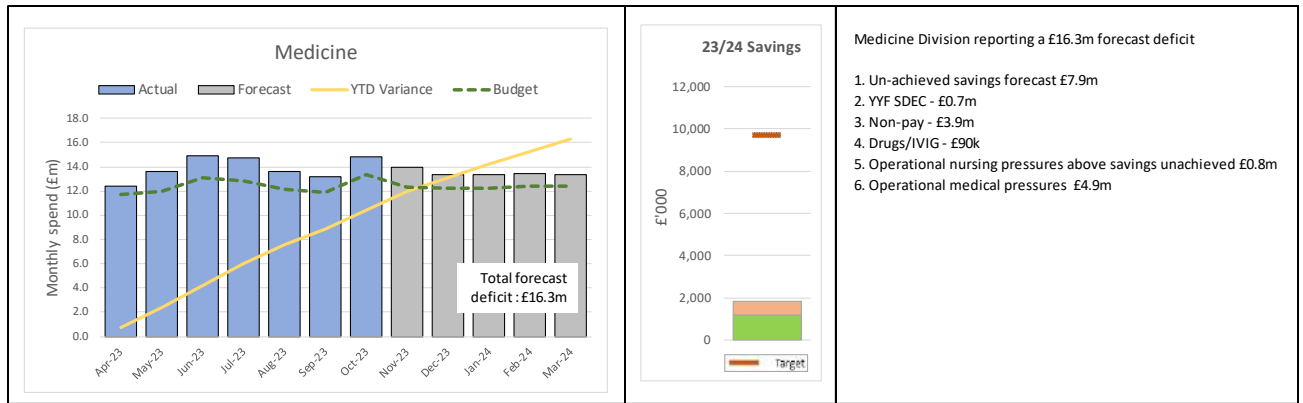
| Division               | Savings Scheme Number | Scheme / Opportunity                                      | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year  |                |                |
|------------------------|-----------------------|---|------|-----------------------|-------------------|----------------|------------|----------------|----------------|
|                        |                       |   |      |                       |                   | Achieved £'000 | Plan £'000 | Forecast £'000 | Variance £'000 |
| Estates and Facilities | ESF-01                | Generic CIP - Pay   | R    | IMTP                  | Red               | 0              | 161        | 0              | (161)          |
| Estates and Facilities | ESF-02                | Parking   | R    | IMTP                  | Green             | 123            | 210        | 210            | 0              |
| Estates and Facilities | ESF-03                | Procurement   | R    | IMTP                  | Green             | 10             | 40         | 27             | (13)           |
| Estates and Facilities | ESF-04                | Rostering Efficiencies                                    | R    | IMTP                  | Amber             | 0              | 642        | 107            | (535)          |
| Estates and Facilities | ESF-05                | estates and facilities strategy                           | R    | IMTP                  | Red               | 0              | 170        | 0              | (170)          |
| Estates and Facilities | ESF-06                | Decarbonisation   | R    | IMTP                  | Green             | 582            | 1,000      | 1,000          | (1)            |
| Estates and Facilities | ESF-08                | Estates Opps / leases (running costs)                     | R    | IMTP                  | Red               | 0              | 1,000      | 0              | (1,000)        |
| Estates and Facilities | ESF-09                | procurement   | R    | IMTP                  | Red               | 0              | 181        | 0              | (181)          |
| Estates and Facilities | ESF-10                | Estates and Facilities avoid agency premiums (50%)        | R    | IMTP                  | Amber             | 0              | 1,095      | 273            | (822)          |
| Estates and Facilities | ESF-11                | Generic CIP - Non-Pay                                     | R    | IMTP                  | Red               | 0              | 340        | 0              | (340)          |
| Estates and Facilities | ESF-12                | Rates Rebates   | NR   | In Year               | Amber             | 0              | 0          | 754            | 754            |
| Estates and Facilities | FAC-02                | Pod-point chargers  | R    | In Year               | Green             | 1              | 0          | 4              | 4              |
| Estates and Facilities | FAC-03                | Catering Subsidy Removal                                  | R    | In Year               | Amber             | 0              | 0          | 117            | 117            |
| Estates and Facilities | FAC-04                | Hot Vending   | R    | In Year               | Green             | 2              | 0          | 14             | 14             |
| Estates and Facilities | FAC-12                | Security @ GUH  | R    | In Year               | Red               | 0              | 0          | 0              | 0              |
| Estates and Facilities | FAC-13                | Security @ NHH  | R    | In Year               | Red               | 0              | 0          | 0              | 0              |
| Estates and Facilities | FAC-14                | Security @ STC  | R    | In Year               | Red               | 0              | 0          | 0              | 0              |
| Estates and Facilities | FAC-15                | Security @ RGH  | R    | In Year               | Red               | 0              | 0          | 0              | 0              |
| Estates and Facilities | FAC-17                | Enhanced Cleaning - reduced WTE's                         | R    | In Year               | Green             | 20             | 0          | 170            | 170            |
| Estates and Facilities | FAC-22                | GUH Carparking  | R    | In Year               | Green             | 6              | 0          | 38             | 38             |
| Estates and Facilities | FAC-23                | All Wales Buying Group Credit for sale of energy procured | NR   | In Year               | Amber             | 0              | 0          | 423            | 423            |
| Estates and Facilities | FAC-24                | NCC Parking - Kingsway & Park Square                      | R    | In Year               | Green             | 6              | 0          | 39             | 39             |
| Estates and Facilities | FAC-28                | Window Cleaning   | R    | In Year               | Green             | 3              | 0          | 15             | 15             |
| Estates and Facilities | FAC1                  | GUH OOH Catering  | R    | In Year               | Amber             | 0              | 0          | 0              | 0              |
| Estates and Facilities | FAC29                 | Removal of water coolers                                  | R    | In Year               | Amber             | 0              | 0          | 2              | 2              |
|                        |                       |   |      |                       |                   | 753            | 4,840      | 3,193          | (1,647)        |

# Divisional analysis – Family & Therapies



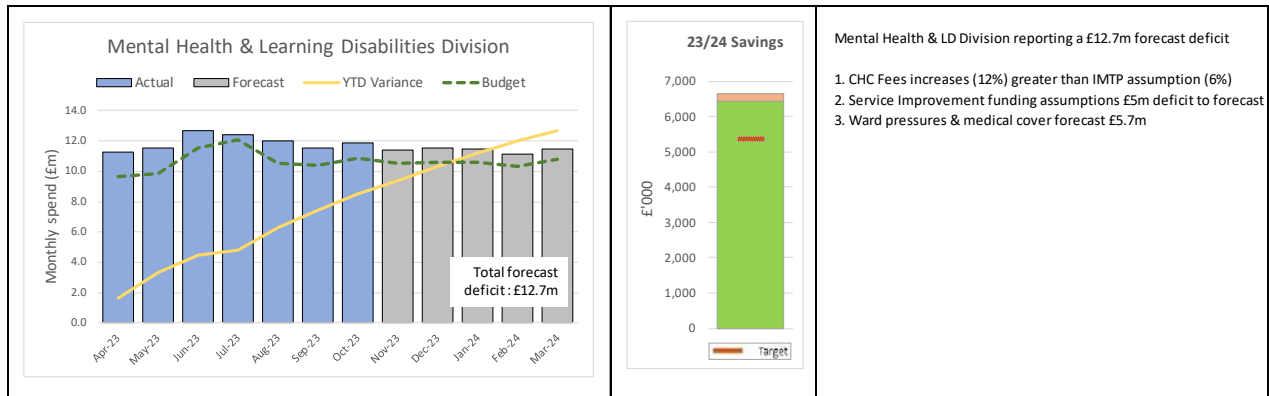
| Division               | Savings Scheme Number | Scheme / Opportunity                                      | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year  |                |                |
|------------------------|-----------------------|---|------|-----------------------|-------------------|----------------|------------|----------------|----------------|
|                        |                       |   |      |                       |                   | Achieved £'000 | Plan £'000 | Forecast £'000 | Variance £'000 |
| Families and Therapies | FAT-01                | Generic CIP - Pay   | R    | IMTP                  | Green             | 124            | 558        | 211            | (347)          |
| Families and Therapies | FAT-02                | BADS  | R    | IMTP                  | Red               | 0              | 25         | 0              | (25)           |
| Families and Therapies | FAT-03                | Outpatient transformation (F2F and Virtual)               | R    | IMTP                  | Red               | 0              | 93         | 0              | (93)           |
| Families and Therapies | FAT-04                | Outpatient transformation (New to Follow Up ratio)        | R    | IMTP                  | Red               | 0              | 134        | 0              | (134)          |
| Families and Therapies | FAT-05                | Procurement   | R    | IMTP                  | Red               | 0              | 25         | 0              | (25)           |
| Families and Therapies | FAT-06                | Rostering Efficiencies                                    | R    | IMTP                  | Green             | 96             | 1,021      | 164            | (857)          |
| Families and Therapies | FAT-07                | Medicines management                                      | R    | IMTP                  | Green             | 21             | 50         | 30             | (20)           |
| Families and Therapies | FAT-08                | procurement   | R    | IMTP                  | Red               | 0              | 72         | 0              | (72)           |
| Families and Therapies | FAT-09                | Generic CIP - Non-Pay                                     | R    | IMTP                  | Red               | 0              | 96         | 0              | (96)           |
| Families and Therapies | FAT-10                | ABUHB Exec decision to cease Flexible Rewards from end of | R    | In Year               | Green             | 7              | 0          | 26             | 26             |
| Families and Therapies | FAT-11                | Medicines management (VRIII Fluids - supplier Switch)     | R    | In Year               | Green             | 0              | 0          | 1              | 1              |
|                        |                       |   |      |                       |                   | 249            | 2,074      | 432            | (1,641)        |

# Divisional analysis – Medicine



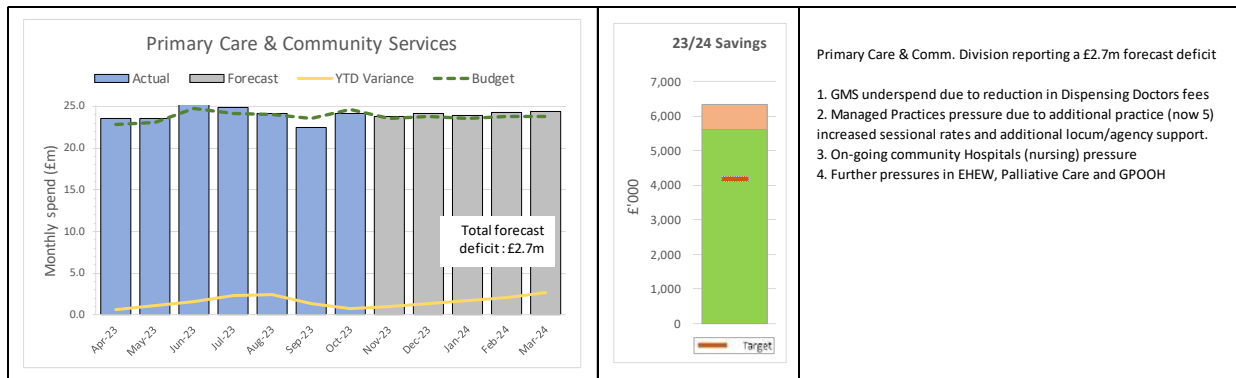
| Division | Savings Scheme Number | Scheme / Opportunity                               | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year    |                |                |
|----------|-----------------------|--|------|-----------------------|-------------------|----------------|--------------|----------------|----------------|
|          |                       |  |      |                       |                   | Achieved £'000 | Plan £'000   | Forecast £'000 | Variance £'000 |
| Medicine | MED-01                | Generic CIP - Pay                                  | R    | IMTP                  | Green             | 12             | 516          | 42             | (474)          |
| Medicine | MED-02                | Outpatient transformation (F2F and Virtual)        | R    | IMTP                  | Red               | 0              | 95           | 0              | (95)           |
| Medicine | MED-03                | Outpatient transformation (New to Follow Up ratio) | R    | IMTP                  | Red               | 0              | 656          | 0              | (656)          |
| Medicine | MED-04                | Beds ( 1 ward Med)                                 | R    | IMTP                  | Red               | 0              | 2,223        | 0              | (2,223)        |
| Medicine | MED-05                | Procurement  | R    | IMTP                  | Amber             | 0              | 25           | 14             | (12)           |
| Medicine | MED-06                | Rostering Efficiencies                             | R    | IMTP                  | Green             | 394            | 738          | 914            | 177            |
| Medicine | MED-07                | Insourcing review                                  | R    | IMTP                  | Red               | 0              | 1,066        | 0              | (1,066)        |
| Medicine | MED-08                | Medicines management                               | R    | IMTP                  | Green             | 60             | 150          | 125            | (25)           |
| Medicine | MED-09                | procurement  | R    | IMTP                  | Green             | 62             | 35           | 77             | 42             |
| Medicine | MED-10                | Slippage in spend regional eyes / endo / path      | NR   | IMTP                  | Red               | 0              | 4,000        | 0              | (4,000)        |
| Medicine | MED-11                | Generic CIP - Non-Pay                              | R    | IMTP                  | Amber             | 0              | 184          | 89             | (95)           |
| Medicine | Med-12                | Green Schemes - Drugs MED 12 & MED 13              | R    | In Year               | Red               | 0              | 0            | 0              | 0              |
| Medicine | Med-13                | Green Scheme - Medical MED 05 & MED 19             | R    | In Year               | Amber             | 0              | 0            | 104            | 104            |
| Medicine | Med-14                | Green Schemes - Non Pay Wound Clinic REF MED-06    | R    | In Year               | Green             | 4              | 0            | 25             | 25             |
| Medicine | Med-15                | Green Schemes - Income Spy Glass MED-07            | R    | In Year               | Amber             | 0              | 0            | 70             | 70             |
| Medicine | Med-16                | Green Scheme - Virtual Outliers                    | R    | In Year               | Amber             | 0              | 0            | 120            | 120            |
| Medicine | Med-22                | Green Scheme - HCRU                                | R    | In Year               | Amber             | 0              | 0            | 250            | 250            |
|          |                       |  |      |                       |                   | <b>532</b>     | <b>9,688</b> | <b>1,830</b>   | <b>(7,858)</b> |

# Divisional analysis – Mental Health and Learning Disabilities



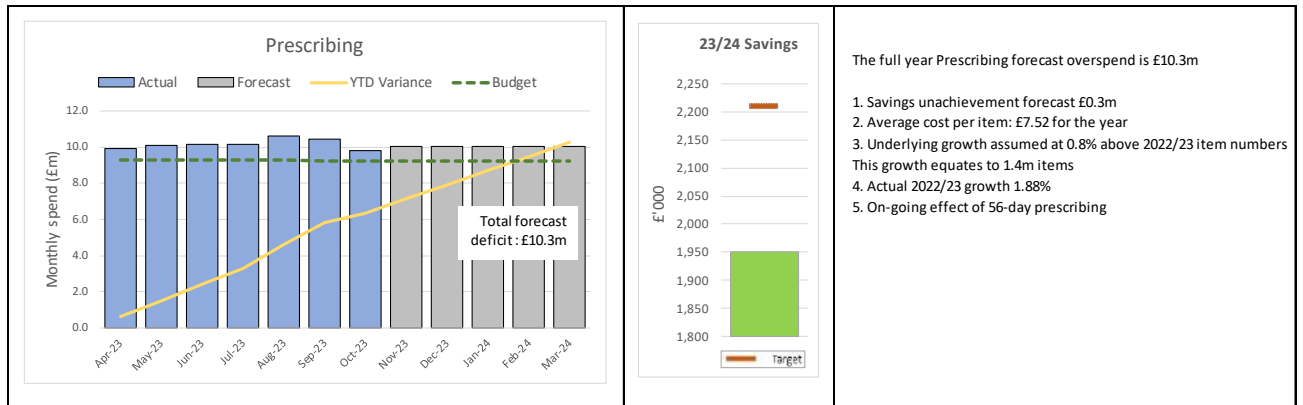
| Division                                | Savings Scheme Number | Scheme / Opportunity                                       | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year  |                |                |
|---|-----------------------|--|------|-----------------------|-------------------|----------------|------------|----------------|----------------|
|   |                       |  |      |                       |                   | Achieved £'000 | Plan £'000 | Forecast £'000 | Variance £'000 |
| Mental Health and Learning Disabilities | MHLD-01               | Generic CIP - Pay  | R    | IMTP                  | Red               | 0              | 107        | 0              | (107)          |
| Mental Health and Learning Disabilities | MHLD-01a              | MH Adults - Reduction of agency costs due to appointment o | R    | IMTP                  | Green             | 20             | 142        | 122            | (20)           |
| Mental Health and Learning Disabilities | MHLD-01b              | OAMH - Reduction in LT Med Agency due to successful recrui | R    | IMTP                  | Green             | 29             | 50         | 50             | 0              |
| Mental Health and Learning Disabilities | MHLD-01c              | Flexi rewards ceasing                                      | R    | IMTP                  | Red               | 0              | 9          | 0              | (9)            |
| Mental Health and Learning Disabilities | MHLD-02               | Generic CIP - Non-Pay                                      | R    | IMTP                  | Red               | 0              | 0          | 0              | 0              |
| Mental Health and Learning Disabilities | MHLD-02a              | Maximise ECT Income generation from private patient refer  | R    | IMTP                  | Green             | 41             | 70         | 70             | 0              |
| Mental Health and Learning Disabilities | MHLD-02b              | PCMHS Counselling commissioning                            | R    | IMTP                  | Green             | 17             | 218        | 100            | (118)          |
| Mental Health and Learning Disabilities | MHLD-02c              | SLA Recovery works & Sanctuary                             | NR   | IMTP                  | Green             | 166            | 0          | 285            | 285            |
| Mental Health and Learning Disabilities | MHLD-03               | Rostering Efficiencies                                     | R    | IMTP                  | Red               | 0              | 562        | 0              | (562)          |
| Mental Health and Learning Disabilities | MHLD-04               | MH CHC - LD  | R    | IMTP                  | Red               | 0              | 922        | 0              | (922)          |
| Mental Health and Learning Disabilities | MHLD-05               | MH CHC High cost packages                                  | R    | IMTP                  | Green             | 33             | 250        | 200            | (50)           |
| Mental Health and Learning Disabilities | MHLD-06               | MH Older Adults Beds                                       | R    | IMTP                  | Red               | 0              | 206        | 0              | (206)          |
| Mental Health and Learning Disabilities | MHLD-06a              | OAMH - Capped beds on Annwylfan (YYF) resulting in lower v | R    | IMTP                  | Green             | 30             | 150        | 30             | (120)          |
| Mental Health and Learning Disabilities | MHLD-07               | Review of Mental Health expenditure                        | NR   | IMTP                  | Red               | 0              | 2,000      | 0              | (2,000)        |
| Mental Health and Learning Disabilities | MHLD-08               | MH CHC (balance to NP plan (3m target @60% of spend for M  | R    | IMTP                  | Red               | 0              | 628        | 0              | (628)          |
| Mental Health and Learning Disabilities | MHLD-09               | procurement  | R    | IMTP                  | Red               | 0              | 55         | 0              | (55)           |
| Mental Health and Learning Disabilities | MHLD-10               | CHC Eligibility Reviews                                    | R    | In Year               | Green             | 105            | 0          | 367            | 367            |
| Mental Health and Learning Disabilities | MHLD-11               | CHC Repatriations to in house wards                        | R    | In Year               | Green             | 503            | 0          | 1,104          | 1,104          |
| Mental Health and Learning Disabilities | MHLD-12               | CHC Right Size Packages                                    | R    | In Year               | Green             | 130            | 0          | 306            | 306            |
| Mental Health and Learning Disabilities | MHLD-13               | CHC Step Down  | R    | In Year               | Green             | 284            | 0          | 601            | 601            |
| Mental Health and Learning Disabilities | MHLD-14               | CHC Change in Need   | R    | In Year               | Green             | 478            | 0          | 1,142          | 1,142          |
| Mental Health and Learning Disabilities | MHLD-15               | Structured Clinical Management                             | R    | In Year               | Amber             | 0              | 0          | 157            | 157            |
| Mental Health and Learning Disabilities | MHLD-16               | Paliperidone HC FYE  | R    | In Year               | Green             | 61             | 0          | 111            | 111            |
| Mental Health and Learning Disabilities | MHLD-17               | Paliperidone Non HC FYE                                    | R    | In Year               | Green             | 51             | 0          | 88             | 88             |
| Mental Health and Learning Disabilities | MHLD-18               | Clozapine repatriation FYE                                 | R    | In Year               | Green             | 39             | 0          | 71             | 71             |
| Mental Health and Learning Disabilities | MHLD-19               | Clozapine price reduction                                  | R    | In Year               | Green             | 3              | 0          | 6              | 6              |
| Mental Health and Learning Disabilities | MHLD-20               | Flexi Rewards Ceasing                                      | R    | In Year               | Green             | 86             | 0          | 301            | 301            |
| Mental Health and Learning Disabilities | MH2                   | Step 9 People Down From Secure Placements                  | R    | In Year               | Green             | 99             | 0          | 479            | 479            |
| Mental Health and Learning Disabilities | MH3                   | Repatriate Individuals From OOA And In House Placements    | R    | In Year               | Green             | 13             | 0          | 75             | 75             |
| Mental Health and Learning Disabilities | MH6                   | Review SIF SLAs  | NR   | In Year               | Green             | 117            | 0          | 200            | 200            |
| Mental Health and Learning Disabilities | MH10                  | Review secure transport options                            | R    | In Year               | Amber             | 0              | 0          | 15             | 15             |
| Mental Health and Learning Disabilities | MH11                  | Flexi Rewards Ceasing                                      | R    | In Year               | Red               | 0              | 0          | 0              | 0              |
| Mental Health and Learning Disabilities | MH4                   | West Sussex Dispute  | NR   | In Year               | Green             | 124            | 0          | 742            | 742            |
| Mental Health and Learning Disabilities | MH12                  | Non Pay Reduction  | R    | In Year               | Amber             | 0              | 0          | 10             | 10             |
|   |                       |  |      |                       |                   | 2,428          | 5,369      | 6,631          | 1,262          |

# Divisional analysis – Primary Care and Community



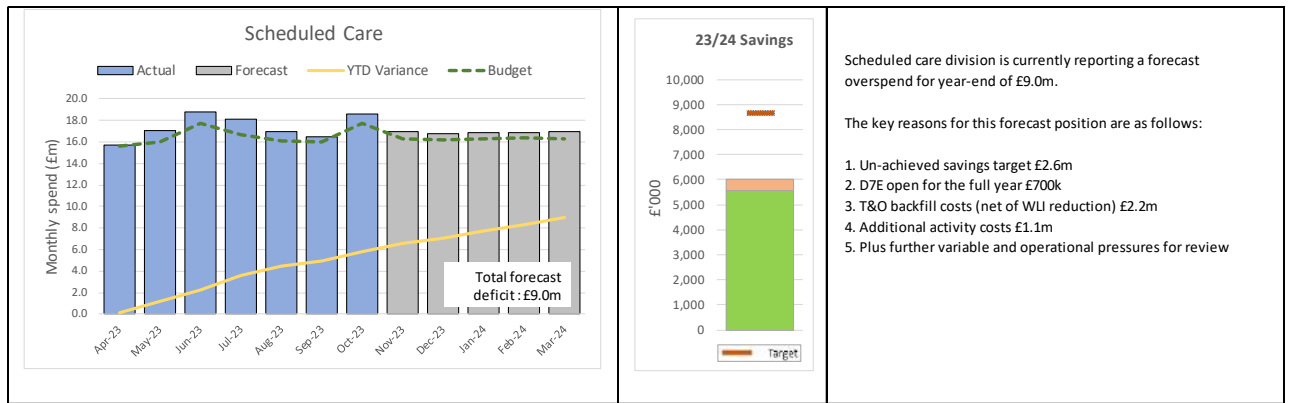
| Division                   | Savings Scheme Number | Scheme / Opportunity                              | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year  |                |                |
|----------------------------|-----------------------|---|------|-----------------------|-------------------|----------------|------------|----------------|----------------|
|                            |                       |   |      |                       |                   | Achieved £'000 | Plan £'000 | Forecast £'000 | Variance £'000 |
| Primary Care and Community | PCC-01                | Generic CIP - Pay                                 | R    | IMTP                  | Green             | 200            | 278        | 278            | 0              |
| Primary Care and Community | PCC-02                | Generic CIP - Non-Pay                             | R    | IMTP                  | Green             | 193            | 291        | 291            | 0              |
| Primary Care and Community | PCC-04                | Beds (1 ward Community)                           | R    | IMTP                  | Red               | 0              | 2,223      | 0              | (2,223)        |
| Primary Care and Community | PCC-05                | Procurement                                       | R    | IMTP                  | Amber             | 0              | 85         | 5              | (80)           |
| Primary Care and Community | PCC-06                | Rostering Efficiencies                            | R    | IMTP                  | Red               | 0              | 1,008      | 0              | (1,008)        |
| Primary Care and Community | PCC-08                | Managed practices                                 | R    | IMTP                  | Green             | 100            | 100        | 100            | 0              |
| Primary Care and Community | PCC-10                | procurement                                       | R    | IMTP                  | Red               | 0              | 185        | 0              | (185)          |
| Primary Care and Community | PCC-11                | LOE - Apixaban                                    | R    | In Year               | Green             | 533            | 0          | 2,103          | 2,103          |
| Primary Care and Community | PCC-12                | LOE - Sitagliptin                                 | R    | In Year               | Green             | 81             | 0          | 186            | 186            |
| Primary Care and Community | PCCS11                | Reduce Face To Face CPD Cost                      | NR   | In Year               | Green             | 6              | 0          | 15             | 15             |
| Primary Care and Community | PCCS17                | Bank MV HCSW                                      | NR   | In Year               | Amber             | 0              | 0          | 26             | 26             |
| Primary Care and Community | PCCS18                | Bank & Agency CCH Registered Nurses               | NR   | In Year               | Amber             | 0              | 0          | 48             | 48             |
| Primary Care and Community | PCCS19                | Reduce Non Pay Monnow Vale Ward                   | NR   | In Year               | Amber             | 0              | 0          | 7              | 7              |
| Primary Care and Community | PCCS2                 | NCN Development Programme Manager No Backfill     | NR   | In Year               | Green             | 6              | 0          | 37             | 37             |
| Primary Care and Community | PCCS20                | Non-Pay Cas Gwent                                 | NR   | In Year               | Amber             | 0              | 0          | 17             | 17             |
| Primary Care and Community | PCCS21                | Non Pay DNS                                       | NR   | In Year               | Amber             | 0              | 0          | 8              | 8              |
| Primary Care and Community | PCCS3                 | Dental Professional Collaborative On Hold         | NR   | In Year               | Green             | 8              | 0          | 25             | 25             |
| Primary Care and Community | PCCS36                | GMS IT Services                                   | NR   | In Year               | Green             | 19             | 0          | 33             | 33             |
| Primary Care and Community | PCCS37                | GMS Improvement Grants                            | NR   | In Year               | Green             | 158            | 0          | 270            | 270            |
| Primary Care and Community | PCCS4                 | Uncommitted SPCC Funding                          | NR   | In Year               | Amber             | 0              | 0          | 27             | 27             |
| Primary Care and Community | PCCS45                | Withdraw Band 7 Advert PC Contracting Team        | NR   | In Year               | Green             | 14             | 0          | 37             | 37             |
| Primary Care and Community | PCCS58                | Remove Band 3 Admin Post Newport                  | NR   | In Year               | Green             | 8              | 0          | 20             | 20             |
| Primary Care and Community | PCCS6                 | Hold Current SPCC Vacancy Band 4                  | NR   | In Year               | Amber             | 0              | 0          | 10             | 10             |
| Primary Care and Community | PCCS7                 | Reduce Spend On SPCC Promotion                    | NR   | In Year               | Green             | 2              | 0          | 5              | 5              |
| Primary Care and Community | PCCS8                 | Delay Recruitment Of Band 8A Academy Nurse        | NR   | In Year               | Green             | 7              | 0          | 20             | 20             |
| Primary Care and Community | PCCS9                 | Delay Recruitment Of Lead Pharmacist for academy  | NR   | In Year               | Green             | 7              | 0          | 21             | 21             |
| Primary Care and Community | PCCS1                 | NCN Academy Funding                               | NR   | In Year               | Green             | 50             | 0          | 175            | 175            |
| Primary Care and Community | PCCS10                | Amendment to ANP Programme                        | NR   | In Year               | Amber             | 0              | 0          | 9              | 9              |
| Primary Care and Community | PCCS26                | GMS LES Additional Clinics                        | NR   | In Year               | Green             | 40             | 0          | 139            | 139            |
| Primary Care and Community | PCCS30                | GDS UDA Clawback 22/23                            | NR   | In Year               | Green             | 282            | 0          | 282            | 282            |
| Primary Care and Community | PCCS32                | GDS CR Clawback 22/23                             | NR   | In Year               | Green             | 1,187          | 0          | 1,187          | 1,187          |
| Primary Care and Community | PCCS67                | Review ONN Overnight vehicle hire                 | NR   | In Year               | Amber             | 0              | 0          | 16             | 16             |
| Primary Care and Community | PCCS69                | Reduce GP & Nurse mobiles                         | NR   | In Year               | Green             | 3              | 0          | 18             | 18             |
| Primary Care and Community | PCCS33                | GDS CR Clawback 23/24                             | NR   | In Year               | Amber             | 0              | 0          | 200            | 200            |
| Primary Care and Community | PCCS12                | UPC To Support Sustainability                     | NR   | In Year               | Amber             | 0              | 0          | 21             | 21             |
| Primary Care and Community | PCCS14                | Additional Managed Practice to Independent Status | NR   | In Year               | Amber             | 0              | 0          | 28             | 28             |
| Primary Care and Community | PCCS38                | WG Improvement Grant                              | NR   | In Year               | Green             | 5              | 0          | 29             | 29             |
| Primary Care and Community | PCCS73                | Review Current Workforce In Managed Practies      | NR   | In Year               | Green             | 28             | 0          | 28             | 28             |
| Primary Care and Community | PCCS51                | Specials And Liquid Preps Review                  | NR   | In Year               | Green             | 1              | 0          | 5              | 5              |
| Primary Care and Community | PCCS52                | ONPOS/NWOS Expanded To GP Surgeries               | NR   | In Year               | Green             | 3              | 0          | 16             | 16             |
| Primary Care and Community | PCCS59                | Non Pay Stock Review                              | NR   | In Year               | Amber             | 0              | 0          | 50             | 50             |
| Primary Care and Community | PCCS76                | District Nursing Variation                        | NR   | In Year               | Amber             | 0              | 0          | 83             | 83             |
| Primary Care and Community | PCCS78                | Community Wards Variation                         | NR   | In Year               | Amber             | 0              | 0          | 175            | 175            |
| Primary Care and Community | PCCS13                | Merge Telephone Contracts In Managed Practices    | NR   | In Year               | Amber             | 0              | 0          | 3              | 3              |
| Primary Care and Community | PCCS79                | Flexi rewards saving                              | NR   | In Year               | Green             | 33             | 0          | 200            | 200            |
| Primary Care and Community | PCCS77                | Reduce Variation In Managed Practices             | NR   | In Year               | Green             | 6              | 0          | 89             | 89             |
|                            |                       |   |      |                       |                   | 2,978          | 4,170      | 6,341          | 2,171          |

## Divisional analysis – Prescribing



| Division    | Savings Scheme Number | Scheme / Opportunity  | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year    |                |                |
|-------------|-----------------------|-----------------------|------|-----------------------|-------------------|----------------|--------------|----------------|----------------|
|             |                       |                       |      |                       |                   | Achieved £'000 | Plan £'000   | Forecast £'000 | Variance £'000 |
| Prescribing | PCC-03                | Generic CIP - Non-Pay | R    | IMTP                  | Green             | 343            | 435          | 435            | 0              |
| Prescribing | PCC-07                | Medicines management  | R    | IMTP                  | Green             | 462            | 1,125        | 1,125          | 0              |
| Prescribing | PCC-09                | Medicines management  | R    | IMTP                  | Green             | 283            | 650          | 391            | (259)          |
|             |                       |                       |      |                       |                   | <b>1,088</b>   | <b>2,210</b> | <b>1,951</b>   | <b>(259)</b>   |

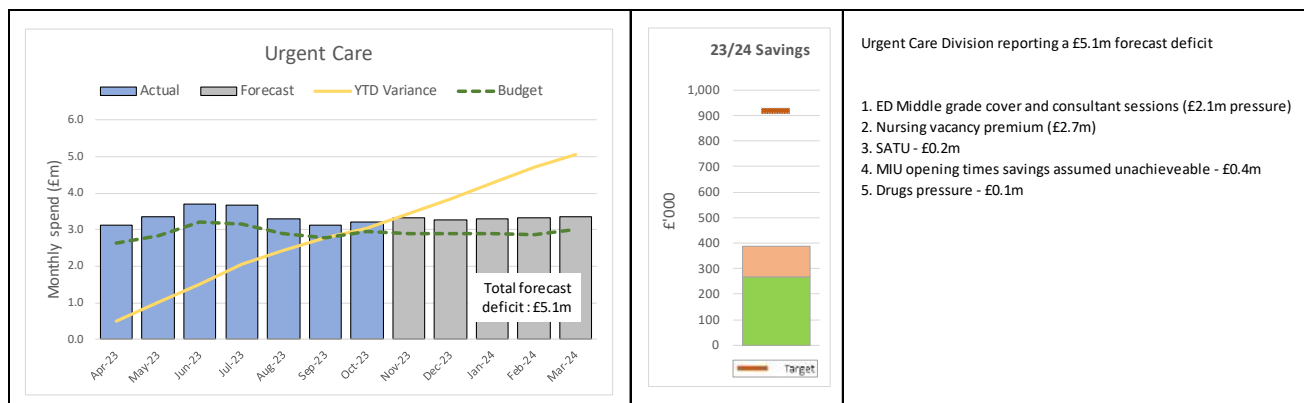
## Divisional analysis – Scheduled Care



| Division       | Savings Scheme Number | Scheme / Opportunity                                      | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year    |                |                |
|----------------|-----------------------|---|------|-----------------------|-------------------|----------------|--------------|----------------|----------------|
|                |                       |   |      |                       |                   | Achieved £'000 | Plan £'000   | Forecast £'000 | Variance £'000 |
| Scheduled Care | SCH-01                | Generic CIP - Pay   | R    | IMTP                  | Red               | 0              | 703          | 0              | (703)          |
| Scheduled Care | SCH-02                | BADS  | R    | IMTP                  | Red               | 0              | 478          | 0              | (478)          |
| Scheduled Care | SCH-03                | RTT WLI   | R    | IMTP                  | Green             | 1,111          | 2,296        | 2,011          | (285)          |
| Scheduled Care | SCH-04                | RTT Backfill  | R    | IMTP                  | Green             | 91             | 962          | 91             | (871)          |
| Scheduled Care | SCH-05                | Outpatient transformation (F2F and Virtual)               | R    | IMTP                  | Red               | 0              | 1,490        | 0              | (1,490)        |
| Scheduled Care | SCH-06                | Outpatient transformation (New to Follow Up ratio)        | R    | IMTP                  | Red               | 0              | 277          | 0              | (277)          |
| Scheduled Care | SCH-07                | SAU rostering   | R    | IMTP                  | Red               | 0              | 155          | 0              | (155)          |
| Scheduled Care | SCH-08                | Procurement   | R    | IMTP                  | Red               | 0              | 586          | 0              | (586)          |
| Scheduled Care | SCH-08a               | Procurement - Ophthalmology B&L theatre consumables       | R    | IMTP                  | Amber             | 0              | 38           | 21             | (17)           |
| Scheduled Care | SCH-08b               | Procurement - Stryker Pricing review                      | R    | IMTP                  | Amber             | 0              | 72           | 40             | (32)           |
| Scheduled Care | SCH-09                | Rostering Efficiencies                                    | R    | IMTP                  | Green             | 878            | 895          | 1,243          | 348            |
| Scheduled Care | SCH-09a               | Ortho Geriatric variable pay saving                       | R    | IMTP                  | Amber             | 0              | 48           | 30             | (18)           |
| Scheduled Care | SCH-10                | Medicines management                                      | R    | IMTP                  | Green             | 430            | 150          | 880            | 730            |
| Scheduled Care | SCH-11                | procurement   | R    | IMTP                  | Red               | 0              | 166          | 0              | (166)          |
| Scheduled Care | SCH-12                | Generic CIP - Non-Pay                                     | R    | IMTP                  | Red               | 0              | 317          | 0              | (317)          |
| Scheduled Care | SCH11                 | Stop backfill   | NR   | In Year               | Green             | 46             | 0            | 46             | 46             |
| Scheduled Care | SCH2                  | Christmas shutdown of elective activity                   | NR   | In Year               | Amber             | 0              | 0            | 50             | 50             |
| Scheduled Care | SCH23                 | Retinue accruals hold for 3 months not 6 months           | NR   | In Year               | Green             | 111            | 0            | 111            | 111            |
| Scheduled Care | SCH6                  | Nursing - Reduction of flexible rewards for agency / bank | R    | In Year               | Green             | 158            | 0            | 700            | 700            |
| Scheduled Care | SCH13                 | Non-uk resident patient spend target                      | NR   | In Year               | Green             | 9              | 0            | 61             | 61             |
| Scheduled Care | SCH12                 | Purchasing off frameworks                                 | R    | In Year               | Amber             | 0              | 0            | 42             | 42             |
| Scheduled Care | SCH22                 | Switch all patients from originator drugs to biosimilar   | NR   | In Year               | Green             | 58             | 0            | 348            | 348            |
| Scheduled Care | SCH24                 | Rationalisation of Uni Knee and removing Zimmer           | R    | In Year               | Amber             | 0              | 0            | 8              | 8              |
| Scheduled Care | SCH9                  | Limit value of study leave with a cap                     | NR   | In Year               | Green             | 1              | 0            | 5              | 5              |
| Scheduled Care | SCH3                  | Medical staff agency spend reduction                      | NR   | In Year               | Green             | 8              | 0            | 50             | 50             |
| Scheduled Care | SCH NEW               | Specialist Rates ITU / Theatres                           | NR   | In Year               | Amber             | 0              | 0            | 268            | 268            |
|                |                       |   |      |                       |                   | <b>2,901</b>   | <b>8,634</b> | <b>6,004</b>   | <b>(2,630)</b> |



## Divisional analysis – Urgent Care



| Division    | Savings Scheme Number | Scheme / Opportunity                 | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year  |                |                |
|-------------|-----------------------|--------------------------------------|------|-----------------------|-------------------|----------------|------------|----------------|----------------|
|             |                       |                                      |      |                       |                   | Achieved £'000 | Plan £'000 | Forecast £'000 | Variance £'000 |
| Urgent care | URG-01                | Generic CIP - Pay                    | R    | IMTP                  | Green             | 84             | 198        | 144            | (54)           |
| Urgent care | URG-02                | Procurement                          | R    | IMTP                  | Amber             | 0              | 25         | 19             | (6)            |
| Urgent care | URG-03                | Rostering Efficiencies               | R    | IMTP                  | Green             | 20             | 170        | 53             | (117)          |
| Urgent care | URG-04                | Reduce opening times of MIU          | R    | IMTP                  | Amber             | 0              | 500        | 100            | (400)          |
| Urgent care | URG-05                | procurement                          | R    | IMTP                  | Amber             | 0              | 4          | 2              | (2)            |
| Urgent care | URG-06                | Generic CIP - Non-Pay                | R    | IMTP                  | Green             | 5              | 22         | 22             | 0              |
| Urgent care | UC-01                 | Hold Recruiting Assistant PFCs       | R    | In Year               | Green             | 10             | 0          | 26             | 26             |
| Urgent care | UC-02                 | Hold Flow Centre Manager Recruitment | R    | In Year               | Green             | 9              | 0          | 23             | 23             |
|             |                       |                                      |      |                       |                   | <b>128</b>     | <b>919</b> | <b>389</b>     | <b>(530)</b>   |

# Divisional analysis – External Commissioning / WHSSC / EASC



| Division                      | Savings Scheme Number | Scheme / Opportunity                        | R/NR | IMTP v In Year scheme | Scheme RAG rating | YTD            | Full year    |                |                |
|-------------------------------|-----------------------|---|------|-----------------------|-------------------|----------------|--------------|----------------|----------------|
|                               |                       |   |      |                       |                   | Achieved £'000 | Plan £'000   | Forecast £'000 | Variance £'000 |
| Contracting and Commissioning | CON-01                | External Contracts                          | R    | IMTP                  | Green             | 1,167          | 2,000        | 2,000          | 0              |
| Contracting and Commissioning | CON-02                | External Contracts                          | R    | In year               | Green             | 193            | 0            | 331            | 331            |
| Contracting and Commissioning | CON-03                | External Contracts                          | NR   | In year               | Green             | 109            | 0            | 207            | 207            |
| WHSSC                         | WHC-01                | WHSSC 1% pathways savings                   | R    | IMTP                  | Red               | 0              | 1,363        | 0              | (1,363)        |
| WHSSC                         | WHC-01a               | WHSSC 1% pathways savings                   | R    | IMTP                  | Green             | 138            | 138          | 138            | 1              |
| WHSSC                         | WHC-02                | WHSSC 10-20-30% savings                     | NR   | In Year               | Green             | 323            | 0            | 554            | 554            |
| WHSSC                         | WHC-03                | WHSSC Integrated Commissioning Plan Savings | NR   | In Year               | Green             | 1,420          | 0            | 2,434          | 2,434          |
|                               |                       |   |      |                       |                   | <b>3,350</b>   | <b>3,500</b> | <b>5,664</b>   | <b>2,164</b>   |

## National Covid-19 Funding Assumptions

The Health Board has received £5.878m of funding relating to Covid-19 schemes. Anticipated WG funding for Covid-19 is listed below;

| Type | Covid-19 Specific allocations - October 2023           | £'000         |
|------|--|---------------|
| HCHS | Nosocomial Covid 19 cases - Investigation and learning | 753           |
| HCHS | C19 PPE (Q1+Q2)  | 603           |
| HCHS | C19 Health Protection (Q1+Q2)                          | 2,446         |
| HCHS | C19 Vaccination programme (Q1+Q2)                      | 1,676         |
| GMS  | GMS Covid19 Vaccinations Q2                            | 400           |
|      | <b>Total Confirmed Covid-19 Allocations</b>            | <b>5,878</b>  |
| HCHS | Adferiad Programme                                     | 1,216         |
| HCHS | C19 Vaccination programme                              | 6,024         |
| HCHS | C19 Health Protection                                  | 2,354         |
| HCHS | C19 PPE  | 797           |
|      | <b>Total Anticipated Covid-19 Allocations</b>          | <b>10,391</b> |
|      | <b>Total Covid-19 Allocations</b>                      | <b>16,270</b> |

In addition, legacy costs for areas such as enhanced cleaning, security, portacabins continue and provide a significant forecast pressure for 2023/24 (forecast c.£7.4m).

## Reserves

### 7769-ALLOCATIONS TO BE DELEGATED

| Confirmed or Anticipated         | R / NR | Description                                      | 23/24             |
|----------------------------------|--------|--|-------------------|
| Confirmed                        | NR     | Regional Planned Care funding-Ophthalmology      | 2,500,000         |
| Confirmed                        | NR     | Regional Planned Care funding-Diagnostics        | 3,540,000         |
| Confirmed                        | NR     | Planned Care Transformation and Recovery         | 1,000,000         |
| 50% confirmed<br>50% anticipated | NR     | Trans Funding-Outpatient Transformation Unit     | 202,919           |
| 50% confirmed                    | NR     | Trans Funding-Medical retina                     | 81,607            |
| £290k Confirmed                  | NR     | PPE 23-24  | 1,005,939         |
| Central income                   | NR     | Training Grade Salary and PGMDE                  | (3,819)           |
| Confirmed                        | NR     | Clinical Leads SLA SP Planned Care Q1 Q2         | 23,319            |
| Confirmed                        | R      | Building Capacity Community Care-Further, Faster | 1,580,000         |
| Confirmed                        | NR     | Vertex months 1 to 6                             | 3,666,242         |
|                                  |        | <b>Confirmed Allocations to be apportioned</b>   | <b>13,596,207</b> |

### 7788-COMMITMENTS TO BE DELEGATED

| Description                            | 23/24          |
|--|----------------|
| Innovation and Development Fund (£10m) | 461,312        |
| <b>Total Commitments</b>               | <b>461,312</b> |

### 7501-SUPPORTING FINANCIAL POSITION

| Description   | 23/24             |
|---|-------------------|
| WG funding allocations and reserves previously held for allocation risk and inflation, retained within reserves to support the financial deficit position | 16,962,774        |
| <b>Total Commitments</b>  | <b>16,962,774</b> |

### 7515-IMTP 23/24 DEFICIT

| Description | 23/24                           |   |            |
|-------------|---------------------------------|---|------------|
|             |                                 |   |            |
| R           | 23/24 recurrent deficit         | (112,848,200)                               |            |
|             | <b>Additional funding 23-24</b> |   |            |
| Confirmed   | NR                              | Underlying deficit                          | 28,800,000 |
| Confirmed   | NR                              | Inflationary uplift (conditional recurrent) | 35,700,000 |
| Confirmed   | NR                              | Inflationary uplift (non-recurrent)         | 14,400,000 |
| Anticipated | NR                              | Energy                                      | 9,500,000  |
|             | <b>Total Commitments</b>        | <b>(24,448,200)</b>                         |            |
|             | <b>Totals</b>                   | <b>6,572,093</b>                            |            |

## Reserves Delegation:

A number of confirmed and anticipated allocations have remained in reserves for month 7 reporting (£13.6m). This funding will be reviewed by the Executive Team to determine whether it is appropriate to delegate to Divisions in the context of the budget setting methodology for 23/24 and the Health Board deficit.

A total of £9.8m was approved and delegated into Divisional positions from reserves in month 7. Significant delegations in-month were:

- **WAST Mobile Data Vehicle Solutions £186k** – Delegate to EASC in line with funding letter and EASC plan (NR)
- **WAST ESMCP Resources 23-24 £90k** – Delegate to EASC in line with funding letter and EASC plan (NR)
- **WAST Control Room Solutions 23-24 £258k** – Delegate to EASC in line with funding letter and EASC plan (NR)
- **Medical and Dental pay award £6.3m** – Pay award actioned in October, backdated to April 23. Anticipate WG funding for £6.3m, and delegate to Divisions as per the CMA analysis taken from payroll. (R)
- **Training Grade Salary and PGMDE £680k** – Increase central income budget in line with HEIW revised income schedule received October 23, and delegate corresponding budget to Divisions as per HEIW detailed analysis. (R)
- **DPIF Video Consultations £1.2m** – Funding confirmed via WG letter to cover period April to December 23. Delegate to CEO in line with YTD spend and forecast (NR)
- **Innovation fund to Cardiology £1.066m** – Recognised in the forecast position within reserves at month 6 as agreed by the Executive team. Delegate to Medicine for month 7 reporting (R)

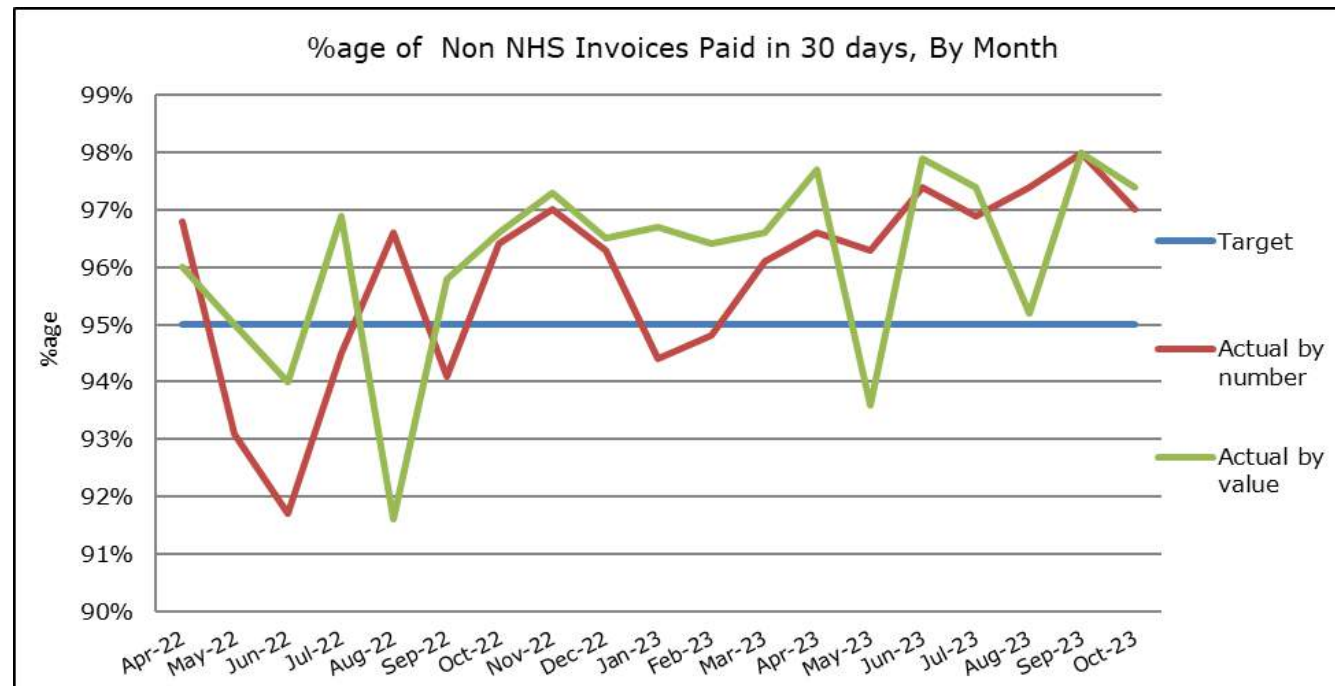
Further delegations will be made in month 8 where confirmed and approved. Other allocations require further information and discussion before delegation can be confirmed.

## Cash Position

The cash balance at the 31st October is £4.502m, which is below the advisory figure set by Welsh Government of £6m.

## Public Sector Payment Policy (PSPP)

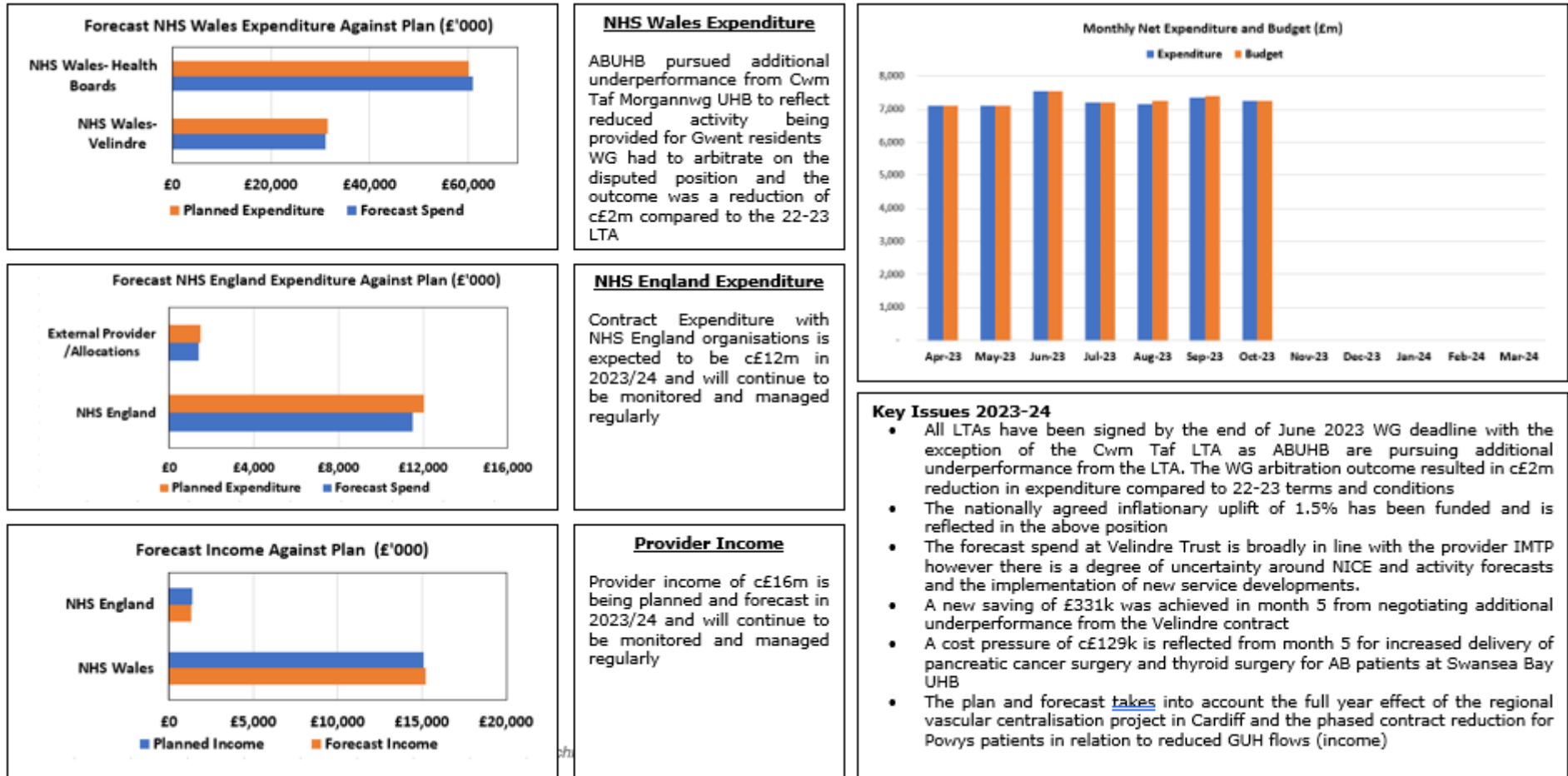
The HB has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days of delivery of goods/services in October and cumulatively. Despite contacting all requisitioners for April to June where the NHS invoices were paid outside of the payment terms, there has been a small decrease in the number of NHS invoices paid within 30 days. The exercise will be repeated for June to September to once again stress the importance of raising orders upfront and receipting on a timely basis.



## Contracting & Commissioning – LTA Spend & Income

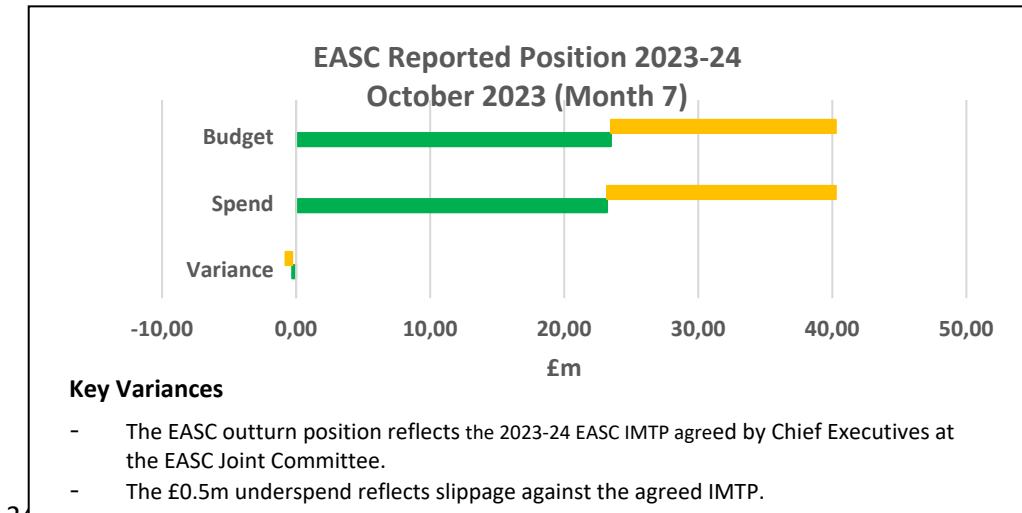
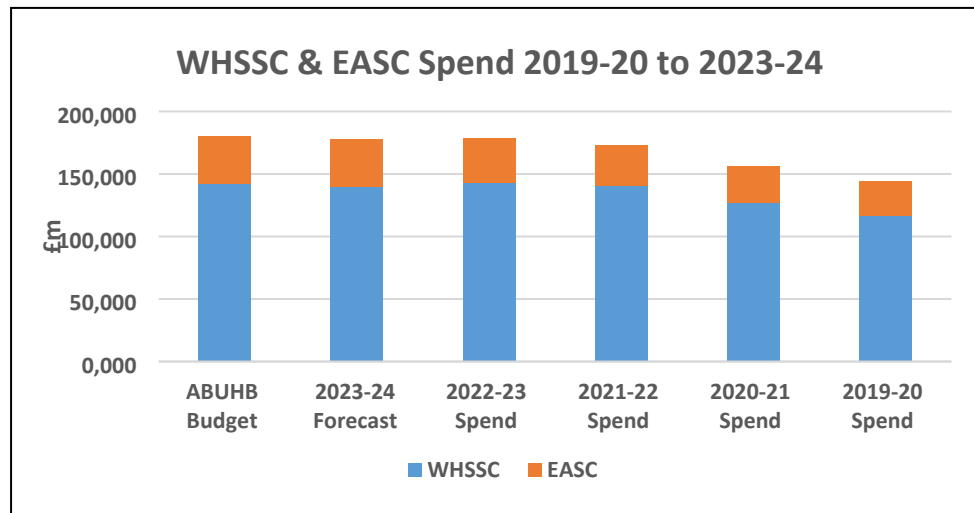
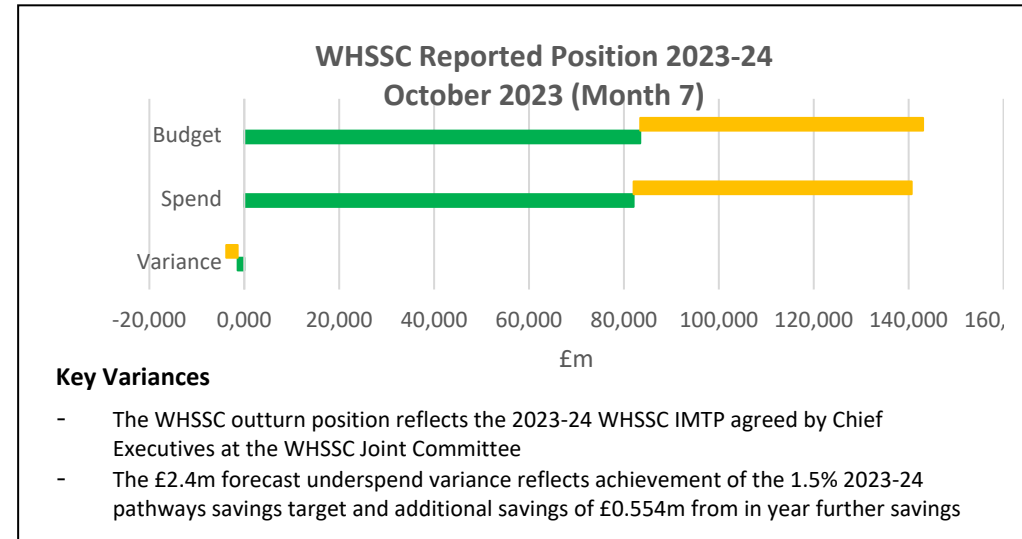
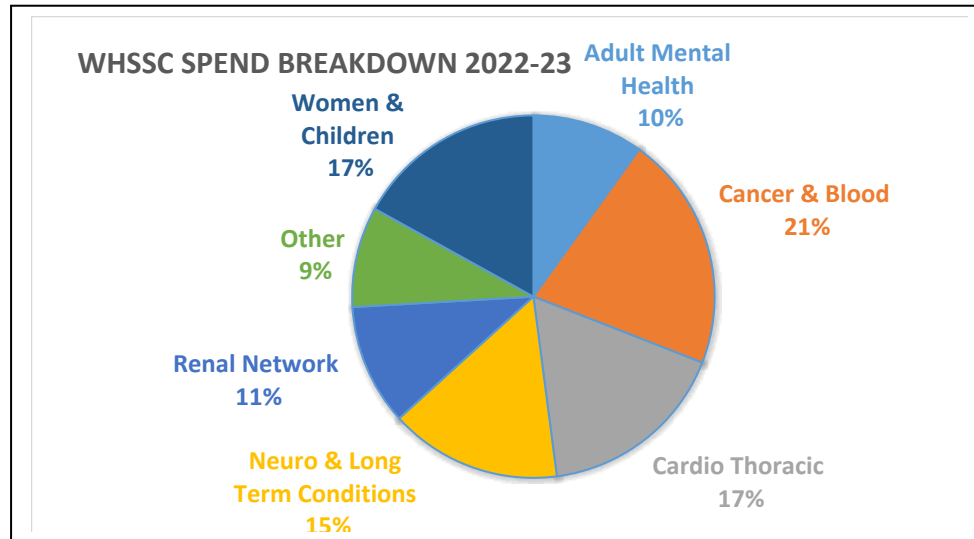
**Month/Financial Year:-** Month 7 (October) 2023-24

At Month 7 the financial performance for Contracting and Commissioning is a £157k underspend against the delegated budget. The key elements contributing to this position at Month 7 are as follows:



## WHSSC & EASC Financial Position 2023-24: Month 7

The Month 7 financial performance for WHSSC & EASC is an underspend of £1.692m. The Month 7 position reflects the agreed IMTP with WHSSC and EASC.





## Balance Sheet

| Balance sheet as at 31st October 2023 |  |                                  |                   |
|---------------------------------------|--|----------------------------------|-------------------|
|                                       | 2023/24<br>Opening<br>balance<br>£000s | 31st<br>October<br>2023<br>£000s | Movement<br>£000s |
| <b>Fixed Assets</b>                   | 893,408                                | 930,737                          | 37,329            |
| <b>Other Non current assets</b>       | 83,283                                 | 100,300                          | 17,017 *          |
| <b>Current Assets</b>                 |  |                                  |                   |
| Inventories                           | 9,576                                  | 9,965                            | 389               |
| Trade and other receivables           | 152,220                                | 169,711                          | 17,491 *          |
| Cash                                  | 4,704                                  | 4,502                            | (202)             |
| Non-current assets 'Held for Sale'    | 0                                      | 0                                | 0                 |
| Total Current Assets                  | 166,500                                | 184,178                          | 17,678            |
| <b>Liabilities</b>                    |  |                                  |                   |
| Trade and other payables              | 242,817                                | 217,690                          | (25,127)          |
| Provisions                            | 168,466                                | 213,641                          | 45,175            |
|                                       | 411,283                                | 431,331                          | 20,048            |
|                                       | <b>731,908</b>                         | <b>783,884</b>                   | <b>51,976</b>     |
| <b>Financed by:-</b>                  |  |                                  |                   |
| General Fund                          | 552,859                                | 586,577                          | 33,718            |
| Revaluation Reserve                   | 179,049                                | 197,307                          | 18,258            |
|                                       | <b>731,908</b>                         | <b>783,884</b>                   | <b>51,976</b>     |

### Fixed Assets:-

- An increase in net additions of £27.2 in relation to new 2023/24 capital expenditure incurred.
- A reduction of £25.0m for depreciation charges. A reduction of £2.3m for IFRS16 related charges.
- An increase in indexation costs of £37.4m

**Other Non-Current Assets:** This relates to an increase in Welsh Risk Pool claims due in more than one year £18.1m, a decrease in intangible assets of £1.2m and an increase in ICR income due in more than one year of £0.1m since the end of 2022/23.

**Inventories:** The increase in year relates to changes in stock held within the divisions

**Current Assets, Trade & Other Receivables:** The main movements since the end of 2022/23 relate to:

- Innovation fund to Cardiology £1m – Recognised in the forecast position within reserves at month 6 as agreed by the Executive team. Delegate to Medicine for month 7 reporting (R)
- Innovation fund to Cardiology £1m – Recognised in the forecast position within reserves at month 6 as agreed by the Executive team. Delegate to Medicine for month 7 reporting (R)
- An increase in the value of prepayments held £5.2m.

**Cash:** The cash balance held at the end of October is £4.502m.

### Liabilities, Provisions:

- The movement since the end of 2022/23 relates to a number of issues the most significant of which are:- a decrease in Capital accruals (£2.2m), an increase in NHS Creditor accruals (£6.0m), a decrease in the level of invoices held for payment from the year end (£5.1m), A decrease in non NHS accruals (£7.5m), a decrease in Tax & Superannuation (£0.5m), a decrease in other creditors (£13.6m), a decrease in the liability for lease payments (£2.1m), an increase in payments on account (£0.1m).
- Due to the increase in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £45.2m.

**General Fund:** This represents the difference in the year to date resource allocation budget and actual cash draw down including capital.

**Health Board Income**  
**WG Funding Allocations: £1.6bn**

| Funding Allocations - October 23 (M07 2023/24) |                  |
|--|------------------|
|  | £'000            |
| HCHS   | 1,460,374        |
| GMS  | 109,005          |
| Pharmacy                                       | 33,709           |
| Dental   | 32,654           |
| <b>Total confirmed allocations</b>             | <b>1,635,742</b> |
| Anticipated allocations                        | 77,035           |
| <b>Total Allocations</b>                       | <b>1,712,778</b> |

**Other Income:**

The HB receives income from a number of sources other than WG, based on the year-to-date income, this is forecast to be approximately £107m. (£108m for 22/23). The majority of this income is delegated to budget holders and therefore nets against their delegated budget positions. The main areas for income are: other NHS Bodies, Frailty, Education & Training, Dental, Child Health Projects, Managed Practices, Retail and Catering.

Estimated funding (allocations & income) for the UHB totals £1.73bn (£1.75bn for 22/23).

**WG anticipated allocations: £77.0m**

| WG Revenue Resource Limit : Anticipated Allocations (October) |   |               |                           |
|---|---|---------------|---------------------------|
| Funding Type  | Description   | Value £'000   | Recurrent / Non Recurrent |
| GMS   | GMS Refresh   | 1,603         | R                         |
| HCHS  | (Provider) SPR's  | 125           | R                         |
| HCHS  | (Provider) Clinical Excellence Awards (CDA's)               | 251           | R                         |
| HCHS  | Technology Enabled Care National Programme (ETTF)           | 1,800         | R                         |
| HCHS  | Informatics - Virtual Consultations                         | 1,065         | R                         |
| HCHS  | WHSSC - National Specialist CAMHS improvements              | 271           | R                         |
| HCHS  | Same Day Emergency Care (SDEC)                              | 1,560         | R                         |
| HCHS  | Adferiad Programme  | 1,216         | NR                        |
| HCHS  | Exceptional-Incremental Real Living Wage                    | 5,404         | NR                        |
| HCHS  | Urgent Primary Care   | 652           | R                         |
| HCHS  | Trans Funding-PSA self-management Prog Platform development | 232           | R                         |
| HCHS  | VBH: Heart Failure and Rehab in the Community               | 506           | R                         |
| HCHS  | Digital Medicines transformation team                       | 306           | NR                        |
| HCHS  | 23-24 C19 Vaccination programme                             | 6,024         | NR                        |
| HCHS  | 23-24 C19 TTP   | 2,354         | NR                        |
| HCHS  | New Medical Training Posts 2017-2022 cohorts                | 1,100         | R                         |
| HCHS  | Capital - DEL Depreciation - Baseline Surplus/Shortfall     | 581           | NR                        |
| HCHS  | Capital - DEL Depreciation - Strategic                      | 337           | NR                        |
| HCHS  | Capital - DEL Depreciation - Accelerated                    | 95            | NR                        |
| HCHS  | Capital - DEL Depreciation - IFRS 16 Leases                 | (344)         | NR                        |
| HCHS  | Capital - AME Depreciation - IFRS 16 Leases (Peppercorn)    | 116           | NR                        |
| HCHS  | Capital - AME Depreciation - Donated Assets                 | 343           | NR                        |
| HCHS  | Capital - AME Depreciation - Impairments                    | 24,267        | NR                        |
| HCHS  | Capital - Removal of Donated assets / Gvnt grant receipts   | (300)         | NR                        |
| HCHS  | IFRS16 Leases New / Renewals DEL Depn                       | 139           | NR                        |
| HCHS  | IFRS16 Leases New / Renewals Revenue Reduction              | (4,015)       | NR                        |
| HCHS  | Mental Capacity Act 23-24                                   | 189           | NR                        |
| HCHS  | Mental Capacity Act Advocacy 23-24                          | 217           | NR                        |
| HCHS  | Consolidated pay award 1.5% Apr-23                          | 9,321         | NR                        |
| HCHS  | Capital - AME Depreciation - Impairment reversals           | (19,552)      | NR                        |
| HCHS  | C19 PPE 23/24   | 797           | NR                        |
| HCHS  | CAMHS Sanctuary provision                                   | 50            | R                         |
| HCHS  | Trans Funding-Outpatient Transformation Unit                | 101           | NR                        |
| HCHS  | Trans Funding-AB Central support costs                      | 216           | NR                        |
| HCHS  | Trans Funding-Glaucoma optom                                | 41            | NR                        |
| HCHS  | Trans Funding-Medical retina                                | 41            | NR                        |
| HCHS  | Trans Funding-Telex/TeleENT project                         | 36            | NR                        |
| HCHS  | Welsh Risk Pool Risk Share agreement 23-24                  | (4,455)       | NR                        |
| HCHS  | Mental Capacity Act 23-24 - Gwent consortium                | 49            | NR                        |
| HCHS  | A4C Pay award 23-24   | 26,554        | R                         |
| GMS   | GP/GMS Increase in list size addtl funding 23-24            | 838           | R                         |
| HCHS  | Informatics - Virtual Consultations platform license        | 1,023         | NR                        |
| HCHS  | Financial position 23-24 - Energy                           | 9,500         | NR                        |
| HCHS  | Pay award-Medical and Dental 5% 23-24                       | 6,384         | R                         |
| <b>Total Anticipated: Per Ledger</b>                          |   | <b>77,035</b> |                           |

## Capital Planning & Performance

|   | 2023/24               |                      |                     |                          |                  |
|---|-----------------------|----------------------|---------------------|--------------------------|------------------|
|   | Original Plan<br>£000 | Revised Plan<br>£000 | Spend to M7<br>£000 | Forecast Outturn<br>£000 | Variance<br>£000 |
| <b>Source:</b>  |                       |                      |                     |                          |                  |
| <b>Discretionary Capital:</b>   |                       |                      |                     |                          |                  |
| Approved Discretionary Capital Funding Allocation                               | 9,521                 | 9,521                |                     | 9,521                    | 0                |
| Less EFAB Contribution  | -629                  | -629                 |                     | -629                     | 0                |
| Less AWCP Brokerage 22/23   | -1,472                | -2,278               |                     | -2,278                   | 0                |
| Grant Income Received   | 0                     | 0                    |                     | 0                        | 0                |
| NBV of Assets Disposed  | 0                     | 427                  |                     | 427                      | 0                |
| <b>Total Approved Discretionary Funding</b>                                     | <b>7,420</b>          | <b>7,041</b>         |                     | <b>7,041</b>             | <b>0</b>         |
| <b>All Wales Capital Programme Funding:</b>                                     |                       |                      |                     |                          |                  |
| AWCP Approved Funding   | 43,396                | 45,541               |                     | 45,541                   | 0                |
| Anticipated YYF Breast Inflation Funding (in Unapproved section of CRL)         | 0                     | 0                    |                     | 20                       | 20               |
| Charitable Donations YYF Breast Centralisation Unit                             | 0                     | 150                  |                     | 150                      | 0                |
| <b>Total Approved AWCP Funding</b>  | <b>43,396</b>         | <b>45,711</b>        |                     | <b>45,711</b>            | <b>20</b>        |
| <b>Total Approved IFRS16 Lease funding</b>                                      | <b>0</b>              | <b>-211</b>          |                     | <b>-211</b>              | <b>0</b>         |
| <b>Total Capital Funding / Capital Resource Limit (CRL)</b>                     | <b>50,816</b>         | <b>52,521</b>        |                     | <b>52,541</b>            | <b>20</b>        |
| <b>Applications:</b>  |                       |                      |                     |                          |                  |
| <b>Discretionary Capital:</b>   |                       |                      |                     |                          |                  |
| Commitments B/f From 2022/23  | 321                   | 644                  | 313                 | 635                      | -8               |
| Statutory Allocations   | 576                   | 590                  | 388                 | 590                      | 0                |
| Divisional Priorities   | 2,868                 | 3,118                | 1,410               | 3,010                    | -108             |
| Corporate Priorities  | 300                   | 1,079                | 511                 | 1,059                    | -20              |
| Informatics National Priority & Sustainability                                  | 2,170                 | 1,301                | 373                 | 1,294                    | -7               |
| Remaining DCP Contingency   | 1,185                 | 310                  | 0                   | 0                        | -310             |
| <b>Total Discretionary Capital</b>  | <b>7,420</b>          | <b>7,041</b>         | <b>2,995</b>        | <b>6,588</b>             | <b>-454</b>      |
| <b>All Wales Capital Programme:</b>   |                       |                      |                     |                          |                  |
| Grange University Hospital Remaining works                                      | -3,517                | -74                  | -182                | -74                      | 0                |
| Tredegar Health & Wellbeing Centre Development                                  | 4,019                 | 3,375                | 3,545               | 3,853                    | 478              |
| NHH Satellite Radiotherapy Centre   | 17,675                | 16,158               | 7,511               | 16,158                   | 0                |
| YYF Breast Centralisation Unit  | 8,685                 | 8,632                | 5,249               | 8,652                    | 20               |
| Newport East Health & Wellbeing Centre Development                              | 10,362                | 9,411                | 3,393               | 9,411                    | 0                |
| RGH Endoscopy Unit  | 4,004                 | 4,914                | 4,460               | 4,914                    | 0                |
| RGH – Block 1 and 2 Demolition and Car Park                                     | 404                   | 554                  | 16                  | 660                      | 106              |
| EFAB Schemes  | 1,764                 | 1,580                | 196                 | 1,580                    | 0                |
| EOY Funding Schemes   | 0                     | 239                  | 177                 | 269                      | 30               |
| MH SISU Development   | 0                     | 10                   | 2                   | 10                       | 0                |
| ICF Schemes   | 0                     | 16                   | 14                  | 16                       | 0                |
| HCF Schemes   | 0                     | 10                   | 9                   | 9                        | -1               |
| ED Waiting Area Funding   | 0                     | 111                  | 86                  | 111                      | 0                |
| CAMHS Sanctuary Hub   | 0                     | 662                  | 111                 | 662                      | 0                |
| National Imaging Programme - 2022/23 Old year schemes                           | 0                     | 55                   | 8                   | 55                       | 0                |
| Digital Eye Care  | 0                     | 10                   | 10                  | 10                       | 0                |
| Radiotherapy Satellite Centre NHH Enabling Works                                | 0                     | 9                    | 2                   | 9                        | 0                |
| SDEC Equipment - Old Year Orders  | 0                     | 19                   | -21                 | 22                       | 3                |
| <b>Total AWCP Capital</b>   | <b>43,396</b>         | <b>45,691</b>        | <b>24,585</b>       | <b>46,327</b>            | <b>636</b>       |
| <b>Total IFRS16 Lease Expenditure</b>   | <b>0</b>              | <b>-211</b>          | <b>-211</b>         | <b>-211</b>              | <b>0</b>         |
| <b>Total Programme Allocation and Expenditure</b>                               | <b>50,816</b>         | <b>52,521</b>        | <b>27,369</b>       | <b>52,704</b>            | <b>183</b>       |
| <b>Forecast Overspend / (Underspend) against Overall Capital Resource Limit</b> |                       |                      |                     |                          | <b>163</b>       |

|   |
|---|
| <b>Aneurin Bevan University Health Board</b>          |
| <b>Finance Report – August (Month 7) 2023/24</b>      |
| <b>Appendix 2 – WG Monthly Monitoring Return (M7)</b> |

| <b>Section</b>                                  | <b>Page Number(s)</b> |
|---|-----------------------|
| <b>Table A: Movement</b>                        | <b>2</b>              |
| <b>Table A1: Underlying Position</b>            | <b>3</b>              |
| <b>Table A2: Risks</b>                          | <b>4</b>              |
| <b>Table B: Monthly Positions</b>               | <b>5</b>              |
| <b>Table B2: Pay &amp; Agency</b>               | <b>6</b>              |
| <b>Table B3: Covid-19</b>                       | <b>7-8</b>            |
| <b>Table C: Identified Savings Schemes</b>      | <b>9</b>              |
| <b>Table D: Welsh NHS Assumptions</b>           | <b>10</b>             |
| <b>Table F: Statement of Financial Position</b> | <b>11</b>             |
| <b>Table G: Cash Flow</b>                       | <b>12</b>             |
| <b>Table H: PSPP</b>                            | <b>13</b>             |
| <b>Table I: Capital RLM</b>                     | <b>14</b>             |
| <b>Table J: Capital In Year Schemes</b>         | <b>15</b>             |
| <b>Table K: Capital Disposals</b>               | <b>16</b>             |
| <b>Table M: Aged Debtors</b>                    | <b>17</b>             |
| <b>Table P: Ringfenced</b>                      | <b>18</b>             |

**Table A: Movement**

|  | In Year Effect<br>£'000 | Non Recurring<br>£'000 | Recurring<br>£'000 | FYE of Recurring<br>£'000 |  | Apr<br>£'000   | May<br>£'000   | Jun<br>£'000   | Jul<br>£'000   | Aug<br>£'000   | Sep<br>£'000   | Oct<br>£'000  | Nov<br>£'000  | Dec<br>£'000  | Jan<br>£'000  | Feb<br>£'000  | Mar<br>£'000  | YTD<br>£'000   | In Year<br>Effect<br>£'000 |          |
|--|-------------------------|------------------------|--------------------|---------------------------|--|----------------|----------------|----------------|----------------|----------------|----------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|----------------------------|----------|
|  |                         |                        |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                |                            |          |
| 1 Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)                              | -89,600                 | 0                      | 89,600             | -89,600                   |  | -7,467         | -7,467         | -7,467         | -7,467         | -7,467         | -7,467         | -7,467        | -7,467        | -7,467        | -7,467        | -7,467        | -7,467        | -7,467         | -52,267                    | -89,600  |
| 2 Planned New Expenditure (Non Covid-19) (Negative Value)  | -101,947                | 518                    | -101,429           | -101,429                  |  | -8,496         | -8,496         | -8,496         | -8,496         | -8,496         | -8,496         | -8,496        | -8,496        | -8,496        | -8,496        | -8,496        | -8,496        | -8,496         | -59,469                    | -101,947 |
| 3 Planned Expenditure For Covid-19 (Negative Value)  | -17,146                 | -17,146                |                    |                           |  | -1,456         | -1,668         | -1,399         | -1,249         | -1,114         | -1,761         | -1,892        | -1,627        | -1,171        | -1,209        | -1,245        | -1,356        | -10,539        | -17,146                    |          |
| 4 Planned Welsh Government Funding (Non Covid-19) (Positive Value)   | 26,662                  | 5,933                  | 20,729             | 20,729                    |  | 2,222          | 2,222          | 2,222          | 2,222          | 2,222          | 2,222          | 2,222         | 2,222         | 2,222         | 2,222         | 2,222         | 2,220         | 15,554         | 26,662                     |          |
| 5 Planned Welsh Government Funding for Covid-19 (Positive Value)   | 17,146                  | 17,146                 |                    |                           |  | 1,456          | 1,668          | 1,399          | 1,249          | 1,114          | 1,761          | 1,892         | 1,627         | 1,171         | 1,209         | 1,245         | 1,356         | 10,539         | 17,146                     |          |
| 6 Planned Provider Income (Positive Value)   | 535                     | 0                      | 535                | 535                       |  | 45             | 45             | 45             | 45             | 45             | 45             | 45            | 45            | 45            | 45            | 45            | 45            | 312            | 535                        |          |
| 7 RRL Profile - phasing only (In Year Effect / Column C must be nil)   | 0                       | 0                      | 0                  | 0                         |  | -2,725         | -514           | 543            | 336            | 324            | 463            | 302           | 291           | 155           | 144           | 133           | 548           | -1,271         | 0                          |          |
| 8 Planned (Finalised) Savings Plan   | 51,502                  | 11,500                 | 40,002             | 40,002                    |  | 4,155          | 1,944          | 4,399          | 4,456          | 4,468          | 4,478          | 4,490         | 4,501         | 4,637         | 4,648         | 4,659         | 4,669         | 28,389         | 51,502                     |          |
| 9 Planned (Finalised) Net Income Generation  | 0                       | 0                      | 0                  | 0                         |  | 0              | 0              | 0              | 0              | 0              | 0              | 0             | 0             | 0             | 0             | 0             | 0             | 0              | 0                          |          |
| 10 Planned Profit / (Loss) on Disposal of Assets   | 0                       | 0                      | 0                  | 0                         |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 11 Planned Release of Uncommitted Contingencies & Reserves (Positive Value)  | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 12   | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 13 Planning Assumptions still to be finalised at Month 1   | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 14 <b>Opening IMTP / Annual Operating Plan</b>   | <b>-112,848</b>         | <b>16,915</b>          | <b>-129,763</b>    | <b>-129,763</b>           |  | <b>-12,266</b> | <b>-12,266</b> | <b>-8,754</b>  | <b>-8,904</b>  | <b>-8,904</b>  | <b>-8,754</b>  | <b>-8,904</b> | <b>-8,904</b> | <b>-8,904</b> | <b>-8,904</b> | <b>-8,904</b> | <b>-8,481</b> | <b>-68,761</b> | <b>-112,848</b>            |          |
| 15 Reversal of Planning Assumptions still to be finalised at Month 1   | 0                       | 0                      | 0                  | 0                         |  | 0              | 0              | 0              | 0              | 0              | 0              | 0             | 0             | 0             | 0             | 0             | 0             | 0              | 0                          |          |
| 16 Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)        | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 17 Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets  | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 18 Other Movement in Month 1 Planned & In Year Net Income Generation   | 0                       | 0                      | 0                  | 0                         |  | 0              | 0              | 0              | 0              | 0              | 0              | 0             | 0             | 0             | 0             | 0             | 0             | 0              | 0                          |          |
| 19 Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement  | -33,499                 | -8,221                 | -25,278            | -25,133                   |  | -3,074         | -1,135         | -3,364         | -3,357         | -1,272         | -3,448         | -2,745        | -3,000        | -3,134        | -3,014        | -2,968        | -2,986        | -18,396        | -33,499                    |          |
| 20 Additional In Year Identified Savings - Forecast  | 24,055                  | 10,700                 | 13,355             | 17,812                    |  | 146            | 97             | 251            | 815            | 815            | 3,039          | 3,216         | 2,721         | 2,641         | 2,962         | 2,847         | 4,506         | 8,379          | 24,055                     |          |
| 21 Variance to Planned RRL & Other Income  | 0                       | 0                      |                    |                           |  | 1,433          | -278           | -3,170         | -1,111         | 0              | 0              | 0             | 891           | 891           | 891           | 891           | 437           | -3,127         | 0                          |          |
| 22 Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 plus virements (Positive Value - additional) | -876                    | -876                   |                    |                           |  | 0              | -201           | -217           | -1,119         | -537           | 487            | -1,043        | 37            | 516           | 485           | 412           | 303           | -2,630         | -876                       |          |
| 23 Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)                 | 88,400                  | 23,900                 | 64,500             | 64,500                    |  |                |                |                |                |                |                | 51,567        | 7,367         | 7,367         | 7,367         | 7,367         | 7,367         | 51,567         | 88,400                     |          |
| 24 Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Positive Value - reduction)             | 4,685                   | 4,685                  |                    |                           |  | -96            | 297            | 217            | 1,119          | 818            | 544            | 1,058         | 435           | 21            | -15           | 125           | 162           | 3,957          | 4,685                      |          |
| 25 In Year Accountancy Gains (Positive Value)  | 0                       | 0                      | 0                  | 0                         |  | 0              | 0              | 0              | 0              | 0              | 0              | 0             | 0             | 0             | 0             | 0             | 0             | 0              | 0                          |          |
| 26 Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)                               | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 27 Savings plans / mitigating actions to be finalised  | 0                       | 0                      |                    |                           |  |                |                |                | -26            | 26             |                |               |               |               |               |               |               |                | 0                          |          |
| 28 In-month operating benefits/pressures   | -10,919                 | -10,919                |                    | 0                         |  |                | -1,152         |                |                | -2,233         | -1,065         | -989          | -1,661        | -871          | -1,535        | -744          | -672          | -5,438         | -10,919                    |          |
| 29 CHC pressures (uplift/growth)   | -6,001                  | -3,001                 | -3,000             | -3,000                    |  | -417           | -1,324         | -417           | -417           | -542           | -542           | -391          | -391          | -391          | -391          | -391          | -391          | -4,048         | -6,001                     |          |
| 30 Prescribing   | -12,601                 | -6,000                 | -6,601             | -7,574                    |  | -333           | -1,169         | -333           | -209           | -2,488         | -1,097         | -1,189        | -1,189        | -1,189        | -1,183        | -1,183        | -1,038        | -6,819         | -12,601                    |          |
| 31 Energy  | 7,532                   | 0                      | 7,532              | 7,532                     |  | 1,112          | 1,152          | 1,272          | 691            | 607            | 708            | 311           | 225           | 421           | 325           | 449           | 258           | 5,853          | 7,532                      |          |
| 32 Covid-19 estates & facilities legacy costs  | -5,555                  | 0                      | -5,555             | -5,555                    |  |                |                |                | -586           | -608           | -608           | -608          | -608          | -608          | -608          | -608          | -713          | -2,410         | -5,555                     |          |
| 33 Income risk (RPB)   | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               | 0             | 0             | 0              | 0                          |          |
| 34   | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 35 Planning Assumptions - EXEC process (Ideas / proposal requiring substantial further development)                            | 0                       | 0                      |                    | 0                         |  |                |                |                |                |                |                |               |               |               | 0             | 0             | 0             | 0              | 0                          |          |
| 36 Planning Assumptions - EXEC process (Ideas / proposal requiring further development)  | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               | 0             | 0             | 0             | 0             | 0              | 0                          |          |
| 37   | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 38   | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 39   | 0                       | 0                      |                    |                           |  |                |                |                |                |                |                |               |               |               |               |               |               |                | 0                          |          |
| 40 <b>Forecast Outturn (- Deficit / + Surplus)</b>   | <b>-67,627</b>          | <b>27,184</b>          | <b>-84,811</b>     | <b>-81,181</b>            |  | <b>-13,494</b> | <b>-15,979</b> | <b>-14,515</b> | <b>-13,105</b> | <b>-14,318</b> | <b>-10,736</b> | <b>40,282</b> | <b>-4,077</b> | <b>-3,240</b> | <b>-3,619</b> | <b>-2,706</b> | <b>-2,121</b> | <b>-41,863</b> | <b>-67,627</b>             |          |
| 41 <b>Covid-19 - Forecast Outturn (- Deficit / + Surplus)</b>  | <b>3,809</b>            |                        |                    |                           |  | <b>-96</b>     | <b>96</b>      | <b>0</b>       | <b>0</b>       | <b>281</b>     | <b>1,031</b>   | <b>15</b>     | <b>472</b>    | <b>537</b>    | <b>471</b>    | <b>537</b>    | <b>465</b>    | <b>1,327</b>   | <b>3,809</b>               |          |
| 42 <b>Operational - Forecast Outturn (- Deficit / + Surplus)</b>   | <b>-61,436</b>          |                        |                    |                           |  | <b>-13,399</b> | <b>-16,075</b> | <b>-14,515</b> | <b>-13,105</b> | <b>-14,599</b> | <b>-11,767</b> | <b>40,268</b> | <b>-4,549</b> | <b>-3,777</b> | <b>-4,090</b> | <b>-3,243</b> | <b>-2,586</b> | <b>-43,190</b> | <b>-61,436</b>             |          |

**Table A1: Underlying Position**

| Section A - By Spend Area  |  | IMTP                                | Full Year Effect of Actions                    |   | Subtotal<br>£'000 | New, Recurring,<br>Full Year Effect<br>of Unmitigated<br>Pressures (-ve)<br>£'000 | IMTP                                |
|----------------------------|--|-------------------------------------|--|---|-------------------|---|-------------------------------------|
|                            |  | Underlying<br>Position b/f<br>£'000 | Recurring<br>Savings (+ve)<br>£'000            | Recurring<br>Allocations /<br>Income (+ve)<br>£'000 |                   |   | Underlying<br>Position c/f<br>£'000 |
|                            |  | 1                                   | Pay - Administrative, Clerical & Board Members | (500)   |                   |   | 500                                 |
| 2                          | Pay - Medical & Dental                               | (17,293)                            |  | 8,000   | (9,293)           | (15,000)  | (24,293)                            |
| 3                          | Pay - Nursing & Midwifery Registered                 | (16,738)                            | 8,108  | 8,700   | 70                | (15,708)  | (15,638)                            |
| 4                          | Pay - Prof Scientific & Technical                    | (257)                               |  | 200   | (57)              | (750)   | (807)                               |
| 5                          | Pay - Additional Clinical Services                   | (9,000)                             | 3,000  | 8,000   | 2,000             | (8,776)   | (6,776)                             |
| 6                          | Pay - Allied Health Professionals                    | (0)                                 |  |   | (0)               |   | (0)                                 |
| 7                          | Pay - Healthcare Scientists                          | (115)                               |  |   | (115)             | 0   | (115)                               |
| 8                          | Pay - Estates & Ancillary                            | (513)                               |  |   | (513)             | (2,328)   | (2,841)                             |
| 9                          | Pay - Students                                       | 0                                   |  |   | 0                 |   | 0                                   |
| 10                         | Non Pay - Supplies and services - clinical           | (16,937)                            | 7,057  | 20,600  | 10,720            | (25,721)  | (15,001)                            |
| 11                         | Non Pay - Supplies and services - general            | (740)                               |  | 2,500   | 1,760             | (2,500)   | (740)                               |
| 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                                   | (13,600)                            | 4,585  | 8,000   | (1,015)           | (4,073)   | (5,088)                             |
| 16                         | Non Pay - External Contractors                       | 0                                   |  |   | 0                 |   | 0                                   |
| 17                         | Health Care Provided by other Orgs – Welsh LHBs      | (1,400)                             | 1,400  |   | 0                 | (1,000)   | (1,000)                             |
| 18                         | Health Care Provided by other Orgs – Welsh Trusts    | 0                                   |  |   | 0                 |   | 0                                   |
| 19                         | Health Care Provided by other Orgs – WHSSC           | (2,000)                             | 2,431  |   | 431               | (431)   | 0                                   |
| 20                         | Health Care Provided by other Orgs – English         | 0                                   |  |   | 0                 |   | 0                                   |
| 21                         | Health Care Provided by other Orgs – Private / Other | (10,506)                            | 7,025  | 8,000   | 4,519             | (13,400)  | (8,881)                             |
| 22                         | <b>Total</b>   | <b>(89,600)</b>                     | <b>34,106</b>                                  | <b>64,500</b>                                       | <b>9,006</b>      | <b>(90,187)</b>   | <b>(81,181)</b>                     |
| Section B - By Directorate |  | IMTP                                | Full Year Effect of Actions                    |   | Subtotal<br>£'000 | New, Recurring,<br>Full Year Effect<br>of Unmitigated<br>Pressures (-ve)<br>£'000 | IMTP                                |
|                            |  | Underlying<br>Position b/f<br>£'000 | Recurring<br>Savings (+ve)<br>£'000            | Recurring<br>Allocations /<br>Income (+ve)<br>£'000 |                   |   | Underlying<br>Position c/f<br>£'000 |
|                            |  | 1                                   | Primary Care                                   | (17,000)  |                   |   | 7,057                               |
| 2                          | Mental Health  | (10,000)                            | 3,000  |   | (7,000)           | (5,914)   | (12,914)                            |
| 3                          | Continuing HealthCare                                | 0                                   | 4,025  |   | 4,025             | (1,292)   | 2,733                               |
| 4                          | Commissioned Services                                | (2,000)                             | 1,400  |   | (600)             | 0   | (600)                               |
| 5                          | Scheduled Care                                       | (23,000)                            | 6,585  |   | (16,415)          | 0   | (16,415)                            |
| 6                          | Unscheduled Care                                     | (20,000)                            | 6,108  |   | (13,892)          | (8,164)   | (22,056)                            |
| 7                          | Children & Women's                                   | (2,000)                             | 2,000  |   | 0                 | (2,703)   | (2,703)                             |
| 8                          | Community Services                                   | 0                                   |  |   | 0                 |   | 0                                   |
| 9                          | Specialised Services                                 | (2,000)                             | 2,431  |   | 431               | (431)   | 0                                   |
| 10                         | Executive / Corporate Areas                          | 0                                   |  | 64,500  | 64,500            | (67,724)  | (3,224)                             |
| 11                         | Support Services (inc. Estates & Facilities)         | (13,600)                            | 1,500  |   | (12,100)          | 0   | (12,100)                            |
| 12                         | <b>Total</b>   | <b>(89,600)</b>                     | <b>34,106</b>                                  | <b>64,500</b>                                       | <b>9,006</b>      | <b>(90,187)</b>   | <b>(81,181)</b>                     |



**Table A2: Risks**

|  |  | FORECAST YEAR END |            |
|--|--|-------------------|------------|
|  |  | £'000             | Likelihood |
| <b>Risks (negative values)</b>                 |  |                   |            |
| 4  | Under delivery of Amber Schemes included in Outturn via Tracker                        |                   | High       |
| 6  | Prescribing  | (500)             | High       |
| 19   | Continued Operational pressures - to ensure Board reported position matches worst case | (2,287)           | Medium     |
| 23   | Allcoation funding risk (including Health Protection)                                  | (4,659)           | Medium     |
| 25   | Non Achievement of savings   | (2,554)           | Medium     |
| 26   | <b>Total Risks</b>   | <b>(10,000)</b>   |            |
| <b>Further Opportunities (positive values)</b> |  |                   |            |
| 27   | Insurance refund (E block)   | 388               | Medium     |
| 28   | Further operational benefits (National policy, refunds and further slippage)           | 199               | Low        |
| 29   | Further benefits (review of options discounted by Clinical Advisory Board)             | 3,149             | Low        |
| 30   | InnU's   | 250               | Low        |
| 31   | Endoscopy Rightsizing  | 487               | Low        |
| 32   | Relases of uncommitted budget  | 527               | High       |
| 33   |  |                   |            |
| 34   | <b>Total Further Opportunities</b>   | <b>5,000</b>      |            |



**Table B: Monthly Positions**

| A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income |                     | Apr             | May             | Jun             | Jul             | Aug             | Sep             | Oct            | Nov            | Dec            | Jan            | Feb            | Mar            | Total YTD        | Forecast year-end position |
|--|---------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|----------------|----------------|----------------|----------------|----------------|----------------|------------------|----------------------------|
|  |                     | £'000           | £'000           | £'000           | £'000           | £'000           | £'000           | £'000          | £'000          | £'000          | £'000          | £'000          | £'000          | £'000            | £'000                      |
| Revenue Resource Limit   | Actual/Fcast        | 126,659         | 121,997         | 141,139         | 136,897         | 132,781         | 129,001         | 178,120        | 142,255        | 160,067        | 143,427        | 146,528        | 153,905        | 966,594          | 1,712,778                  |
| Capital Donation / Government Grant Income (Health Board only)   | Actual/Fcast        | 0               | 0               | 42              | 0               | 0               | 60              | 0              | 0              | 35             | 0              | 0              | 163            | 102              | 300                        |
| Welsh NHS Local Health Boards & Trusts Income  | Actual/Fcast        | 1,837           | 1,739           | 1,891           | 2,043           | 1,912           | 1,844           | 2,045          | 1,959          | 1,959          | 1,959          | 1,959          | 1,959          | 13,311           | 23,105                     |
| WHSSC Income   | Actual/Fcast        | 896             | 896             | 859             | 1,046           | 933             | 862             | 936            | 914            | 914            | 914            | 914            | 914            | 6,428            | 10,999                     |
| Welsh Government Income (Non RRL)  | Actual/Fcast        | (369)           | 419             | 491             | 372             | 103             | 286             | (587)          | 117            | 117            | 117            | 117            | 7,117          | 715              | 8,300                      |
| Other Income   | Actual/Fcast        | 5,070           | 5,044           | 5,588           | 5,737           | 5,396           | 5,393           | 5,374          | 5,350          | 5,350          | 5,350          | 5,350          | 5,350          | 37,602           | 64,352                     |
| <b>Income Total</b>  |                     | <b>134,093</b>  | <b>130,095</b>  | <b>150,010</b>  | <b>146,095</b>  | <b>141,125</b>  | <b>137,446</b>  | <b>185,888</b> | <b>150,595</b> | <b>168,442</b> | <b>151,767</b> | <b>154,868</b> | <b>169,409</b> | <b>1,024,751</b> | <b>1,819,833</b>           |
| Primary Care Contractor (excluding drugs, including non resource limited expenditure)                    | Actual/Fcast        | 15,621          | 16,175          | 16,316          | 16,684          | 16,428          | 14,719          | 15,441         | 16,100         | 16,100         | 16,100         | 16,100         | 17,700         | 111,384          | 193,484                    |
| Primary Care - Drugs & Appliances  | Actual/Fcast        | 9,911           | 10,119          | 10,175          | 10,159          | 10,594          | 10,421          | 9,835          | 10,331         | 10,285         | 10,285         | 10,235         | 10,235         | 71,214           | 122,586                    |
| Provided Services - Pay  | Actual/Fcast        | 59,888          | 62,050          | 73,082          | 69,139          | 63,642          | 61,747          | 65,918         | 63,841         | 63,751         | 64,068         | 66,357         | 64,384         | 455,466          | 777,865                    |
| Provider Services - Non Pay (excluding drugs & depreciation)   | Actual/Fcast        | 12,972          | 12,216          | 13,471          | 11,188          | 13,091          | 12,022          | 13,719         | 13,147         | 13,247         | 13,597         | 13,547         | 14,800         | 88,679           | 157,017                    |
| Secondary Care - Drugs   | Actual/Fcast        | 4,901           | 4,918           | 4,279           | 6,584           | 4,703           | 4,733           | 6,102          | 5,350          | 5,350          | 5,350          | 5,350          | 5,262          | 36,220           | 62,882                     |
| Healthcare Services Provided by Other NHS Bodies   | Actual/Fcast        | 25,297          | 27,471          | 28,095          | 26,476          | 25,716          | 26,688          | 27,136         | 26,700         | 26,700         | 26,700         | 26,700         | 26,700         | 186,879          | 320,381                    |
| Non Healthcare Services Provided by Other NHS Bodies   | Actual/Fcast        | 0               | 0               | 0               | 0               | 0               | 0               | 0              | 0              | 0              | 0              | 0              | 0              | 0                | 0                          |
| Continuing Care and Funded Nursing Care  | Actual/Fcast        | 10,665          | 11,144          | 10,706          | 10,591          | 10,578          | 10,418          | 10,482         | 10,603         | 10,603         | 10,603         | 10,603         | 10,545         | 74,584           | 127,539                    |
| Other Private & Voluntary Sector   | Actual/Fcast        | 1,176           | 1,236           | 1,226           | 1,282           | 1,611           | 975             | 1,240          | 1,200          | 1,200          | 1,200          | 1,200          | 1,200          | 8,746            | 14,746                     |
| Joint Financing and Other  | Actual/Fcast        | 3,049           | 2,775           | 3,455           | 2,664           | 4,389           | 2,307           | 2,551          | 3,107          | 3,107          | 3,107          | 3,107          | 10,107         | 21,190           | 43,724                     |
| Losses, Special Payments and Irrecoverable Debts   | Actual/Fcast        | 441             | 440             | (394)           | 383             | 322             | 157             | 305            | 163            | 163            | 163            | 163            | 163            | 1,654            | 2,471                      |
| Exceptional (Income) / Costs - (Trust Only)  | Actual/Fcast        |                 |                 |                 |                 |                 |                 |                |                |                |                |                |                | 0                | 0                          |
| Total Interest Receivable - (Trust Only)   | Actual/Fcast        |                 |                 |                 |                 |                 |                 |                |                |                |                |                |                | 0                | 0                          |
| Total Interest Payable - (Trust Only)  | Actual/Fcast        |                 |                 |                 |                 |                 |                 |                |                |                |                |                |                | 0                | 0                          |
| DEL Depreciation\Accelerated Depreciation\Impairments  | Actual/Fcast        | 3,638           | 4,434           | 4,057           | 4,013           | 4,035           | 3,930           | 4,525          | 4,093          | 4,092          | 4,174          | 4,172          | 4,081          | 28,631           | 49,243                     |
| AME Donated Depreciation\Impairments   | Actual/Fcast        | 28              | (6,902)         | 57              | 38              | 38              | 38              | (11,674)       | 38             | 17,084         | 39             | 39             | 6,352          | (18,379)         | 5,174                      |
| Uncommitted Reserves & Contingencies   | Actual/Fcast        |                 |                 |                 |                 |                 |                 |                |                |                |                |                |                | 0                | 0                          |
| Profit/Loss Disposal of Assets   | Actual/Fcast        | 0               | (0)             | 0               | 0               | 295             | 27              | 27             | 0              | 0              | 0              | 0              | 0              | 347              | 347                        |
| <b>Cost - Total</b>  | <b>Actual/Fcast</b> | <b>147,587</b>  | <b>146,075</b>  | <b>164,525</b>  | <b>159,200</b>  | <b>155,441</b>  | <b>148,181</b>  | <b>145,606</b> | <b>154,673</b> | <b>171,682</b> | <b>155,387</b> | <b>157,574</b> | <b>171,529</b> | <b>1,066,615</b> | <b>1,877,460</b>           |
| <b>Net surplus/ (deficit)</b>  | <b>Actual/Fcast</b> | <b>(13,494)</b> | <b>(15,980)</b> | <b>(14,515)</b> | <b>(13,105)</b> | <b>(14,317)</b> | <b>(10,735)</b> | <b>40,282</b>  | <b>(4,077)</b> | <b>(3,240)</b> | <b>(3,619)</b> | <b>(2,706)</b> | <b>(2,121)</b> | <b>(41,864)</b>  | <b>(57,627)</b>            |

**Table B2: Pay & Agency**

| A - Pay Expenditure   |   | 1             | 2             | 3             | 4             | 5             | 6             | 7             | 8             | 9             | 10            | 11            | 12            | Total YTD          | Forecast year-end position          |
|---|---|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|--------------------|-------------------------------------|
| REF   | TYPE  | Apr<br>£'000  | May<br>£'000  | Jun<br>£'000  | Jul<br>£'000  | Aug<br>£'000  | Sep<br>£'000  | Oct<br>£'000  | Nov<br>£'000  | Dec<br>£'000  | Jan<br>£'000  | Feb<br>£'000  | Mar<br>£'000  | £'000              | £'000                               |
| 1   | Administrative, Clerical & Board Members        | 9,826         | 9,824         | 12,656        | 11,677        | 10,234        | 10,024        | 10,244        | 10,000        | 10,000        | 10,000        | 10,300        | 10,000        | 74,485             | 124,785                             |
| 2   | Medical & Dental                                | 14,244        | 15,137        | 14,914        | 14,773        | 14,981        | 14,572        | 18,323        | 15,300        | 15,300        | 15,300        | 15,300        | 15,200        | 106,944            | 183,344                             |
| 3   | Nursing & Midwifery Registered                  | 18,935        | 19,299        | 23,568        | 22,278        | 20,144        | 19,538        | 19,554        | 19,700        | 19,700        | 20,000        | 20,500        | 20,000        | 143,316            | 243,216                             |
| 4   | Prof Scientific & Technical                     | 2,316         | 2,344         | 2,879         | 2,867         | 2,530         | 2,538         | 2,573         | 2,700         | 2,700         | 2,700         | 2,850         | 2,700         | 18,047             | 31,697                              |
| 5   | Additional Clinical Services                    | 9,192         | 9,567         | 12,060        | 11,125        | 10,124        | 9,377         | 9,416         | 10,000        | 10,000        | 10,000        | 10,600        | 10,250        | 70,861             | 121,711                             |
| 6   | Allied Health Professionals                     | 3,601         | 3,687         | 4,509         | 4,296         | 3,830         | 3,834         | 3,773         | 3,850         | 3,850         | 3,900         | 4,100         | 3,950         | 27,530             | 47,180                              |
| 7   | Healthcare Scientists                           | 1,112         | 1,133         | 1,364         | 1,297         | 1,165         | 1,140         | 1,119         | 1,200         | 1,200         | 1,200         | 1,300         | 1,200         | 8,330              | 14,430                              |
| 8   | Estates & Ancillary                             | 3,556         | 3,692         | 4,427         | 4,048         | 3,517         | 3,560         | 3,573         | 3,700         | 3,600         | 3,700         | 4,000         | 3,700         | 26,373             | 45,073                              |
| 9   | Students  | 4             | 4             | 6             | 5             | 4             | 5             | 2             | 7             | 7             | 7             | 7             | 7             | 30                 | 65                                  |
| 10  | <b>TOTAL PAY EXPENDITURE</b>                    | <b>62,786</b> | <b>64,687</b> | <b>76,383</b> | <b>72,366</b> | <b>66,529</b> | <b>64,588</b> | <b>68,577</b> | <b>66,457</b> | <b>66,357</b> | <b>66,807</b> | <b>68,957</b> | <b>67,007</b> | <b>475,916</b>     | <b>811,501</b>                      |
| <b>Analysis of Pay Expenditure</b>  |   |               |               |               |               |               |               |               |               |               |               |               |               |                    |                                     |
| 11  | LHB Provided Services - Pay                     | 59,888        | 62,050        | 73,082        | 69,139        | 63,642        | 61,747        | 65,918        | 63,841        | 63,751        | 64,068        | 66,357        | 64,384        | 455,466            | 777,865                             |
| 12  | Other Services (incl. Primary Care) - Pay       | 2,898         | 2,637         | 3,301         | 3,227         | 2,887         | 2,841         | 2,659         | 2,616         | 2,606         | 2,739         | 2,600         | 2,623         | 20,450             | 33,636                              |
| 13  | <b>Total - Pay</b>                              | <b>62,786</b> | <b>64,687</b> | <b>76,383</b> | <b>72,366</b> | <b>66,529</b> | <b>64,588</b> | <b>68,577</b> | <b>66,457</b> | <b>66,357</b> | <b>66,807</b> | <b>68,957</b> | <b>67,007</b> | <b>475,916</b>     | <b>811,501</b>                      |
| <b>B - Agency / Locum (premium) Expenditure - Analysed by Type of Staff</b> |   |               |               |               |               |               |               |               |               |               |               |               |               |                    |                                     |
| REF   | TYPE  | Apr<br>£'000  | May<br>£'000  | Jun<br>£'000  | Jul<br>£'000  | Aug<br>£'000  | Sep<br>£'000  | Oct<br>£'000  | Nov<br>£'000  | Dec<br>£'000  | Jan<br>£'000  | Feb<br>£'000  | Mar<br>£'000  | Total YTD<br>£'000 | Forecast year-end position<br>£'000 |
| 1   | Administrative, Clerical & Board Members        | 72            | 64            | 77            | 49            | 41            | 39            | 86            | 50            | 40            | 40            | 40            | 40            | 428                | 638                                 |
| 2   | Medical & Dental                                | 1,185         | 2,048         | 1,500         | 1,192         | 1,426         | 1,118         | 1,118         | 1,150         | 975           | 975           | 975           | 975           | 9,587              | 14,637                              |
| 3   | Nursing & Midwifery Registered                  | 1,434         | 1,387         | 1,394         | 1,575         | 1,650         | 1,807         | 1,573         | 1,550         | 1,350         | 1,350         | 1,350         | 1,350         | 10,820             | 17,770                              |
| 4   | Prof Scientific & Technical                     | (1)           | 6             | 11            | 29            | 1             | 21            | 46            | 0             | 0             | 0             | 0             | 0             | 113                | 113                                 |
| 5   | Additional Clinical Services                    | 295           | 341           | 210           | 161           | 237           | 183           | 80            | 150           | 125           | 125           | 125           | 125           | 1,507              | 2,157                               |
| 6   | Allied Health Professionals                     | 171           | 219           | 147           | 196           | 196           | 192           | 123           | 160           | 150           | 150           | 150           | 150           | 1,244              | 2,004                               |
| 7   | Healthcare Scientists                           | 57            | 63            | 31            | 59            | 47            | 29            | 8             | 45            | 40            | 40            | 40            | 40            | 294                | 499                                 |
| 8   | Estates & Ancillary                             | 682           | 675           | 483           | 490           | 341           | 471           | 489           | 450           | 425           | 425           | 425           | 425           | 3,631              | 5,781                               |
| 9   | Students  | 0             | 0             | 0             | 0             | 0             | 0             | 0             | 0             | 0             | 0             | 0             | 0             | 0                  | 0                                   |
| 10  | <b>TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE</b> | <b>3,895</b>  | <b>4,803</b>  | <b>3,853</b>  | <b>3,751</b>  | <b>3,939</b>  | <b>3,860</b>  | <b>3,523</b>  | <b>3,555</b>  | <b>3,105</b>  | <b>3,105</b>  | <b>3,105</b>  | <b>3,105</b>  | <b>27,624</b>      | <b>43,599</b>                       |
| 11  | Agency/Locum (premium) % of pay                 | 6.2%          | 7.4%          | 5.0%          | 5.2%          | 5.9%          | 6.0%          | 5.1%          | 5.3%          | 4.7%          | 4.6%          | 4.5%          | 4.6%          | 5.8%               | 5.4%                                |

**Table B3: Covid-19 (1)**

| Health Promotion (including Testing, Tracing and Surveillance) - Additional costs due to C19 |  | 1     | 2     | 3     | 4     | 5     | 6     | 7     | 8     | 9     | 10    | 11    | 12    | Total YTD | Forecast year-end position |
|--|--|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-----------|----------------------------|
|  |  | Apr   | May   | Jun   | Jul   | Aug   | Sep   | Oct   | Nov   | Dec   | Jan   | Feb   | Mar   | £'000     | £'000                      |
| A1   | Health Protection (including Testing, Tracing and Surveillance) (Additional costs due to C19) enter as positive values - actual/forecast | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000     | £'000                      |
| 1  | Health Protection (including Testing, Tracing and Surveillance) (Additional costs due to C19) enter as positive values - actual/forecast |       |       |       |       |       |       |       |       |       |       |       |       |           |                            |
| 2  | Provider Pay (Establishment, Temp & Agency)  |       |       |       |       |       |       |       |       |       |       |       |       |           |                            |
| 3  | Administrative, Clerical & Board Members   | 280   | 282   | 251   | (185) | (57)  | 33    | 77    | 116   | 116   | 116   | 116   | 116   | 5,861     | 1,262                      |
| 4  | Medical & Dental   | 5     | 5     | 7     | (17)  | 2     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | (24)      | 2                          |
| 5  | Nursing & Midwifery Registered   | 21    | 21    | 20    | 21    | 35    | 16    | 15    | 22    | 22    | 22    | 22    | 22    | 1,431     | 259                        |
| 6  | Prof Scientific & Technical  | 0     | 7     | 8     | 13    | (28)  | 0     | 0     | 0     | 0     | 0     | 0     | 0     | (50)      | 0                          |
| 7  | Additional Clinical Services   | 186   | 186   | 168   | (42)  | (286) | 23    | 25    | 39    | 39    | 39    | 39    | 39    | 1,280     | 456                        |
| 8  | Allied Health Professionals  | 60    | 66    | 52    | 14    | 71    | 27    | 25    | 40    | 40    | 40    | 40    | 40    | 2,579     | 515                        |
| 9  | Healthcare Scientists  | 0     | 0     | 0     | 0     | 21    | 21    | 21    | 21    | 21    | 21    | 21    | 21    | 1,261     | 168                        |
| 10   | Estates & Ancillary  | 18    | 20    | 16    | 15    | (34)  | 5     | 6     | 7     | 7     | 7     | 7     | 7     | 318       | 79                         |
| 11   | Students   | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0         | 0                          |
| 12   | Sub total Health Protection (including Testing, Tracing and Surveillance) Provider Pay   | 570   | 587   | 522   | (181) | (276) | 125   | 168   | 245   | 245   | 245   | 245   | 245   | 12,656    | 2,741                      |
| 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 A3 - Complete Analysis to the Right       | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0         | 0                          |
| 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     | 436   | 60    | 72    | 92    | 92    | 92    | 92    | 92    | 6,591     | 1,025                      |
| 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                          |
| 26   | Sub total Health Protection (including Testing, Tracing and Surveillance) Non Pay  | 0     | 0     | 0     | 0     | 436   | 60    | 72    | 92    | 92    | 92    | 92    | 92    | 6,591     | 1,025                      |
| 27   | Total Health Protection (including Testing, Tracing and Surveillance)  | 570   | 587   | 522   | (181) | 160   | 185   | 240   | 337   | 337   | 337   | 337   | 337   | 19,247    | 3,766                      |
| COVID-19 Vaccination Programme (immunisation)- Additional costs due to C19                   |  |       |       |       |       |       |       |       |       |       |       |       |       |           |                            |
| A2   | COVID-19 Vaccination Programme (immunisation) (Additional costs due to C19) enter as positive values - actual/forecast                   |       |       |       |       |       |       |       |       |       |       |       |       |           |                            |
| 30   | Provider Pay (Establishment, Temp & Agency)  |       |       |       |       |       |       |       |       |       |       |       |       |           |                            |
| 31   | Administrative, Clerical & Board Members   | 225   | 179   | 184   | 38    | 56    | 121   | 158   | 143   | 143   | 143   | 143   | 143   | 8,856     | 1,674                      |
| 32   | Medical & Dental   | 2     | 4     | 5     | 1     | 3     | 3     | 3     | 3     | 3     | 3     | 3     | 3     | 202       | 37                         |
| 33   | Nursing & Midwifery Registered   | 153   | 99    | 81    | 91    | (1)   | 43    | (74)  | 53    | 53    | 53    | 53    | 53    | 2,665     | 654                        |
| 34   | Prof Scientific & Technical  | 25    | 13    | 18    | 31    | 17    | 17    | 29    | 21    | 21    | 21    | 21    | 21    | 1,414     | 255                        |
| 35   | Additional Clinical Services   | 55    | 12    | 26    | 24    | 0     | 0     | (117) | 0     | 0     | 0     | 0     | 0     | (566)     | 0                          |
| 36   | Allied Health Professionals  | 13    | 3     | 10    | 0     | (0)   | 25    | 188   | 35    | 35    | 35    | 35    | 35    | 2,840     | 413                        |
| 37   | Healthcare Scientists  | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0         | 0                          |
| 38   | Estates & Ancillary  | 2     | 2     | 3     | 3     | 2     | 2     | 3     | 3     | 3     | 3     | 3     | 3     | 166       | 30                         |
| 39   | Students   | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0     | 0         | 0                          |
| 40   | Sub total COVID-19 Vaccination (Immunisation) Programme Provider Pay   | 476   | 311   | 327   | 188   | 78    | 212   | 189   | 257   | 257   | 257   | 257   | 257   | 15,576    | 3,063                      |
| 41   | Primary Care Contractor (excluding drugs)  | 0     | 0     | 0     | 0     | 0     | 400   | (110) | 99    | 99    | 99    | 99    | 99    | 5,803     | 786                        |
| 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 A3  | 90    | 29    | 34    | (212) | 73    | 71    | 159   | 113   | 47    | 113   | 47    | 119   | 5,012     | 682                        |
| 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 COVID-19 Vaccination (Immunisation) Programme Non Pay  | 90    | 29    | 34    | (212) | 73    | 471   | 49    | 212   | 146   | 212   | 146   | 218   | 10,815    | 1,468                      |
| 55   | Total COVID-19 Vaccination (Immunisation) Programme Expenditure  | 566   | 340   | 361   | (24)  | 150   | 683   | 238   | 469   | 402   | 469   | 402   | 475   | 26,391    | 4,530                      |
| 56   | Planned COVID-19 Vaccination (Immunisation) Expenditure (In Opening Plan)  | 566   | 541   | 514   | 489   | 514   | 1,068 | 1,296 | 1,032 | 513   | 525   | 522   | 519   | 45,196    | 8,100                      |
| 57   | Movement From Opening Planned COVID-19 Vaccination (Immunisation) Programme Expenditure  | 0     | 201   | 153   | 513   | 364   | 386   | 1,057 | 564   | 111   | 57    | 120   | 44    | 18,805    | 3,570                      |

**Table B3: Covid-19 (2)**

|  |  | Apr                             | May        | Jun        | Jul        | Aug          | Sep        | Oct        | Nov        | Dec        | Jan        | Feb        | Mar        | Total YTD     | Forecast year-end position |
|--|--|---------------------------------|------------|------------|------------|--------------|------------|------------|------------|------------|------------|------------|------------|---------------|----------------------------|
|  |  | £'000                           | £'000      | £'000      | £'000      | £'000        | £'000      | £'000      | £'000      | £'000      | £'000      | £'000      | £'000      | £'000         | £'000                      |
|  |  | <i>Enter as positive values</i> |            |            |            |              |            |            |            |            |            |            |            |               |                            |
| <b>Nosocomial, PPE, Long Covid &amp; Other - Additional costs due to C19</b> |  |                                 |            |            |            |              |            |            |            |            |            |            |            |               |                            |
| A3   | <b>Nosocomial, PPE, Long Covid &amp; Other (Additional costs due to C19) enter as positive value - actual/forecast</b> |                                 |            |            |            |              |            |            |            |            |            |            |            |               |                            |
| 64   | <b>Provider Pay (Establishment, Temp &amp; Agency)</b>   |                                 |            |            |            |              |            |            |            |            |            |            |            |               |                            |
| 65   | Administrative, Clerical & Board Members   | 78                              | 23         | 30         | 32         | (47)         | 39         | 92         | 35         | 35         | 35         | 35         | 35         | 2,311         | 422                        |
| 66   | Medical & Dental   | 4                               | 54         | 23         | 11         | (59)         | 7          | 8          | 10         | 10         | 10         | 10         | 10         | 428           | 98                         |
| 67   | Nursing & Midwifery Registered   | 40                              | 39         | 38         | 7          | 26           | 27         | 30         | 22         | 23         | 23         | 23         | 23         | 1,585         | 322                        |
| 68   | Prof Scientific & Technical  | 0                               | 0          | 5          | 38         | (23)         | 6          | 17         | 13         | 14         | 14         | 14         | 14         | 790           | 112                        |
| 69   | Additional Clinical Services   | 0                               | 3          | 3          | 2          | 14           | 6          | 5          | 6          | 6          | 6          | 6          | 6          | 399           | 63                         |
| 70   | Allied Health Professionals  | 26                              | 9          | 10         | (8)        | 92           | 26         | 38         | 30         | 30         | 30         | 30         | 30         | 2,072         | 342                        |
| 71   | Healthcare Scientists  | 0                               | 0          | 0          | 0          | (20)         | 0          | 0          | 0          | 0          | 0          | 0          | 0          | (20)          | 0                          |
| 72   | Estates & Ancillary  | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 73   | Students   | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 74   | 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                          |
| 75   |  | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 76   |  | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 77   |  | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 78   | <b>Sub total Other C-19 Provider Pay</b>   | <b>148</b>                      | <b>129</b> | <b>109</b> | <b>101</b> | <b>(16)</b>  | <b>110</b> | <b>190</b> | <b>116</b> | <b>118</b> | <b>118</b> | <b>118</b> | <b>118</b> | <b>7,564</b>  | <b>1,358</b>               |
| 79   | Primary Care Contractor (excluding drugs)  | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 80   | Do not Use   | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 81   | Primary Care - Drugs   | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 82   | Secondary Care - Drugs   | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 83   | Provider - Non Pay (Clinical & General Supplies, Rent, Rates, Equipment etc) <b>Exclude PPE - see separate line</b>    | 18                              | 63         | 66         | 69         | (190)        | 15         | (23)       | 12         | 12         | 12         | 12         | 12         | 138           | 81                         |
| 84   | Provider - Non Pay - PPE   | 96                              | 90         | 104        | 104        | 108          | 100        | 135        | 130        | 135        | 133        | 133        | 132        | 8,324         | 1,400                      |
| 85   | Healthcare Services Provided by Other NHS Bodies   | 35                              | 0          | 0          | 0          | (35)         | 0          | 0          | 0          | 0          | 0          | 0          | 0          | (140)         | 0                          |
| 86   | Non Healthcare Services Provided by Other NHS Bodies   | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 87   | Continuing Care and Funded Nursing Care  | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 88   | Other Private & Voluntary Sector   | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 89   | Joint Financing and Other (includes Local Authority)   | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 90   | 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                          |
| 98   | <b>Sub total Other C-19 Non Pay</b>  | <b>149</b>                      | <b>153</b> | <b>170</b> | <b>174</b> | <b>(116)</b> | <b>115</b> | <b>112</b> | <b>142</b> | <b>147</b> | <b>145</b> | <b>145</b> | <b>144</b> | <b>8,322</b>  | <b>1,481</b>               |
| 99   | <b>Total Other C-19 Expenditure</b>  | <b>296</b>                      | <b>282</b> | <b>279</b> | <b>275</b> | <b>(132)</b> | <b>225</b> | <b>302</b> | <b>258</b> | <b>265</b> | <b>263</b> | <b>263</b> | <b>262</b> | <b>15,885</b> | <b>2,839</b>               |
| 100  | Planned Other C-19 Expenditure (In Opening Plan)   | 200                             | 379        | 342        | 330        | 352          | 351        | 352        | 327        | 379        | 369        | 361        | 503        | 25,112        | 4,246                      |
| 101  | Movement From Opening Planned Other C-19 Expenditure   | (96)                            | 96         | 63         | 55         | 484          | 126        | 50         | 69         | 114        | 106        | 98         | 241        | 9,227         | 1,406                      |
| <b>Overall Covid-19 Position</b>   |  |                                 |            |            |            |              |            |            |            |            |            |            |            |               |                            |
| 108  | Total Planned COVID-19 Expenditure   | 1,456                           | 1,668      | 1,399      | 1,249      | 1,114        | 1,761      | 1,892      | 1,627      | 1,171      | 1,209      | 1,245      | 1,356      | 91,816        | 17,146                     |
| 109  | Total Actual/Forecast COVID-19 Expenditure   | 1,431                           | 1,210      | 1,162      | 70         | 178          | 1,093      | 781        | 1,063      | 1,004      | 1,068      | 1,002      | 1,074      | 61,524        | 11,136                     |
| 110  | Movement from Planned Expenditure  | 25                              | 458        | 237        | 1,179      | 936          | 668        | 1,111      | 564        | 167        | 140        | 243        | 282        | 30,292        | 6,010                      |
| 111  | Total Planned Funding  | 1,456                           | 1,668      | 1,399      | 1,249      | 1,114        | 1,761      | 1,892      | 1,627      | 1,171      | 1,209      | 1,245      | 1,356      | 91,816        | 17,146                     |
| 112  | Total Actual/Forecast COVID-19 Funding excluding Virements   | 1,456                           | 1,467      | 1,182      | 130        | 459          | 2,248      | 849        | 1,664      | 1,687      | 1,694      | 1,657      | 1,658      | 97,592        | 16,152                     |
| 113  | Total Actual/Forecast COVID-19 Virements   | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 114  | Total Actual/Forecast Funding  | 1,456                           | 1,467      | 1,182      | 130        | 459          | 2,248      | 849        | 1,664      | 1,687      | 1,694      | 1,657      | 1,658      | 97,592        | 16,152                     |
| 115  | Movement from Planned Funding  | 0                               | (201)      | (217)      | (1,119)    | (655)        | 487        | (1,043)    | 37         | 516        | 485        | 412        | 303        | 5,776         | (994)                      |
| 116  | Net Planned Position   | 0                               | 0          | 0          | 0          | 0            | 0          | 0          | 0          | 0          | 0          | 0          | 0          | 0             | 0                          |
| 117  | Actual / Forecast Net Impact on overall Financial Position due to Covid-19   | 25                              | 257        | 20         | 60         | 281          | 1,155      | 69         | 601        | 683        | 626        | 655        | 585        | 36,068        | 5,015                      |
| 118  | Net Movement from Plan   | 25                              | 257        | 20         | 60         | 281          | 1,155      | 69         | 601        | 683        | 626        | 655        | 585        | 36,068        | 5,015                      |

**Table C: Identified Savings Schemes**

|    |   | 1             | 2        | 3        | 4        | 5        | 6       | 7       | 8       | 9        | 10      | 11      | 12     | Total YTD | Full-year forecast | YTD as %age of FY<br>YTD variance as %age of YTD | Assessment |        | Full In-Year forecast |           | Full-Year Effect of Recurring Savings<br>£'000 |        |  |
|----|---|---------------|----------|----------|----------|----------|---------|---------|---------|----------|---------|---------|--------|-----------|--------------------|--|------------|--------|-----------------------|-----------|--|--------|--|
|    |   | Apr           | May      | Jun      | Jul      | Aug      | Sep     | Oct     | Nov     | Dec      | Jan     | Feb     | Mar    |           |                    |  | 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   | 150      | 150      | 150      | 150      | 150     | 150     | 150     | 150      | 150     | 150     | 150    | 151       | 1,049              | 1,800  |            | 250    | 1,550                 |           |  |        |  |
| 2  |   | Actual/F'cast | 43       | 145      | 251      | 658      | 279     | 566     | 427     | 740      | 617     | 810     | 695    | 809       | 2,368              | 6,038  | 39.22%     | 5,618  | 420                   | 580       | 5,458  | 7,305  |  |
| 3  |   | Variance      | (107)    | (5)      | 101      | 508      | 129     | 416     | 277     | 590      | 467     | 660     | 545    | 658       | 1,319              | 4,238  | 125.70%    | 5,368  | (1,130)               |           |  |        |  |
| 4  | Commissioned Services                           | Budget/Plan   | 292      | 167      | 304      | 304      | 304     | 304     | 304     | 304      | 304     | 304     | 304    | 304       | 1,979              | 3,500  |            | 2,138  | 1,363                 |           |  |        |  |
| 5  |   | Actual/F'cast | 167      | 167      | 167      | 660      | 394     | 1,332   | 463     | 463      | 463     | 462     | 462    | 462       | 3,350              | 5,664  | 59.14%     | 5,664  | 0                     | 3,195     | 2,469  | 2,469  |  |
| 6  |   | Variance      | (125)    | 0        | (137)    | 356      | 90      | 1,028   | 159     | 159      | 159     | 159     | 158    | 158       | 1,370              | 2,164  | 69.23%     | 3,526  | (1,363)               |           |  |        |  |
| 7  | Medicines Management (Primary & Secondary Care) | Budget/Plan   | 117      | 73       | 143      | 154      | 166     | 177     | 188     | 199      | 210     | 221     | 232    | 244       | 1,019              | 2,125  |            | 2,125  | 0                     |           |  |        |  |
| 8  |   | Actual/F'cast | 139      | 41       | 178      | 153      | 351     | 532     | 634     | 599      | 610     | 622     | 633    | 644       | 2,027              | 5,137  | 39.47%     | 5,137  | 0                     | 21        | 5,116  | 6,892  |  |
| 9  |   | Variance      | 22       | (33)     | 34       | (2)      | 185     | 356     | 446     | 400      | 400     | 400     | 400    | 401       | 1,009              | 3,011  | 99.01%     | 3,011  | 0                     |           |  |        |  |
| 10 | Non Pay   | Budget/Plan   | 1,389    | 640      | 1,465    | 1,470    | 1,470   | 1,470   | 1,470   | 1,470    | 1,470   | 1,470   | 1,470  | 1,471     | 9,373              | 16,724   |            | 6,939  | 9,785                 |           |  |        |  |
| 11 |   | Actual/F'cast | 101      | 93       | 369      | 273      | 2,116   | 762     | 816     | 814      | 785     | 787     | 805    | 2,117     | 4,529              | 9,838  | 46.03%     | 8,065  | 1,773                 | 6,221     | 3,617  | 3,916  |  |
| 12 |   | Variance      | (1,289)  | (547)    | (1,095)  | (1,197)  | 646     | (708)   | (654)   | (655)    | (685)   | (683)   | (664)  | 646       | (4,845)            | (6,886)  | (51.69%)   | 1,126  | (8,012)               |           |  |        |  |
| 13 | Pay   | Budget/Plan   | 2,207    | 914      | 2,337    | 2,378    | 2,378   | 2,378   | 2,378   | 2,503    | 2,503   | 2,503   | 2,499  | 14,968    | 27,353             |  | 8,353      | 19,000 |                       |           |  |        |  |
| 14 |   | Actual/F'cast | 778      | 461      | 320      | 170      | 756     | 821     | 1,101   | 1,548    | 1,611   | 1,858   | 1,887  | 1,892     | 4,408              | 13,205   | 33.38%     | 9,165  | 4,040                 | 1,786     | 11,419   | 12,099 |  |
| 15 |   | Variance      | (1,429)  | (453)    | (2,016)  | (2,207)  | (1,622) | (1,556) | (1,276) | (829)    | (891)   | (644)   | (616)  | (607)     | (10,561)           | (14,148)   | (70.55%)   | 812    | (14,960)              |           |  |        |  |
| 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        | 115     | 56      | 1,519   | 56       | 56      | 56      | 56     | 264       | 1,690              | 2,177  | 77.65%     | 1,940  | 237                   | 2,177     | 0  | 0      |  |
| 18 |   | Variance      | 0        | 0        | 0        | 0        | 115     | 56      | 1,519   | 56       | 56      | 56      | 56     | 264       | 1,690              | 2,177  |            | 1,940  | 237                   |           |  |        |  |
| 19 | Total   | Budget/Plan   | 4,155    | 1,944    | 4,399    | 4,456    | 4,468   | 4,478   | 4,490   | 4,501    | 4,637   | 4,648   | 4,659  | 4,669     | 28,389             | 51,502   |            | 19,805 | 31,697                |           |  |        |  |
| 20 |   | Actual/F'cast | 1,227    | 906      | 1,286    | 1,914    | 4,011   | 4,069   | 4,960   | 4,221    | 4,143   | 4,596   | 4,538  | 6,189     | 18,372             | 42,058   | 43.68%     | 35,588 | 6,470                 | 13,980    | 28,078   | 32,682 |  |
| 21 |   | Variance      | (2,928)  | (1,038)  | (3,113)  | (2,542)  | (457)   | (409)   | 471     | (280)    | (494)   | (52)    | (121)  | 1,520     | (10,017)           | (9,444)  | (35.29%)   | 15,783 | (25,227)              |           |  |        |  |
| 22 | Variance in month                               | (70.48%)      | (53.41%) | (70.77%) | (57.05%) | (10.23%) | (9.14%) | 10.48%  | (6.22%) | (10.65%) | (1.13%) | (2.60%) | 32.56% | (35.29%)  |                    |  |            |        |                       |           |  |        |  |
| 23 | In month achievement against FY forecast        | 2.92%         | 2.15%    | 3.06%    | 4.55%    | 9.54%    | 9.68%   | 11.79%  | 10.04%  | 9.85%    | 10.93%  | 10.79%  | 14.71% |           |                    |  |            |        |                       |           |  |        |  |

**Table D: Welsh NHS Assumptions**

| LHB/Trust                    | Contracted    | Non           | Total         | Contracted     | Non           | Total          |
|------------------------------|---------------|---------------|---------------|----------------|---------------|----------------|
|                              | Income        | Contracted    | Income        | Expenditure    | Contracted    | Expenditure    |
|                              | £'000         | £'000         | £'000         | £'000          | £'000         | £'000          |
| Swansea Bay University       | 286           | 732           | 1,018         | 984            | 3,008         | 3,992          |
| Aneurin Bevan University     | 0             | 0             | 0             | 0              | 0             | 0              |
| Betsi Cadwaladr University   | 0             | 61            | 61            | 0              | 1,260         | 1,260          |
| Cardiff & Vale University    | 1,144         | 1,211         | 2,355         | 36,389         | 3,937         | 40,326         |
| Cwm Taf Morgannwg University | 1,729         | 425           | 2,154         | 20,022         | 1,297         | 21,319         |
| Hywel Dda University         | 301           | 26            | 327           | 419            | 849           | 1,268          |
| Powys                        | 11,077        | 3,677         | 14,754        | 164            | 159           | 323            |
| Public Health Wales          | 0             | 4,156         | 4,156         | 0              | 1,765         | 1,765          |
| Velindre                     | 0             | 9,289         | 9,289         | 25,402         | 53,398        | 78,800         |
| NWSSP                        | 0             | 0             | 0             | 0              | 0             | 0              |
| DHCW                         | 0             | 888           | 888           | 0              | 5,311         | 5,311          |
| Wales Ambulance Services     | 0             | 245           | 245           | 0              | 10,583        | 10,583         |
| WHSSC                        | 11,914        | 0             | 11,914        | 151,995        | (1,491)       | 150,504        |
| EASC                         | 0             | 0             | 0             | 46,139         | 0             | 46,139         |
| HEIW                         | 0             | 13,767        | 13,767        | 0              | 20            | 20             |
| NHS Executive                | 0             | 0             | 0             | 0              | 0             | 0              |
| <b>Total</b>                 | <b>26,451</b> | <b>34,477</b> | <b>60,928</b> | <b>281,514</b> | <b>80,096</b> | <b>361,610</b> |

**Table F – Statement of Financial Position**

| Table F - Statement of Financial Position For Monthly Period | Opening Balance<br>Beginning of<br>Apr 23 | Closing Balance<br>End of<br>Oct 23 | Forecast Closing Balance<br>End of<br>Mar 24 |
|--|---|-------------------------------------|--|
|  | £'000                                     | £'000                               | £'000  |
| <b>Non-Current Assets</b>                                    |   |                                     |  |
| Property, plant and equipment                                | 893,409                                   | 930,737                             | 911,912                                      |
| Intangible assets  | 5,091                                     | 3,840                               | 3,259  |
| Trade and other receivables                                  | 77,466                                    | 95,734                              | 77,466                                       |
| Other financial assets                                       | 726                                       | 726                                 | 726  |
| <b>Non-Current Assets sub total</b>                          | <b>976,692</b>                            | <b>1,031,037</b>                    | <b>993,363</b>                               |
| <b>Current Assets</b>  |   |                                     |  |
| Inventories  | 9,576                                     | 9,965                               | 9,576  |
| Trade and other receivables                                  | 152,162                                   | 169,653                             | 152,162                                      |
| Other financial assets                                       | 58  | 58                                  | 58   |
| Cash and cash equivalents                                    | 4,704                                     | 4,502                               | (56,463)                                     |
| Non-current assets classified as held for sale               | 0   | 0                                   | 0  |
| <b>Current Assets sub total</b>                              | <b>166,500</b>                            | <b>184,178</b>                      | <b>105,333</b>                               |
| <b>TOTAL ASSETS</b>  | <b>1,143,192</b>                          | <b>1,215,215</b>                    | <b>1,098,696</b>                             |
| <b>Current Liabilities</b>                                   |   |                                     |  |
| Trade and other payables                                     | 222,125                                   | 198,933                             | 194,288                                      |
| Borrowings (Trust Only)                                      | 0   | 0                                   | 0  |
| Other financial liabilities                                  | 0   | 0                                   | 0  |
| Provisions   | 87,280                                    | 112,762                             | 87,280                                       |
| <b>Current Liabilities sub total</b>                         | <b>309,405</b>                            | <b>311,695</b>                      | <b>281,568</b>                               |
| <b>NET ASSETS LESS CURRENT LIABILITIES</b>                   | <b>833,787</b>                            | <b>903,520</b>                      | <b>817,128</b>                               |
| <b>Non-Current Liabilities</b>                               |   |                                     |  |
| Trade and other payables                                     | 20,692                                    | 18,757                              | 20,692                                       |
| Borrowings (Trust Only)                                      | 0   | 0                                   | 0  |
| Other financial liabilities                                  | 0   | 0                                   | 0  |
| Provisions   | 81,186                                    | 100,879                             | 81,186                                       |
| <b>Non-Current Liabilities sub total</b>                     | <b>101,878</b>                            | <b>119,636</b>                      | <b>101,878</b>                               |
| <b>TOTAL ASSETS EMPLOYED</b>                                 | <b>731,909</b>                            | <b>783,884</b>                      | <b>715,250</b>                               |
| <b>FINANCED BY:</b>  |   |                                     |  |
| <b>Taxpayers' Equity</b>                                     |   |                                     |  |
| General Fund   | 552,846                                   | 586,577                             | 524,843                                      |
| Revaluation Reserve  | 179,063                                   | 197,307                             | 190,407                                      |
| PDC (Trust only)   |   |                                     |  |
| Retained earnings (Trust Only)                               |   |                                     |  |
| Other reserve  |   |                                     |  |
| <b>Total Taxpayers' Equity</b>                               | <b>731,909</b>                            | <b>783,884</b>                      | <b>715,250</b>                               |



**Table G: Cash Flow**

|                 | April<br>£'000   | May<br>£'000   | June<br>£'000  | July<br>£'000  | Aug<br>£'000   | Sept<br>£'000  | Oct<br>£'000   | Nov<br>£'000   | Dec<br>£'000   | Jan<br>£'000   | Feb<br>£'000   | Mar<br>£,000   | Total<br>£,000 |                  |
|-----------------|--|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|------------------|
| <b>RECEIPTS</b> |  |                |                |                |                |                |                |                |                |                |                |                |                |                  |
| 1               | WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA only | 148,150        | 133,350        | 164,250        | 136,950        | 138,850        | 160,300        | 130,000        | 147,000        | 157,160        | 128,860        | 130,550        | 109,195        | 1,684,615        |
| 2               | WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only     | 0              | 0              | 0              | 0              | 0              | 0              | 0              | 0              | 0              | 0              | (726)          | (726)          |                  |
| 3               | WG Revenue Funding - Other (e.g. invoices)                       | 242            | 265            | 236            | 193            | 676            | 300            | 303            | 310            | 250            | 320            | 500            | 1,200          | 4,795            |
| 4               | WG Capital Funding - Cash Limit - LHB & SHA only                 | 5,000          | 2,700          | 4,500          | 6,300          | 6,200          | 800            | 4,300          | 5,000          | 5,000          | 4,500          | 5,000          | 5,855          | 55,155           |
| 5               | Income from other Welsh NHS Organisations                        | 7,346          | 3,999          | 3,618          | 6,412          | 5,185          | 4,023          | 5,909          | 4,700          | 4,800          | 5,000          | 4,500          | 7,505          | 62,997           |
| 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   | 5              | 1              | 0              | 39             | 6              | 16             | 0              | 0              | 0              | 0              | 0              | 0              | 67               |
| 10              | Other - (Specify in narrative)                                   | 13,119         | 4,565          | 4,765          | 5,365          | 8,075          | 2,905          | 9,698          | 4,970          | 5,290          | 6,850          | 7,920          | 10,960         | 84,482           |
| 11              | <b>TOTAL RECEIPTS</b>  | <b>173,862</b> | <b>144,880</b> | <b>177,369</b> | <b>155,259</b> | <b>158,992</b> | <b>168,344</b> | <b>150,210</b> | <b>161,980</b> | <b>172,500</b> | <b>145,530</b> | <b>148,470</b> | <b>133,989</b> | <b>1,891,385</b> |
| <b>PAYMENTS</b> |  |                |                |                |                |                |                |                |                |                |                |                |                |                  |
| 12              | Primary Care Services : General Medical Services                 | 9,763          | 7,601          | 9,181          | 8,081          | 7,675          | 8,212          | 8,423          | 9,211          | 9,891          | 9,353          | 8,133          | 11,765         | 107,289          |
| 13              | Primary Care Services : Pharmacy Services                        | 5,256          | 5              | 5,954          | 5              | 2,523          | 4,890          | 1              | 2,580          | 5,300          | 8              | 2,650          | 3,210          | 32,382           |
| 14              | Primary Care Services : Prescribed Drugs & Appliances            | 20,731         | 14             | 19,758         | 603            | 10,875         | 21,214         | 178            | 8,750          | 18,105         | 8              | 8,690          | 10,980         | 119,906          |
| 15              | Primary Care Services : General Dental Services                  | 2,788          | 2,822          | 2,767          | 2,766          | 2,790          | 2,726          | 2,395          | 2,799          | 2,626          | 2,740          | 2,680          | 3,350          | 33,249           |
| 16              | Non Cash Limited Payments  | (143)          | (65)           | (601)          | 585            | (52)           | (700)          | 508            | (30)           | (599)          | 437            | (49)           | (17)           | (726)            |
| 17              | Salaries and Wages   | 59,942         | 62,122         | 70,887         | 67,064         | 63,261         | 60,054         | 60,085         | 60,281         | 60,582         | 59,762         | 61,210         | 66,890         | 752,140          |
| 18              | Non Pay Expenditure  | 73,409         | 66,399         | 67,832         | 69,558         | 65,663         | 71,834         | 71,201         | 74,530         | 72,599         | 68,063         | 61,049         | 89,780         | 851,917          |
| 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  | 4,851          | 3,150          | 4,556          | 3,488          | 4,998          | 4,612          | 4,606          | 5,072          | 5,050          | 4,550          | 5,050          | 6,395          | 56,378           |
| 22              | Other items (Specify in narrative)                               | 5              | 1              | 0              | 7              | 1              | 3              | 0              | 0              | 0              | 0              | 0              | 0              | 17               |
| 23              | <b>TOTAL PAYMENTS</b>  | <b>176,602</b> | <b>142,049</b> | <b>180,334</b> | <b>152,157</b> | <b>157,734</b> | <b>172,845</b> | <b>147,397</b> | <b>163,193</b> | <b>173,554</b> | <b>144,921</b> | <b>149,413</b> | <b>192,353</b> | <b>1,952,552</b> |
| 24              | Net cash inflow/outflow  | (2,740)        | 2,831          | (2,965)        | 3,102          | 1,258          | (4,501)        | 2,813          | (1,213)        | (1,054)        | 609            | (943)          | (58,364)       |                  |
| 25              | Balance b/f  | 4,704          | 1,964          | 4,795          | 1,830          | 4,932          | 6,190          | 1,689          | 4,502          | 3,289          | 2,235          | 2,844          | 1,901          |                  |
| 26              | Balance c/f  | 1,964          | 4,795          | 1,830          | 4,932          | 6,190          | 1,689          | 4,502          | 3,289          | 2,235          | 2,844          | 1,901          | (58,463)       |                  |

**Table H: PSPP**

| <b>30 DAY COMPLIANCE</b>                              |          | ACTUAL Q1 |            | ACTUAL Q2 |            | ACTUAL Q3 |            | ACTUAL Q4 |            | YEAR TO DATE |            | FORECAST YEAR END |            |
|---|----------|-----------|------------|-----------|------------|-----------|------------|-----------|------------|--------------|------------|-------------------|------------|
|   | Target % | Actual %  | Variance % | Actual %  | Variance % | Actual %  | Variance % | Actual %  | Variance % | Actual %     | Variance % | Forecast %        | Variance % |
| <b>PROMPT PAYMENT OF INVOICE PERFORMANCE</b>          |          |           |            |           |            |           |            |           |            |              |            |                   |            |
| % of NHS Invoices Paid Within 30 Days - By Value      | 95.0%    | 91.6%     | -3.4%      | 91.5%     | -3.5%      |           | -95.0%     |           | -95.0%     | 91.5%        | -3.5%      | 95.0%             | 0.0%       |
| % of NHS Invoices Paid Within 30 Days - By Number     | 95.0%    | 89.3%     | -5.7%      | 87.0%     | -8.0%      |           | -95.0%     |           | -95.0%     | 88.3%        | -6.7%      | 95.0%             | 0.0%       |
| % of Non NHS Invoices Paid Within 30 Days - By Value  | 95.0%    | 96.5%     | 1.5%       | 96.8%     | 1.8%       |           | -95.0%     |           | -95.0%     | 96.7%        | 1.7%       | 96.7%             | 1.7%       |
| % of Non NHS Invoices Paid Within 30 Days - By Number | 95.0%    | 96.7%     | 1.7%       | 97.4%     | 2.4%       |           | -95.0%     |           | -95.0%     | 97.1%        | 2.1%       | 97.1%             | 2.1%       |
| <b>10 DAY COMPLIANCE</b>                              |          |           |            |           |            |           |            |           |            |              |            |                   |            |
|   |          | Actual %  |            | Actual %  |            | Actual %  |            | Actual %  |            | Actual %     |            | Actual %          |            |
| <b>PROMPT PAYMENT OF INVOICE PERFORMANCE</b>          |          |           |            |           |            |           |            |           |            |              |            |                   |            |
| % of NHS Invoices Paid Within 10 Days - By Value      |          | 87.4%     |            | 87.0%     |            |           |            |           |            | 87.2%        |            | 87.2%             |            |
| % of NHS Invoices Paid Within 10 Days - By Number     |          | 29.7%     |            | 38.4%     |            |           |            |           |            | 33.6%        |            | 33.6%             |            |
| % of Non NHS Invoices Paid Within 10 Days - By Value  |          | 56.4%     |            | 55.4%     |            |           |            |           |            | 55.9%        |            | 55.9%             |            |
| % of Non NHS Invoices Paid Within 10 Days - By Number |          | 29.9%     |            | 29.7%     |            |           |            |           |            | 29.8%        |            | 29.8%             |            |

**Table I: Capital RLM**

| Ref:   | Performance against CRL / CEL  | Plan<br>£'000 | Actual<br>£'000 | Variance<br>£'000 | Plan<br>£'000 | F'cast<br>£'000 | Variance<br>£'000 |
|--|--|---------------|-----------------|-------------------|---------------|-----------------|-------------------|
| <b>Gross expenditure</b>                         |  |               |                 |                   |               |                 |                   |
| <b>All Wales Capital Programme:</b>              |  |               |                 |                   |               |                 |                   |
| <b>Schemes:</b>                                  |  |               |                 |                   |               |                 |                   |
| 1  | Primary Care - Fees - Tredegar - Main scheme                           | 3,375         | 3,545           | 170               | 3,375         | 3,853           | 478               |
| 2  | Primary Care Fees - Newport East                                       | 3,357         | 3,393           | 36                | 9,411         | 9,411           | 0                 |
| 3  | Radiotherapy Satellite - Main Scheme                                   | 7,768         | 7,511           | (257)             | 16,158        | 16,158          | 0                 |
| 4  | Efab - Infrastructure  | 143           | 112             | (31)              | 560           | 560             | 0                 |
| 6  | Efab - Fire  | 55            | 57              | 2                 | 885           | 885             | 0                 |
| 6  | Efab - Decarbonisation   | 35            | 26              | (9)               | 135           | 135             | 0                 |
| 7  | Breast Centralisation YFF  | 5,921         | 5,249           | (672)             | 8,482         | 8,502           | 20                |
| 8  | Plaid Agreement - Mental Health Sanitary Hubs                          | 120           | 111             | (9)               | 662           | 662             | 0                 |
| 9  | Grange University Hospital - Brokerage pending VAT reclaim             | 0             | 0               | 0                 | 0             | 0               | 0                 |
| 10   | Grange University Hospital   | (143)         | (182)           | (39)              | (74)          | (74)            | 0                 |
| 11   | Endoscopy Expansion - RGH  | 4,139         | 4,400           | 261               | 4,914         | 4,914           | 0                 |
| 12   | Royal Gwent Demolition   | 165           | 16              | (149)             | 554           | 660             | 106               |
| 13   | Specialist inpatient services Unit - Development Fees                  | 6             | 2               | (5)               | 10            | 10              | 0                 |
| 14   | B/F - End of Year Funding - November 2022                              | 177           | 177             | 0                 | 239           | 269             | 30                |
| 15   | Emergency Department Waiting Area Improvements                         | 86            | 86              | 0                 | 111           | 111             | 0                 |
| 16   | Housing Care fund  | 9             | 9               | 0                 | 10            | 9               | (1)               |
| 17   | Eye Care Transfer from C&V   | 10            | 10              | 0                 | 10            | 10              | 0                 |
| 18   | ICF - Trethomas Feasibility  | 8             | 6               | (2)               | 8             | 8               | 0                 |
| 19   | ICF - Pontllanfraith Feasibility                                       | 8             | 7               | (1)               | 8             | 8               | 0                 |
| 20   | Radiotherapy Satellite Centre at Nevill Hall Hospital - Enabling Works | 3             | 2               | (1)               | 9             | 9               | 0                 |
| 21   | SDEC   | (21)          | (21)            | 0                 | 19            | 22              | 3                 |
| 22   | National Programme - Imaging P2  | 8             | 8               | 0                 | 55            | 55              | 0                 |
| 42   | <b>Sub Total</b>   | <b>25,229</b> | <b>24,585</b>   | <b>(644)</b>      | <b>45,641</b> | <b>46,177</b>   | <b>636</b>        |
| <b>Discretionary:</b>                            |  |               |                 |                   |               |                 |                   |
| 43   | I.T  | 720           | 611             | (109)             | 2,241         | 2,241           | 0                 |
| 44   | Equipment  | 1,053         | 1,063           | 10                | 1,692         | 1,692           | 0                 |
| 45   | Statutory Compliance   | 483           | 419             | (64)              | 620           | 620             | 0                 |
| 46   | Estates  | 978           | 882             | (95)              | 2,061         | 2,035           | (26)              |
| 47   | Other  |               |                 |                   |               |                 |                   |
| 48   | <b>Sub Total</b>   | <b>3,234</b>  | <b>2,995</b>    | <b>(239)</b>      | <b>6,614</b>  | <b>6,588</b>    | <b>(26)</b>       |
| <b>Other (Including IFRS 16 Leases) Schemes:</b> |  |               |                 |                   |               |                 |                   |
| 49   | Charitable Funds Donated Assets  | 102           | 102             | 0                 | 300           | 300             | 0                 |
| 50   | IFRS16 New Leases / Lease Renewals                                     | (211)         | (211)           | 0                 | (211)         | (211)           | 0                 |
| 69   | <b>Sub Total</b>   | <b>(109)</b>  | <b>(109)</b>    | <b>0</b>          | <b>89</b>     | <b>89</b>       | <b>0</b>          |
| 70   | <b>Total Expenditure</b>   | <b>28,353</b> | <b>27,470</b>   | <b>(883)</b>      | <b>52,244</b> | <b>52,854</b>   | <b>610</b>        |
| <b>Donations:</b>                                |  |               |                 |                   |               |                 |                   |
| 77   | Charitable Funds (includes contribution to YFF-UBU)                    | 102           | 102             | 0                 | 300           | 300             | 0                 |
| 78   | <b>Sub Total</b>   | <b>102</b>    | <b>102</b>      | <b>0</b>          | <b>300</b>    | <b>300</b>      | <b>0</b>          |
| <b>Asset Disposals:</b>                          |  |               |                 |                   |               |                 |                   |
| 79   | Equipment disposals various - RGH E Block                              | 371           | 371             | 0                 | 371           | 371             | 0                 |
| 80   | Ventilator disposals   | 57            | 57              | 0                 | 57            | 57              | 0                 |
| 90   | <b>Sub Total</b>   | <b>427</b>    | <b>427</b>      | <b>0</b>          | <b>427</b>    | <b>427</b>      | <b>0</b>          |
| 91   | <b>Technical Adjustments</b>   |               |                 | <b>0</b>          |               |                 | <b>0</b>          |
| 92   | <b>CHARGE AGAINST CRL / CEL</b>  | <b>27,824</b> | <b>26,941</b>   | <b>(883)</b>      | <b>51,517</b> | <b>52,127</b>   | <b>610</b>        |
| 93   | <b>PERFORMANCE AGAINST CRL / CEL (Under)/Over</b>                      |               | <b>(25,003)</b> |                   |               | <b>183</b>      |                   |

**Table J: Capital In year Schemes**

|  |   |                  | £'000         | £'000         | £'000        | £'000        | £'000        | £'000        | £'000        | £'000        | £'000        | £'000        | £'000        | £'000        | £'000        | £'000        | £'000            | £'000         | £'000  | £'000 |  |
|--|---|------------------|---------------|---------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|------------------|---------------|--------|-------|--|
| 1  | Primary Care - Fees - Tredegar - Main scheme                          | Lorraine Morgan  | 3,853         | 6,224         | 139          | 727          | 657          | 484          | 771          | 721          | 46           | 119          | 109          | 24           | 24           | 32           | 46,071           | 3,853         | High   |       |  |
| 2  | Primary Care Fees - Newport East                                      | Lorraine Morgan  | 9,300         | 9,500         | 110          | 725          | 199          | 503          | 446          | 530          | 881          | 1,083        | 864          | 1,253        | 1,382        | 1,436        | 1,051,323        | 9,411         | Medium |       |  |
| 3  | Radiotherapy Satellite - Main Scheme                                  | Lorraine Morgan  | 15,958        | 16,200        | 734          | 848          | 1,394        | 208          | 1,786        | 1,293        | 1,249        | 1,458        | 1,785        | 1,793        | 1,810        | 1,800        | 1,530,014        | 16,158        | Medium |       |  |
| 4  | Efab - Infrastructure   | Mark Arscott     | 500           | 600           | 1            | 20           | 1            | 4            | 89           | (3)          | 0            | 38           | 32           | 107          | 142          | 129          | 79,206           | 560           | Medium |       |  |
| 5  | Efab - Fire   | Mark Arscott     | 800           | 900           | 0            | 0            | 0            | 0            | 0            | 0            | 57           | 85           | 173          | 260          | 208          | 101          | 161,721          | 885           | Medium |       |  |
| 6  | Efab - Decarbonisation  | Mark Arscott     | 120           | 150           | 0            | 0            | 0            | 0            | 0            | 20           | 6            | 0            | 47           | 62           | 0            | 0            | 24,624           | 135           | Low    |       |  |
| 7  | Breast Centralisation YYF   | Hannah Capel     | 8,450         | 8,502         | 313          | 513          | 984          | 637          | 1,052        | 722          | 1,028        | 1,712        | 855          | 563          | 79           | 44           | 519,556          | 8,502         | Low    |       |  |
| 8  | Plaid Agreement - Mental Health Sanctuary Hubs                        | Kola Gamede      | 550           | 662           | 0            | 0            | 18           | (1)          | 65           | 27           | 1            | 15           | 30           | 15           | 230          | 261          | 84,790           | 662           | Medium |       |  |
| 9  | Grange University Hospital - Brokerage pending VAT reclaim            | Hannah Evans     | 0             | 0             | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 0                | 0             | Low    |       |  |
| 10   | Grange University Hospital  | Hannah Capel     | (100)         | (74)          | 70           | 18           | 5            | 77           | (26)         | (337)        | 10           | 40           | 40           | 20           | 8            |              | 17,862           | (74)          | Low    |       |  |
| 11   | Endoscopy Expansion - RGH   | Lorraine Morgan  | 4,900         | 4,914         | 866          | 213          | 944          | 296          | 728          | 621          | 793          | 211          | 168          | 25           | 25           | 25           | 106,761          | 4,914         | Low    |       |  |
| 12   | Royal Gwent Demolition  | Hannah Capel     | 660           | 710           | 0            | 0            | 0            | 13           | 0            | 3            | 0            | 150          | 150          | 150          | 150          | 44           | 113,423          | 660           | Medium |       |  |
| 13   | Specialist inpatient services Unit - Development Fees                 | Andrew Walker    | 10            | 10            | 1            | (0)          | (0)          | 1            | 0            | 0            | 0            | 4            | 5            | 0            | 0            | 0            | 1,113            | 10            | Low    |       |  |
| 14   | B/F - End of Year Funding – November 2022                             | Various          | 269           | 269           | 0            | 36           | 94           | (4)          | 35           | 26           | 0            | 16           | 41           | 20           | 31           |              | 15,915           | 269           | Low    |       |  |
| 15   | Emergency Department Waiting Area Improvements                        | Various          | 111           | 111           | 85           | 1            | 0            | 0            | 0            | 0            | 0            | 0            | 13           | 13           | 0            | 0            | 5,465            | 111           | Low    |       |  |
| 16   | Housing Care fund   | Various          | 9             | 9             | 0            | 0            | 0            | 0            | 0            | 9            | 0            | 0            | 0            | 0            | 0            | 0            | 0                | 9             | Low    |       |  |
| 17   | Eye Care Transfer from C&V  | Glenys Mansfield | 10            | 10            | 3            | 3            | 4            | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 0                | 10            | Low    |       |  |
| 18   | ICF - Trethomas Feasibility   | David Powell     | 8             | 8             | 4            | (4)          | 3            | 0            | 0            | 4            | 0            | 2            | 0            | 0            | 0            | 0            | 145              | 8             | Low    |       |  |
| 19   | ICF - Pontllanfraith Feasibility                                      | David Powell     | 8             | 8             | 3            | (3)          | 4            | 0            | 0            | 3            | 0            | 1            | 0            | 0            | 0            | 0            | 60               | 8             | Low    |       |  |
| 20   | RadiotherapySatellite Centre at Nevill Hall Hospital – Enabling Works | Lorraine Morgan  | 9             | 9             | 0            | 0            | 1            | 1            | (1)          | (2)          | 3            | 7            | 0            | 0            | 0            | 0            | 773              | 9             | Low    |       |  |
| 21   | SDEC  | Paul Underwood   | 22            | 22            | 0            | (21)         | 0            | 0            | 0            | 0            | 0            | 0            | 10           | 10           | 10           | 13           | 7,730            | 22            | Low    |       |  |
| 22   | National Programme - Imaging P2                                       | Arvind Kumar     | 55            | 55            | 0            | 0            | 0            | 0            | 8            | 0            | 0            | 0            | 0            | 0            | 0            | 0            | 4,756            | 55            | Low    |       |  |
| 34   | <b>Sub Total</b>  |                  | <b>45,502</b> | <b>48,799</b> | <b>2,328</b> | <b>3,075</b> | <b>4,308</b> | <b>2,218</b> | <b>4,953</b> | <b>3,612</b> | <b>4,091</b> | <b>4,965</b> | <b>4,301</b> | <b>4,326</b> | <b>4,068</b> | <b>3,933</b> | <b>3,771,307</b> | <b>46,177</b> |        |       |  |
| <b>Discretionary:</b>                            |   |                  |               |               |              |              |              |              |              |              |              |              |              |              |              |              |                  |               |        |       |  |
| 35   | I.T.  | Various          | 2,200         | 2,320         | 171          | 166          | 265          | (2)          | (118)        | 56           | 72           | 244          | 763          | 119          | 72           | 433          | 246,429          | 2,241         | Low    |       |  |
| 36   | Equipment   | Various          | 1,600         | 1,750         | 16           | 80           | 0            | 379          | 258          | 247          | 104          | 252          | 148          | 50           | 59           | 100          | 88,288           | 1,692         | Low    |       |  |
| 37   | Statutory Compliance  | Various          | 620           | 700           | 99           | 45           | 46           | 128          | 87           | 33           | (20)         | 33           | 44           | 22           | 42           | 61           | 29,865           | 620           | Low    |       |  |
| 38   | Estates   | Various          | 1,900         | 2,100         | 35           | 212          | 121          | 238          | 84           | 162          | 31           | 250          | 333          | 372          | 109          | 89           | 208,981          | 2,035         | Low    |       |  |
| 39   | Other   | Various          |               |               |              |              |              |              |              |              |              |              |              |              |              |              | 0                | 0             |        |       |  |
| 40   | <b>Sub Total</b>  |                  | <b>6,320</b>  | <b>6,870</b>  | <b>321</b>   | <b>503</b>   | <b>432</b>   | <b>743</b>   | <b>310</b>   | <b>498</b>   | <b>187</b>   | <b>780</b>   | <b>1,288</b> | <b>562</b>   | <b>281</b>   | <b>682</b>   | <b>573,563</b>   | <b>6,588</b>  |        |       |  |
| <b>Other Schemes (Including IFRS 16 Leases):</b> |   |                  |               |               |              |              |              |              |              |              |              |              |              |              |              |              |                  |               |        |       |  |
| 41   | Charitable Funds - donated assets / YYF UBU Cont                      | Various          | 250           | 300           | 0            | 0            | 42           | 0            | 0            | 60           | 0            | 0            | 85           | 50           | 0            | 63           | 34,111           | 300           | Low    |       |  |
| 42   | IFRS16 New Leases / Lease Renewals                                    | Various          | (211)         | (211)         |              |              |              |              |              | (211)        |              |              |              |              |              |              | 0                | (211)         | Low    |       |  |
| 61   | <b>Sub Total</b>  |                  | <b>39</b>     | <b>89</b>     | <b>0</b>     | <b>0</b>     | <b>42</b>    | <b>0</b>     | <b>0</b>     | <b>(151)</b> | <b>0</b>     | <b>0</b>     | <b>85</b>    | <b>50</b>    | <b>0</b>     | <b>63</b>    | <b>34,111</b>    | <b>89</b>     |        |       |  |
| 62   | <b>Total Capital Expenditure</b>                                      |                  | <b>51,861</b> | <b>55,758</b> | <b>2,649</b> | <b>3,579</b> | <b>4,781</b> | <b>2,961</b> | <b>5,263</b> | <b>3,960</b> | <b>4,278</b> | <b>5,745</b> | <b>5,674</b> | <b>4,938</b> | <b>4,349</b> | <b>4,679</b> | <b>4,378,981</b> | <b>52,854</b> |        |       |  |

**Table K – Capital Disposals**

| A: In Year Disposal of Assets |                                    |   |   |                                  |       |                |                   |              |   |
|-------------------------------|------------------------------------|---|---|----------------------------------|-------|----------------|-------------------|--------------|---|
|                               | Description                        | Date of Ministerial Approval to Dispose (Land & Buildings only) | Date of Ministerial Approval to Retain Proceeds > £0.5m | Date of Disposal                 | NBV   | Sales Receipts | Cost of Disposals | Gain/ (Loss) | Comments  |
|                               |                                    | MM/YY (text format, e.g. Apr 23)                                | MM/YY (text format, e.g. Apr 23)                        | MM/YY (text format, e.g. Feb 24) | £'000 | £'000          | £'000             | £'000        |   |
| 1                             | <b>Equipment disposals various</b> |   |   | Apr-23                           | 0     | 5              | 5                 | 0            |   |
| 2                             | Equipment disposals various        |   |   | May-23                           | 0     | 1              | 1                 | 0            |   |
| 3                             | Equipment disposals various        |   |   | Jun-23                           | 0     | 0              | 0                 | 0            |   |
| 4                             | Equipment disposals RGH E Block    |   |   | Jul-23                           | 299   | 306            | 7                 | 0            | Welsh Risk Pool claim to be submitted to cover loss on disposal                                       |
| 5                             | Equipment disposals RGH E Block    |   |   | Aug-23                           | 32    | (266)          | 0                 | (298)        | Welsh Risk Pool claim to be submitted to cover loss on disposal - shown as a loss until income receiv |
| 6                             | Other equipment disposals various  |   |   | Aug-23                           | 0     | 5              | 1                 | 4            |   |
| 7                             | Equipment disposals RGH E Block    |   |   | Sep-23                           | 39    | 0              | 0                 | (39)         |   |
| 8                             | Other equipment disposals various  |   |   | Sep-23                           | 0     | 16             | 3                 | 13           |   |
| 9                             | Ventilator disposals               |   |   | Oct-23                           | 57    | 30             | 0                 | (27)         |   |
| 10                            | Other equipment disposals various  |   |   | Oct-23                           | 0     | 0              | 0                 | 0            |   |
| 11                            |                                    |   |   |                                  |       |                |                   | 0            |   |
| 12                            |                                    |   |   |                                  |       |                |                   | 0            |   |
| 13                            |                                    |   |   |                                  |       |                |                   | 0            |   |
| 14                            |                                    |   |   |                                  |       |                |                   | 0            |   |
| 15                            |                                    |   |   |                                  |       |                |                   | 0            |   |
| 16                            |                                    |   |   |                                  |       |                |                   | 0            |   |
| 17                            |                                    |   |   |                                  |       |                |                   | 0            |   |
| 18                            |                                    |   |   |                                  |       |                |                   | 0            |   |
| 19                            |                                    |   |   |                                  |       |                |                   | 0            |   |
|                               | <b>Total for in-year</b>           |   |   |                                  | 427   | 97             | 16                | (347)        |   |

**Table M: Aged Debtors**

| Debtor                                      | Inv #  | Inv Date       | Orig Inv £ | Outstand. Inv £ | Valid Entry                 | >11 weeks but <17 weeks | Over 17 weeks | Arbitration Due Date | Comments                                     |
|---|--------|----------------|------------|-----------------|-----------------------------|-------------------------|---------------|----------------------|--|
| CWM TAF MORGANNWG UHB                       | 224022 | 13 July 2023   | 11876.99   | 11,876.99       | Yes, valid entry for period | 11,876.99               |               | 09 November 2023     | Paid 08.11.23                                |
| CWM TAF MORGANNWG UHB                       | 224239 | 26 July 2023   | 22552.70   | 17,405.85       | Yes, valid entry for period | 17,405.85               |               | 22 November 2023     | Confirmed to be Paid w/c 06.11.23            |
| CWM TAF MORGANNWG UHB                       | 224312 | 31 July 2023   | 308.00     | 308.00          | Yes, valid entry for period | 308.00                  |               | 27 November 2023     | Awaiting Confirmation of payment date        |
| HEALTH EDUCATION & IMPROVEMENT WALES        | 224279 | 27 July 2023   | 15587.15   | 15,587.15       | Yes, valid entry for period | 15,587.15               |               | 23 November 2023     | Paid 01.11.23                                |
| HEALTH EDUCATION & IMPROVEMENT WALES        | 224280 | 27 July 2023   | 10704.83   | 10,704.83       | Yes, valid entry for period | 10,704.83               |               | 23 November 2023     | Paid 01.11.23                                |
| HEALTH EDUCATION & IMPROVEMENT WALES        | 224281 | 27 July 2023   | 5455.60    | 5,455.60        | Yes, valid entry for period | 5,455.60                |               | 23 November 2023     | Awaiting Confirmation of payment date        |
| HEALTH EDUCATION & IMPROVEMENT WALES        | 224287 | 27 July 2023   | 3739.19    | 3,739.19        | Yes, valid entry for period | 3,739.19                |               | 23 November 2023     | Invoice to be cancelled - incorrectly raised |
| PUBLIC HEALTH WALES NHS TRUST               | 223971 | 11 July 2023   | 24.72      | 24.72           | Yes, valid entry for period | 24.72                   |               | 07 November 2023     | Paid 07.11.23                                |
| PUBLIC HEALTH WALES NHS TRUST               | 223996 | 13 July 2023   | 7528.66    | 7,528.66        | Yes, valid entry for period | 7,528.66                |               | 09 November 2023     | Paid 07.11.23                                |
| PUBLIC HEALTH WALES NHS TRUST               | 224021 | 13 July 2023   | 16736.56   | 16,736.56       | Yes, valid entry for period | 16,736.56               |               | 09 November 2023     | Paid 07.11.23                                |
| PUBLIC HEALTH WALES NHS TRUST               | 224118 | 20 July 2023   | 2256.57    | 2,256.57        | Yes, valid entry for period | 2,256.57                |               | 16 November 2023     | Paid 07.11.23                                |
| PUBLIC HEALTH WALES NHS TRUST               | 224271 | 27 July 2023   | 13009.50   | 1,543.43        | Yes, valid entry for period | 1,543.43                |               | 23 November 2023     | Previously Paid on 14.09.23                  |
| PUBLIC HEALTH WALES NHS TRUST               | 224273 | 27 July 2023   | 63000.00   | 63,000.00       | Yes, valid entry for period | 63,000.00               |               | 23 November 2023     | Paid 07.11.23                                |
| POWYS HEALTH BOARD                          | 223581 | 31 May 2023    | 1622.43    | 1,622.43        | Yes, valid entry for period |                         | 1,622.43      | 27 September 2023    | Paid 10.11.23                                |
| POWYS HEALTH BOARD                          | 224232 | 26 July 2023   | 10411.00   | 875.10          | Yes, valid entry for period | 875.10                  |               | 22 November 2023     | Awaiting Confirmation of payment date        |
| POWYS HEALTH BOARD                          | 224313 | 31 July 2023   | 616.00     | 616.00          | Yes, valid entry for period | 616.00                  |               | 27 November 2023     | Awaiting Confirmation of payment date        |
| POWYS HEALTH BOARD                          | 224349 | 02 August 2023 | 1549.74    | 1,549.74        | Yes, valid entry for period | 1,549.74                |               | 29 November 2023     | Awaiting Confirmation of payment date        |
| POWYS HEALTH BOARD                          | 224353 | 02 August 2023 | 4794.18    | 4,794.18        | Yes, valid entry for period | 4,794.18                |               | 29 November 2023     | Awaiting Confirmation of payment date        |
| POWYS HEALTH BOARD                          | 224366 | 07 August 2023 | 284.00     | 284.00          | Yes, valid entry for period | 284.00                  |               | 04 December 2023     | Awaiting Confirmation of payment date        |
| SWANSEA BAY UNIVERSITY HEALTH BOARD         | 224112 | 20 July 2023   | 921.27     | 921.27          | Yes, valid entry for period | 921.27                  |               | 16 November 2023     | Awaiting Confirmation of payment date        |
| WELSH AMBULANCE NHS TRUST                   | 223929 | 05 July 2023   | 7066.96    | 7,066.96        | Yes, valid entry for period | 7,066.96                |               | 01 November 2023     | Awaiting Confirmation of payment date        |
| WELSH AMBULANCE NHS TRUST                   | 224373 | 07 August 2023 | 4512.25    | 4,512.25        | Yes, valid entry for period | 4,512.25                |               | 04 December 2023     | Paid 09.11.23                                |
| WELSH HEALTH SPECIALISED SERVICES COMMITTEE | 224301 | 27 July 2023   | 186495.00  | 186,495.00      | Yes, valid entry for period | 186,495.00              |               | 23 November 2023     | To be paid w/c 13.11.23                      |
|   |        |                | 391,053.30 | 364,904.48      |                             | 363,282.05              | 1,622.43      |                      |  |



**Table P: Ringfenced**

|  |                                     | Expenditure (£000s) - Variance (- deficit/+surplus) |              |       |       |       |       |        |           |         |          |          |         |          |       | Total  | Total  | Total  |
|--|-------------------------------------|---|--------------|-------|-------|-------|-------|--------|-----------|---------|----------|----------|---------|----------|-------|--------|--------|--|
| Table A: Allocation Paper (23/24 New Ring Fenced)            |                                     | WG Annual Allocation                                | Current Plan | April | May   | June  | July  | August | September | October | November | December | January | February | March | YTD    | Annual | Variance against WG Allocation (+over/under spend) |
| Recovery Funding (£120m)                                     | Plan                                | 22,605  | 22,605       | 1,884 | 1,884 | 1,884 | 1,884 | 1,884  | 1,884     | 1,884   | 1,884    | 1,884    | 1,884   | 1,884    | 1,881 | 13,188 | 22,605 |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              | 1,884 | 1,884 | 1,884 | 1,884 | 1,884  | 1,884     | 1,884   | 1,884    | 1,884    | 1,884   | 1,884    | 1,881 | 13,188 | 22,605 |  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |
| Value Based Funding (£14m)                                   | Plan                                | 2,686   | 2,686        | 74    | 74    | 74    | 225   | 225    | 225       | 298     | 298      | 298      | 298     | 298      | 299   | 1,195  | 2,686  |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              | 74    | 74    | 74    | 225   | 225    | 225       | 298     | 298      | 298      | 298     | 298      | 299   | 1,195  | 2,686  |  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |
| Regional Integration Fund (£132.7m)                          | Plan                                | 24,663  | 24,683       | 1,529 | 2,053 | 2,199 | 897   | 3,630  | 2,047     | 333     | 2,275    | 2,284    | 2,442   | 2,941    | 2,053 | 6,698  | 12,888 | 24,683   |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              | 1,529 | 2,053 | 2,199 | 897   | 3,630  | 2,047     | 333     | 2,275    | 2,284    | 2,442   | 2,941    | 2,054 | 12,888 | 24,683 |  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |
| Genomics for Precision Medicine Strategy (£10.1m)            | Plan                                | 1,904   | 1,904        | 159   | 159   | 159   | 159   | 159    | 159       | 159     | 159      | 159      | 159     | 159      | 159   | 1,111  | 1,904  |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              | 159   | 159   | 159   | 159   | 159    | 159       | 159     | 159      | 159      | 159     | 159      | 159   | 1,111  | 1,904  |  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |
| Critical Care Funding (£18.7m)                               | Plan                                | 2,753   | 2,753        | 229   | 229   | 229   | 229   | 229    | 229       | 229     | 229      | 229      | 229     | 229      | 234   | 1,603  | 2,753  |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              | 229   | 229   | 229   | 229   | 229    | 229       | 229     | 229      | 229      | 229     | 229      | 234   | 1,603  | 2,753  |  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |
| check  |                                     |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        |  |
| Table B : Additional In-Year (23/24 Anticipated & Allocated) |                                     | WG Annual Allocation                                | Current Plan | April | May   | June  | July  | August | September | October | November | December | January | February | March | YTD    | Annual | Variance against WG Allocation (+over/under spend) |
| Urgent Emergency Care Allocations                            | Plan                                | 7,489   | 7,489        | 590   | 593   | 625   | 644   | 630    | 630       | 629     | 629      | 629      | 629     | 629      | 631   | 4,342  | 7,489  |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              | 723   | 732   | 767   | 738   | 756    | -12       | 648     | 653      | 655      | 653     | 653      | 723   | 4,353  | 7,690  |  |
|  | Variance against current plan       |   |              | 133   | 139   | 142   | 94    | 126    | (642)     | 19      | 24       | 26       | 24      | 24       | 92    | 12     | 201    | 201  |
| Mental Health (SIF) Allocations                              | Plan                                | 3,508   | 3,508        | 228   | 228   | 228   | 261   | 261    | 261       | 340     | 340      | 340      | 340     | 340      | 340   | 1,809  | 3,508  |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              | 228   | 228   | 228   | 261   | 261    | 261       | 340     | 340      | 340      | 340     | 340      | 340   | 1,809  | 3,508  |  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |
| Planned Care   | Plan                                | 6,040   | 6,040        | 258   | 258   | 258   | 405   | 405    | -36       | 1,203   | 845      | 610      | 610     | 610      | 614   | 2,751  | 6,040  |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              | 258   | 258   | 258   | 405   | 405    | -36       | 1,203   | 845      | 610      | 610     | 610      | 614   | 2,751  | 6,040  |  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |
| Value Based Health Care                                      | Plan                                | 506   | 506          | 42    | 42    | 42    | 42    | 42     | 42        | 42      | 42       | 42       | 42      | 42       | 44    | 294    | 506    |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              | 42    | 42    | 42    | 42    | 42     | 42        | 42      | 42       | 42       | 42      | 42       | 44    | 294    | 506    |  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |
| Recovery   | Plan                                |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |
| Spare  | Plan                                |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        |  |
|  | Actual/Forecast - not yet committed |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Actual/Forecast - committed         |   |              |       |       |       |       |        |           |         |          |          |         |          |       |        |        | 0  |
|  | Variance against current plan       |   |              | 0     | 0     | 0     | 0     | 0      | 0         | 0       | 0        | 0        | 0       | 0        | 0     | 0      | 0      | 0  |







# ABUHB – Month 8 (Nov-23)

## Financial Position and Forecast F&PC - Early Brief

# Month 8 position - overview



## Key Points:

Month 8 variance £5m (deficit) – this is in line with previous run rates

Year to date variance £46.7m (deficit)

Forecast £57.6m (deficit) – as per month 6 and 7

## Forecast movements:

Delegated budget deficits increased by £5.4m offset by Primary care funding £1m, WHSSC savings put to reserves £1.6m and release of £1.8m contingency reserves and £1m balance sheet provision release.

Overall able to hold the forecast but risks to managing the position if any further unexpected costs emerge.

## Savings:

Bed Savings now removed (winter surge) from plans contributing to the revised adverse forecast.

Need to identify further opportunities to provide mitigation of risks and decrease forecast deficit.

## Cash:

Strategic Cash request has been challenged by WG aligned to deficit being above control total.

# Key in-month movements :- Month 8 position



- Prescribing – Price per item increase from £7.52 to £7.58.
- CHC – reduction in CHC numbers and associated non-recurrent benefits.
- Medicine – endoscopy funding delegated from reserves.
- Family & Therapies – reduction in Adferiad WG funding.
- Estates & Facilities – bed contract and inflationary pressures.
- Litigation – on-going increase and conversion into 'probable' cases
- Commissioning – activity increases linked to Velindre Commissioning – further

| Summary Reported position - November 2023 (M08)              | Full Year Budget<br>£000s | YTD Reported<br>Variance<br>£000s | Prior month<br>reported<br>variance<br>£000s | Movement<br>from prior<br>month<br>£000s |
|--|---------------------------|-----------------------------------|--|--|
| <b>Operational Divisions:-</b>                               |                           |                                   |  |  |
| Primary Care and Community                                   | 287,829                   | 824                               | 800  | 24                                       |
| Prescribing  | 111,133                   | 7,260                             | 6,373  | 887                                      |
| Community CHC & FNC  | 73,656                    | (1,264)                           | (620)  | (644)                                    |
| Mental Health  | 127,706                   | 9,381                             | 8,495  | 886                                      |
| <b>Total Primary Care, Community and Mental Health</b>       | <b>600,323</b>            | <b>16,201</b>                     | <b>15,048</b>                                | <b>1,153</b>                             |
| Scheduled Care   | 197,364                   | 6,653                             | 5,841  | 812                                      |
| Clinical Support Services                                    | 62,608                    | (988)                             | (977)  | (11)                                     |
| Medicine   | 153,091                   | 9,341                             | 10,394                                       | (1,053)                                  |
| Urgent Care  | 34,984                    | 3,374                             | 3,041  | 334                                      |
| Family & Therapies   | 132,478                   | 2,475                             | 1,860  | 615                                      |
| Estates and Facilities                                       | 87,676                    | 4,244                             | 3,961  | 283                                      |
| Director of Operations                                       | 8,283                     | 488                               | 441  | 47                                       |
| <b>Total Director of Operations</b>                          | <b>676,484</b>            | <b>25,586</b>                     | <b>24,560</b>                                | <b>1,026</b>                             |
| <b>Total Operational Divisions (Chief Operating Officer)</b> | <b>1,276,807</b>          | <b>41,787</b>                     | <b>39,608</b>                                | <b>2,179</b>                             |
| Corporate Divisions  | 121,390                   | (2,145)                           | (2,418)                                      | 273                                      |
| Specialist Services  | 184,327                   | (2,333)                           | (1,692)                                      | (641)                                    |
| External Contracts   | 87,226                    | 216                               | (157)  | 373                                      |
| Capital Charges  | 54,118                    | 351                               | 347  | 4  |
| <b>Total Delegated Position</b>                              | <b>1,723,868</b>          | <b>37,875</b>                     | <b>35,688</b>                                | <b>2,187</b>                             |
| Total Reserves   | 847                       | 8,835                             | 6,176  | 2,659                                    |
| Total Income   | (1,724,715)               | (0)                               | (0)  | (0)                                      |
| <b>Total Reported Position</b>                               | <b>0</b>                  | <b>46,711</b>                     | <b>41,864</b>                                | <b>4,847</b>                             |



## Month 8 forecast

- Prescribing – Price per item increase from £7.52 to £7.56 (+£1.2m).
- Primary Care – GMS income and slippage (-£1.2m)
- Primary Care – Ruperra bed closures (24 beds from 1<sup>st</sup> February) (-£0.3m)
- Medicine – RHCU beds not closing, additional beds (+£0.6m)
- Medicine – 2 agency COTE locums for 4 months (+£0.2m), Endoscopy budget £2m
- Family & Therapies – reduction in Adferiad WG funding (+£0.7m).
- COO – Bed savings removed from forecast (+£2.2m).
- Nurse Director – Enhanced Care savings removed (+£0.5m)

| Summary Reported position - November 2023 (M08)              | Annual Year Budget<br>£000s | Full-year forecast at M07<br>£000s | Full-year forecast at M08<br>£000s | Movement<br>£000s |
|--|-----------------------------|------------------------------------|------------------------------------|-------------------|
| <b>Operational Divisions:-</b>                               |                             |                                    |                                    |                   |
| Primary Care and Community                                   | 287,829                     | 2,701                              | 1,317                              | (1,385)           |
| Prescribing  | 111,133                     | 10,253                             | 11,221                             | 968               |
| Community CHC & FNC  | 73,656                      | (3,549)                            | (3,623)                            | (74)              |
| Mental Health  | 127,706                     | 12,681                             | 12,652                             | (29)              |
| <b>Total Primary Care, Community and Mental Health</b>       | <b>600,323</b>              | <b>22,086</b>                      | <b>21,567</b>                      | <b>(519)</b>      |
| Scheduled Care   | 197,364                     | 8,980                              | 9,140                              | 160               |
| Clinical Support Services                                    | 62,608                      | (512)                              | (536)                              | (24)              |
| Medicine   | 153,091                     | 16,264                             | 13,310                             | (2,954)           |
| Urgent Care  | 34,984                      | 5,053                              | 5,030                              | (23)              |
| Family & Therapies   | 132,478                     | 3,058                              | 3,715                              | 656               |
| Estates and Facilities                                       | 87,676                      | 6,138                              | 5,922                              | (216)             |
| Director of Operations                                       | 8,283                       | (1,518)                            | 871                                | 2,389             |
| <b>Total Director of Operations</b>                          | <b>676,484</b>              | <b>37,463</b>                      | <b>37,451</b>                      | <b>(12)</b>       |
| <b>Total Operational Divisions (Chief Operating Officer)</b> | <b>1,276,807</b>            | <b>59,550</b>                      | <b>59,018</b>                      | <b>(531)</b>      |
| Corporate Divisions  | 121,390                     | (1,755)                            | (2,376)                            | (621)             |
| Specialist Services  | 184,327                     | (2,901)                            | (3,500)                            | (599)             |
| External Contracts   | 87,226                      | (201)                              | 399                                | 600               |
| Capital Charges  | 54,118                      | 303                                | 336                                | 33                |
| <b>Total Delegated Position</b>                              | <b>1,723,868</b>            | <b>54,995</b>                      | <b>53,876</b>                      | <b>(1,119)</b>    |
| Total Reserves   | 847                         | 2,632                              | 3,750                              | 1,119             |
| Total Income   | (1,724,715)                 |                                    |                                    | 0                 |
| <b>Total Reported Position</b>                               | <b>0</b>                    | <b>57,627</b>                      | <b>57,627</b>                      | <b>(0)</b>        |

# Month 6 to Month 8 forecast comparison



| ABUHB                                  | Full-year Forecast at M06 | Full-year Forecast at M07 | Full-year Forecast at M08 | Movement from Month 6 to Month 8<br>£000s | Notes - for changes from Month 6 to Month 8  |
|--|---------------------------|---------------------------|---------------------------|---|--|
| Primary Care and Community Prescribing | 3,459                     | 2,701                     | 1,317                     | (2,142)                                   | Funding/Slippage - COTE transfer, PADM, other (-£1.7m), Ruperra beds (-£0.3m), additional savings (-£0.1m)   |
| Community CHC & FNC                    | (2,732)                   | (3,549)                   | (3,623)                   | (891)                                     | PAR £7.58 (from £7.53), growth lower YTD 0.46% than 0.8% forecast (last 12 months is 1.04%)  |
| Mental Health & LD                     | 12,914                    | 12,681                    | 12,652                    | (261)                                     | RIF funding (£0.3m), Reduction in DTA and CHC placements, CHC growth offset by funding, Powys income and variable pay reduction  |
| Scheduled Care                         | 8,574                     | 8,980                     | 9,140                     | 566                                       | Haematology drug growth new treatment (+£0.2m), Hearing aids (+£0.15m), Med agency in ENT (+£0.1m), T&O 156 week waits (+£0.1m)  |
| Clinical Support Services              | (432)                     | (512)                     | (536)                     | (104)                                     | (-£0.1m) decrease due to radiographer vacancies  |
| Medicine                               | 16,918                    | 16,264                    | 13,310                    | (3,608)                                   | COTE Medical premium to PCCS (+£0.7m), Nursing (+£0.4m), Diabetes, CPAP (+£0.7m) Funding - Endoscopy, Cardiology, YF, HEIW (-£6m), Savings reduction not closing RHCU (+£0.3m), Increased costs for 18 extra beds opening (6 RAZ, 12 D1W) in Q4 (+£0.3m) |
| Urgent Care                            | 5,138                     | 5,053                     | 5,030                     | (108)                                     | ED Medical & Income reduction (c.-£0.1m)   |
| Family & Therapies                     | 2,703                     | 3,058                     | 3,715                     | 1,012                                     | Adferiad funding pressure (£0.6m), Diabetes pumps (+£0.3m), all other reasons (£0.1m)  |
| Estates and Facilities                 | 5,988                     | 6,138                     | 5,922                     | (66)                                      | Savings GUH OOH and beds contract costs offset by energy reductions  |
| Chief Operating Officer                | (1,674)                   | (1,518)                   | 871                       | 2,545                                     | £2.25m bed savings plan now assumed to be unachieved, increase in transport costs (+£0.15m), specific MH post (+£0.1m)   |
| <b>Total Chief Operating Officer</b>   | <b>61,315</b>             | <b>59,550</b>             | <b>59,018</b>             | <b>(2,297)</b>                            |  |
| Corporate Divisions                    | (2,998)                   | (1,755)                   | (2,376)                   | 622                                       | Enhanced Care savings plan in Nurse Director treansferred to divisions (+£0.5m), Litigation cases now classed as 'probable' (+£0.4m) off-set by non-recurrent vacancies and other benefits from balance sheet review (£0.6m)                             |
| Commissioning / WHSSC / EASC           | (3,102)                   | (3,102)                   | (3,101)                   | 0   | Commissioning increase of £0.6m (Velindre, C&V and NHS England activity & drug increase) off-set by EASC slippage against plan   |
| WG additional funding                  | 0                         | (88,400)                  | (88,400)                  | (88,400)                                  | £78.9m confirmed, £9.5m energy anticipated (risk on energy anticipation)   |
| IMTP variance                          | 112,848                   | 112,848                   | 112,848                   | 0   | Phased evenly  |
| Supporting Financial Position          | (16,938)                  | (16,963)                  | (19,832)                  | (2,894)                                   | IMTP contingency released to serves (£1.85m), WHSSC/EASC to savings reserves (£1.65m)  |
| All other reserves / other             | (5,427)                   | (4,551)                   | (530)                     | 4,897                                     | Further Faster funding included to be allocated £1.58m. Allocations delegated including Cardiology (£1.066m) and PPE (£0.343m)   |
| Reserves and Others                    | 90,483                    | 2,934                     | 4,086                     | (86,397)                                  |  |
| <b>Total Delegated Position</b>        | <b>145,699</b>            | <b>57,627</b>             | <b>57,627</b>             | <b>(88,072)</b>                           |  |





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

|  |  |
|--|--|
| <b>DYDDIAD Y CYFARFOD:<br/>DATE OF MEETING:</b>      | 21 December 2023   |
| <b>CYFARFOD O:<br/>MEETING OF:</b>                   | Finance and Performance Committee  |
| <b>TEITL YR ADRODDIAD:<br/>TITLE OF REPORT:</b>      | NHS Benchmarking Network – General Update  |
| <b>CYFARWYDDWR<br/>ARWEINIOL:<br/>LEAD DIRECTOR:</b> | Rob Holcombe – Executive Director Finance,<br>Value Based Healthcare and Procurement |
| <b>SWYDDOG ADRODD:<br/>REPORTING OFFICER:</b>        | Chris Commins – AFD Out of Hospital Divisions<br>Greg Bowen – AFD Hospital Divisions |

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

Ar Gyfer Trafodaeth/For Discussion

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

The purpose of this report is to update the Committee on the latest position of the Health Board's Benchmarking exercise for the current financial year, whilst also drawing out key messages from a sample of recently completed projects. The committee are also asked to note the proposals for how we use insight from the reports to identify possible savings and efficiency opportunities, and provide views.

**Cefndir / Background**

NHS Benchmarking Network (NHSBN) is a member led organisation of which the Health Board subscribes. The network consists of over 230 organisations across the United Kingdom, including, Wales, England, Scotland, and Northern Ireland. All Health Boards in Wales are members.

Following network meetings which discuss key health sector issues, an annual work plan (see below) is available to the Health Board as part of our membership which comprises a wide range of benchmarking projects on topics of interest to members,



together with projects aimed at the more specific interests in four sectors: Commissioning, Community, Acute and Mental Health. As a foundation member the Health Board can participate in any of the benchmarking projects for which it is eligible. Projects are not compulsory for all members who are eligible.

| 2023/24 Projects (2022/23 data)   | Data Collection   | Validation       | Reporting         | National Findings (Virtual) Event |
|---|---|------------------|-------------------|-----------------------------------|
| <b>Whole System</b>   |   |                  |                   |                                   |
| Integrated Care Benchmarker   | Contact the team for more information   |                  |                   |                                   |
| ICB Theme Reports/Stories   |   |                  |                   |                                   |
| Whole System Beds   |   |                  |                   |                                   |
| <b>Acute</b>  |   |                  |                   |                                   |
| Outpatients - The project looks at a range of metrics around acute outpatient departments, across service model, access, capacity, activity, workforce, finance and quality. Some specific deep-dive areas include PIFU, A&G and the elective care backlog.   | 11th Apr - 12th May 2023  | May - Jun 2023   | September 2023    | 3rd October 2023                  |
| Acute Pharmacy and Medicines Optimisation - This project focuses on acute pharmacy services, covering several key topics, including medicines spend, pharmacy workforce overview, budget, dispensing and antimicrobials.  | 24th April - 9th June 2023  | Jun - Jul 2023   | September 2023    | 11th October 2023                 |
| Emergency Care - Benchmarking A&E departments, Urgent Treatment Centres and walk-in facilities, this project analyses key issues including senior cover, patient flow and staffing levels.  | 24th April - 9th June 2023  | Jun - Jul 2023   | October 2023      | 22nd November 2023                |
| Managing Frailty in the Acute Setting - A review of the pathway for frail older people through secondary care, including pathways, comprehensive geriatric assessment, acute frailty services, older people's wards, discharge, and outcomes.   | 22nd May - 6th July 2023  | Jul - Aug 2023   | November 2023     | 6th December 2023                 |
| <b>Community</b>  |   |                  |                   |                                   |
| District Nursing - A focused deep dive into district nursing services, looking at service models, demand, capacity, workforce, finance and outcomes.  | 24th April - 9th June 2023  | Jun - Jul 2023   | September 2023    | 18th October 2023                 |
| Intermediate Care - This project looks at the capacity and responsiveness of community intermediate care services, including urgent community response, home based, bed based and reablement services that support admission avoidance and supported discharge.   | 24th April - 9th June 2023  | Jun - Jul 2023   | October 2023      | 30th November 2023                |
| Healthy Child Programme - Open to health visiting, school nursing and 0-19 services, this project will provide benchmarking across service models, demand, capacity, workforce and outcomes aligned with the Healthy Child Programme guidance.  | 22nd May - 6th July 2023  | Jul - Aug 2023   | October 2023      | 8th November 2023                 |
| Community Indicators (monthly)  | Contact the team for more information   |                  | Monthly Reports   |                                   |
| <b>Acute and Community</b>  |   |                  |                   |                                   |
| Therapies - This project explores AHP services across both acute and community settings, enabling services to benchmark against either their acute or community counterparts as well as at a system level.  | 22nd May - 6th July 2023  | Jul - Aug 2023   | November 2023     | 12th December 2023                |
| Virtual Wards - A snapshot of the implementation of virtual wards, to include data from both community and acute providers.   | January 2024  | February 2024    | March 2024        | April 2024                        |
| <b>Mental Health, Learning Disabilities and Autism Services (MHLDA)</b>   |   |                  |                   |                                   |
| Adults & Older Adult Mental Health - Access detailed data across activity, workforce, quality and finance across community and inpatient settings to examine the balance of care in the provision of services.  | 17th Apr - 5th June 2023  | June - July 2023 | October 2023      | October 2023                      |
| Child & Young Persons (CYP) Mental Health Services - Access detailed data across activity, workforce, quality and finance across community and inpatient settings to examine the balance of care in the provision of services.  | 2nd May - 26th June 2023  | June - July 2023 | October 2023      | October 2023                      |
| Learning Disabilities/ ASD Services - This project compares the main service portfolios of specialist LD providers and quantifies the nature and shape of services provided and the NHS Improvement project focuses on organisational governance, service quality, patient and staff views of service delivery. | The Learning Disabilities and Autism benchmarking project 'dates for the diary' are currently under consultation with the Network's MHLDA Reference Group. This may result in the 2023/24 project timescales being brought forward to match other projects within the sector. We appreciate that members want to plan resource for upcoming data collections, and anticipate that finalised project dates for 2023/24 will be confirmed by the end of March. Our Support Team will liaise with all members as soon as this has been agreed. |                  |                   |                                   |
| MHLDA Services Tracker (quarterly)  | Contact the team for more information   |                  | Quarterly Reports |                                   |
| <b>All Sectors</b>  |   |                  |                   |                                   |
| National Cost Collection Analysis Reports   | National Data   |                  | December 2023     |                                   |
| Opportunity Reports   | Project Data  |                  | March 2024        |                                   |

Each project consists of a Data Collection, Validation and Reporting Phase, and are ran over a period of up to six months, dependant on complexity. A specification document is made available by the network and the Business Intelligence Team within Finance liaise with relevant services and collate each return before submitting to the network. During Validation, an opportunity exists for health boards to review current position against peers and investigate any outlying areas. As part of reporting NHSBN produce a range of outputs including an Interactive toolkit, Bespoke report, High-level report, Good Practice compendium, and Feedback events which includes good practice case studies.

The network grants access to a portal where interactive toolkits can be accessed along with registration for upcoming events and recording of past events ([Link - HS Benchmarking Network](#)). Access to the portal can be given by the Business Intelligence Team in Finance and there is an unlimited number of users allowed as part of the subscription.

Locally, the Business Intelligence team produce summary reports and efficiency reports, where possible, with the assistance of key stakeholders across services. These reports provide insight into projects ensuring that correct key messages are being delivered. These messages include showcasing areas where services are performing well and areas of opportunity for improvement. These reports when published will be made available to stakeholders and via the financial challenge tile on the intranet.

Engagement across the Health Board varies for each project. Some services can be resistant where they cannot foresee the benefits, whereas proactive services who engage early utilise and develop reports with the assistance of the Business Intelligence team so that further insight can be gained.

The insight derived from some previous benchmarking returns has provoked wider work completed by the team which has been presented previously i.e. Theatre Utilisation, and Cataracts etc. The primary output of the benchmarking returns is comparison and potential opportunity of non-financial metrics, however where possible the Finance team will convert these into a financial worth to include within our organisation wide benchmarking compendium, which in turn also inform financial savings and efficiency opportunities on an on-going basis.

### **Asesiad / Assessment**

It is the expectation of the Executive Team that Benchmarking projects that are applicable to the Health Board are participated in. This year Welsh Government mandated the participation in the following exercises; -

- Intermediate Care
- Emergency Care
- Pharmacy
- Managing Frailty
- Mental Health

For the current programme of work the Health Board have participated in all available benchmarking projects except for Therapies, and the Healthy Child Programme. For both projects it was decided that the specification produced by the network and scoping of the exercises would result in incorrect messages being delivered due to the differing currencies and the way we distribute services in Wales compared to England. This has been fed back to the Network who welcome the opportunity to work with the Health Board in the creation of a 'Wales Only' return. However, this is dependent on appetite from all Health Boards participating.

Participation to projects across Wales is sporadic even with the mandate by Welsh Government. It is disappointing that for some projects that we have participated in that there is no Wales Peer group for us to compare ourselves against as the Health Board are the only participant. However, it is still possible to compare to other UK organisations.

|                  | Acute       |   |                |                  | Community        |                   |              | Acute and Community |                        | Mental Health, Learning Disability and Autism Services |                                       |                     |
|------------------|-------------|---|----------------|------------------|------------------|-------------------|--------------|---------------------|------------------------|--|---------------------------------------|---------------------|
|                  | Outpatients | Acute Pharmacy and Medicines Optimisation | Emergency Care | Managing Frailty | District Nursing | Intermediate Care | Health Child | Therapies           | Virtual Wards          | Adult and Older Adult Mental Health                    | Child and Young Persons Mental Health | Learning Disability |
| Aneurin Bevan    | ✓           | ✓   | ✓              | ✓                | ✓                | ✓                 |              |                     | Launching January 2024 | ✓  | ✓                                     | ✓                   |
| Betsi Cadwaladr  |             | ✓   | ✓              |                  |                  |                   |              |                     |                        | ✓  | ✓                                     | ✓                   |
| Cardiff and Vale | ✓           | ✓   | ✓              |                  | ✓                |                   |              |                     |                        | ✓  | ✓                                     | ✓                   |
| Powys            |             | ✓   | ✓              |                  |                  |                   | ✓            |                     |                        | ✓  | ✓                                     | ✓                   |
| Cwm Taf          |             | ✓   | ✓              |                  |                  |                   |              |                     |                        | ✓  | ✓                                     | ✓                   |
| Hywel Dda        |             | ✓   | ✓              |                  |                  |                   |              |                     | ✓                      | ✓  | ✓                                     |                     |
| Swansea Bay      |             | ✓   | ✓              |                  |                  | ✓                 |              |                     | ✓                      | ✓  | ✓                                     |                     |

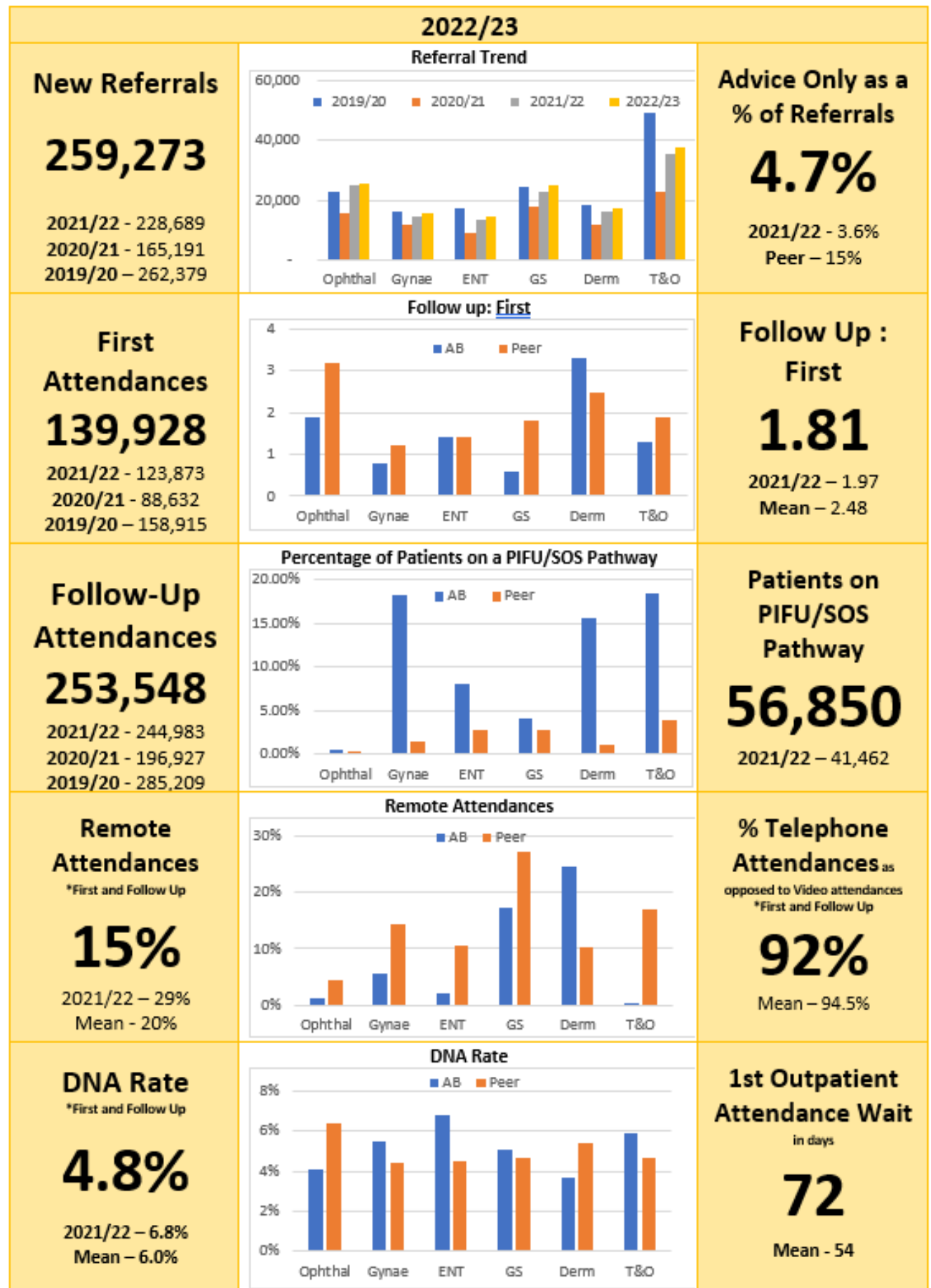
### Current Work Plan Position

Most projects run throughout the summer following the financial year end with reporting planned between August and December. The majority of projects for the current year are in the final stages of reporting and delivery of the summary reports.

|  | Data Collection | Validation                                      |     |          |               |                   | Reporting       |                  |            |                  |                      |         |
|--|-----------------|---|-----|----------|---------------|-------------------|-----------------|------------------|------------|------------------|----------------------|---------|
|  |                 | R1  | R2  | Internal | Draft Toolkit | Final Toolkit     | Bespoke Reports | Internal Reports |            |                  | Sent to Stakeholders |         |
| <b>Acute</b>   |                 |   |     |          |               |                   |                 |                  | DRAFT      | Service Sign Off | Final Output         |         |
| Outpatients  | ✓               | ✓   | ✓   | ✓        | ✓             | ✓                 | ✓               | ✓                | ✓          | ✓                | ✓                    | ✓       |
| Acute Pharmacy and Medicine Optimisation                         | ✓               | ✓   | ✓   | ✓        | ✓             | ✓                 | ✓               | ✓                | ✓          | ✓                | ✓                    | ✓       |
| Emergency Care   | ✓               | ✓   | ✓   | ✓        | ✓             | ✓                 | ✓               | ✓                | By End Nov | Early Dec        | Early Dec            |         |
| Managing Frailty in Acute Setting                                | ✓               | ✓   | ✓   | ✓        | ✓             | not yet release - |                 |                  | Dec        | Dec              | Jan                  | Jan     |
| <b>Community</b>   |                 |   |     |          |               |                   |                 |                  |            |                  |                      |         |
| District Nursing   | ✓               | ✓   | ✓   | ✓        | ✓             | ✓                 | ✓               | ✓                | ✓          | ✓                | ✓                    | ✓       |
| Intermediate Care  | ✓               | ✓   | ✓   | ✓        | ✓             | ✓                 | ✓               | ✓                | Mid Nov    | End Nov          | Mid Dec              | Mid Dec |
| Healthy Child Programme  | *               | *   | *   | *        | *             | *                 | *               | *                | *          | *                | *                    | *       |
| Acute and Community Therapies                                    | *               | *   | *   | *        | *             | *                 | *               | *                | *          | *                | *                    | *       |
| Virtual Wards  |                 | Await Scoping of Project - Project Opens Feb 24 |     |          |               |                   |                 |                  |            |                  |                      |         |
| <b>Mental Health, Learning Disabilities, and Autism Services</b> |                 |   |     |          |               |                   |                 |                  |            |                  |                      |         |
| Adults and Older Adult Mental Health                             | ✓               | ✓   | ✓   | ✓        | ✓             | ✓                 | ✓               | ✓                | ✓          | ✓                | ✓                    | ✓       |
| Child and Young Person Mental Health Services                    | ✓               | ✓   | ✓   | ✓        | ✓             | ✓                 | ✓               | ✓                | ✓          | Mid Dec          | Jan                  | Jan     |
| Learning Disabilities/ASD  | ✓               | Dec   | Jan | Jan      | Jan           | Jan               | Feb             | Feb              | Feb        | Mar              | Mar                  | Mar     |

Two of the recently completed projects are Outpatients and Pharmacy and Medicines Optimisation. Extracts from the report and key messages are included below; -

## Outpatients



The Outpatient Benchmarking project has run annually since 2016. The project collects data between April 2022 and March 2023 and aims to provide a detailed analysis of Outpatients departments.

There are 46 participants across the UK. Powys Teaching Health Board are the only other organisation in Wales to participate despite the mandating of the exercise by Welsh Government. As a result of this there is no Welsh peer group available.

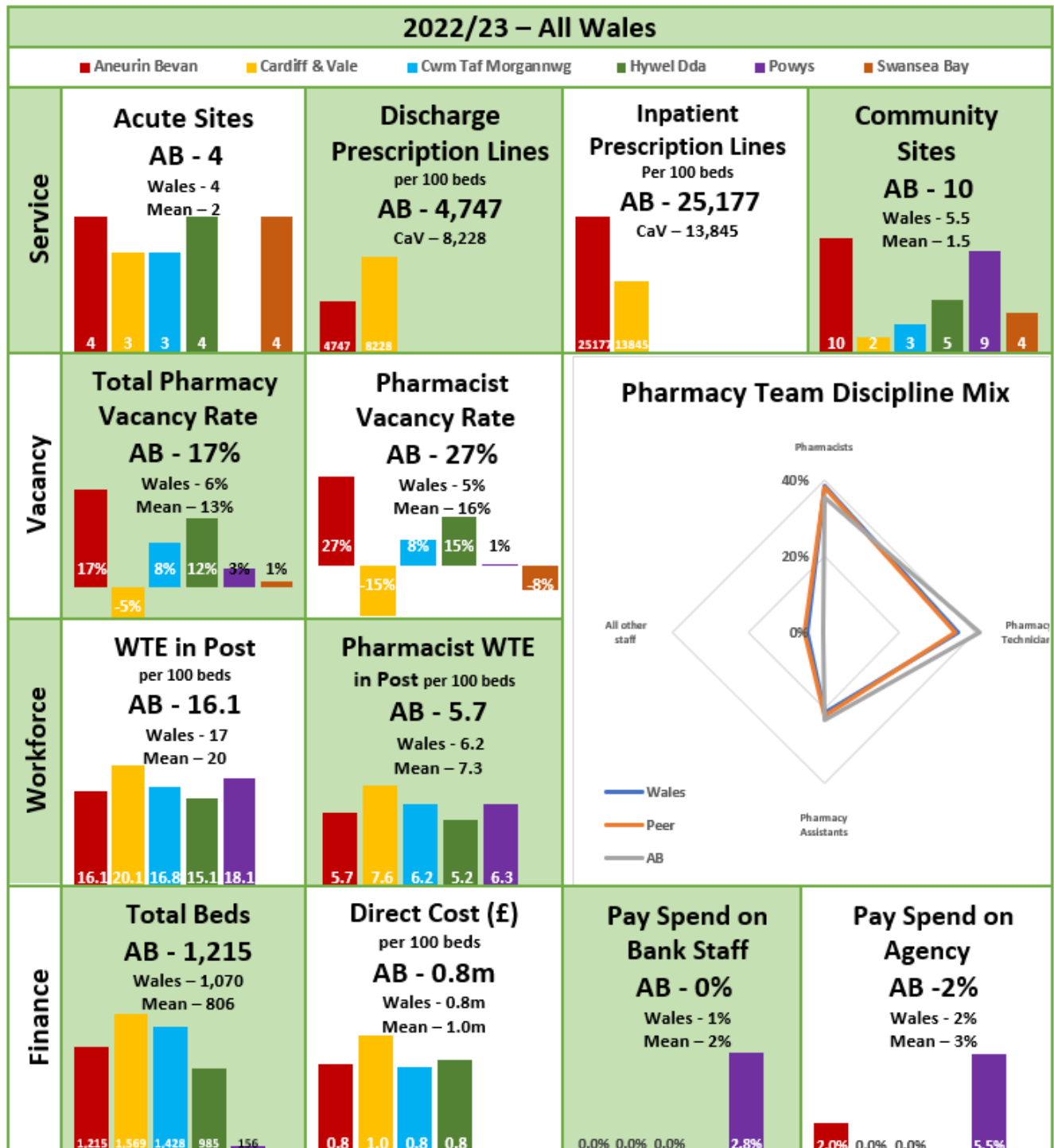
### Key Project Findings

The Health Board, along with NHS Wales and Welsh Government recognise that there is a need to modernise outpatients. There has been growing demand for outpatients in secondary care and the traditional model of outpatient care is no longer fit for purpose. It is not only costly but has a negative impact on patient experience. It places unnecessary financial and time costs on patients, clinicians, the NHS, and the public purse.

- Referrals received to our outpatient services have increased by 13% since 2021-22 and are now higher than pre-pandemic levels for the first time. Each of the specialties in scope of the exercise have seen year on year increases in referrals to services.
- Advice and Guidance provides efficient, integrated e-referral and e-advice to manage care. It provides better-enabled communication, with advice provided to primary care with access to consultant advice on investigations, interventions, and potential referrals. This enables the management of non-urgent cases in the most appropriate setting, helping reduce unnecessary referrals. 4.7% of referrals were Advice Only or Advice and Guidance during 2022/23. This is an increase on the previous fiscal year at 3.6% however, the health board are behind English counterparts who provide Advice and Guidance for 15% of their referrals.
- Following the pattern of referrals, attendances have increased during the period by 13%. In England, Outpatient transformation focuses on reducing follow-up activity by 25% against the 2019/20 baseline by March 2024. There were 6% fewer Follow-up appointments in 2022/23 compared to 2019/20 for AB. The Follow Up to First Appointment ratio continues to improve and is above peers nationally for most specialties.
- See-on-Symptom (SOS) and Patient Initiated Follow-Ups (PIFU) are seen as key in reducing the number of unnecessary follow-up attendances. Welsh Governments three-year strategy and action plan (2023-2026) on 'The role of Outpatients in transforming Planned Care in Wales' requires health boards to demonstrate an annual increase in the use of SOS and PIFU. The health board currently has nearly 57,000 patients on the PIFU/SOS list compared to 42,000 in 2021/22. The HB are in the top quartile of peers for the majority of specialties.
- The rapid and radical transformation from face-to-face care to Remote Attendances during COVID meant that the health board were able to continue the operation of some outpatient services. 15% of our outpatient attendances were remote during 2022/23 and below the national mean of 20%. This is a drop of around 14% from 2021/22 where we were above the peer average.
- The DNA rate is a key measure of efficient use of resource in outpatients. The rate for the period is 4.8% for specialties measured in the exercise. This represents

a better than peer average and ahead of the 5% DNA Target rate for the health board set by Welsh Government.

## Pharmacy



The Pharmacy & Medicines Optimisation Benchmarking project has run annually since 2015. In Wales, it was decided by the Chief Pharmacist that participation by all Health Boards every third year. The project collects data between April 2022 and March 2023 and aims to provide a detailed analysis of Pharmacy and Medicines Optimisation.

There are 78 participants across the UK. Six Welsh organisations participated in the exercise albeit with varying levels of completeness. ABUHB are one of the largest



organisations to participate in terms of turnover, number of beds and Occupied Bed Days.

## Key Project Findings

### *Service*

Aneurin Bevan Pharmacy Team offer a wide range of services including a dedicated pharmacy homecare team (93% of participants offered this service), a defined medicines information services team (76%), Specialist pharmacy staff for cancer (97%) and critical care (93%).

As well as having one of the highest reported number of beds, the number of inpatient prescription lines per bed is in the upper quartile, while the number of discharge prescription lines is below the UK mean.

### *Workforce*

The provision of pharmacy services requires a highly skilled, focused, and motivated workforce to deliver high quality patient care across a range of sites and settings. The benchmarked staff per 100 beds is below the mean nationally and in Wales.

### *Vacancy*

Participants across the project report that the broad range of work of acute pharmacy team is stretched by vacancies within workforce. This issue is particularly pertinent at AB with the Pharmacy team vacancy rate is 17% (Wales Mean 6%) and this places AB in the Upper quartile of respondents. The Pharmacist vacancy rate of 27% (Wales Mean 5%) is also in the upper quartile of peers. As a result of the high pharmacist vacancy rate, the discipline mix in the pharmacy team relies more heavily on technicians when comparing to peers nationally.

### *Inpatient Prescription Lines*

The number of Inpatient Prescription lines per 100 beds (25,177) is higher than both the Wales mean (19,511) and the total benchmarking mean (17,243). Further work will need to be undertaken in this area, however only one other Welsh Health board has completed this section and operate a different service model.

### *Average Discharge Prescription Turnaround Time*

There are some areas of this exercise that ABUHB have not completed such as "Average discharge prescription turnaround time". It would be useful going forward to have this information to review if the significant vacancies are having an adverse impact on patient discharges.

### *Finance*

Total Direct Costs of the pharmacy are significantly below Welsh peers and AB are below peers for Bank and Agency spend. The availability of locum staff is extremely limited and while this assists with lower costs extra pressure is being placed on existing staff.

### *Actions Taken to Date*

The Business Intelligence team and the Business Partner Accountant have met with the Head of Pharmacy – Operational Services to review the benchmarking report and highlight the areas where more work is required. The Head of Pharmacy has also discussed the report at a recent Divisional Pharmacy Assurance meeting.



### Summary

Pharmacy Workforce is an issue for AB where the organisation has an already low establishment baseline per 100 beds, when compared to the rest of Wales. This coupled with a high vacancy rate, particularly for pharmacists results in an extremely stretched workforce. The usual sources of cover via bank and agency are also difficult to attain in the current market.

### **Next Steps**

As the Benchmarking projects play an important role in providing appropriate insight in order to develop savings and efficiency opportunities we have proposed moving forward, that we will roll out the publication of the benchmarking returns as follows;

- 
- Data Validation exercise performed between BI team and service.
- Draft report and insight shared with DOF.
- Summary Report shared with service lead and key stakeholders.
- Meeting to cover key messages with service lead and corporate triumvirate of Finance, Workforce and Planning.
- Presentation at divisional management team meeting where Feedback and key action points agreed.
- Final corporate briefing distributed to executive and divisional lead.

### **Argymhelliad / Recommendation**

The committee is asked to; -

- Note the work completed to date on the NHS Benchmarking Networks annual work plan for 23-24
- Note how these returns are used to provide potential efficiency and financial savings opportunity moving forward.

| <b>Amcanion: (rhaid cwblhau)</b><br><b>Objectives: (must be completed)</b>                                   |  |
|--|--|
| Cyfeirnod Cofrestr Risg<br>Corfforaethol a Sgôr Cyfredol:<br>Corporate Risk Register<br>Reference and Score: | N/A  |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):   | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item. |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><a href="#">Link to IMTP</a>                                       | Choose an item.<br>Choose an item.<br>Governance   |

|   |  |
|---|--|
| Galluogwyr allweddol o fewn y CTCI<br>Key Enablers within the IMTP  | Governance   |
| Amcanion cydraddoldeb strategol<br>Strategic Equality Objectives<br><a href="#">Strategic Equality Objectives 2020-24</a> | Improve the Wellbeing and engagement of our staff<br>Choose an item.<br>Choose an item.<br>Choose an item. |

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

| <b>Effaith: (rhaid cwblhau)<br/>Impact: (must be completed)</b>                |   |
|--|---|
| <b>Resource Assessment:</b>  | A resource assessment is required to support decision making by the Board and/or Executive Committee, including policy and strategy development and implementation plans; investment and/or disinvestment opportunities; and service change proposals. Please confirm you have completed the following:                     |
| • <b>Workforce</b>   | Not Applicable  |
| • <b>Service Activity &amp; Performance</b>                                    | Yes, outlined within the paper  |
| • <b>Financial</b>   | Yes, outlined within the paper  |
| <b>Asesiad Effaith Cydraddoldeb Equality Impact Assessment (EIA) completed</b> | <b>No does not meet requirements</b><br><br>An EQIA is required whenever we are developing a policy, strategy, strategic implementation plan or a proposal for a new service or service change. If you require advice on whether an EQIA is required contact <a href="mailto:ABB.EDI@wales.nhs.uk">ABB.EDI@wales.nhs.uk</a> |

**Deddf Llesiant  
Cenedlaethau'r Dyfodol – 5  
ffordd o weithio  
Well Being of Future  
Generations Act – 5 ways  
of working**

<https://futuregenerations.wales/about-us/future-generations-act/>

Choose an item.

Choose an item.

N/A



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

|  |  |
|--|--|
| <b>DYDDIAD Y CYFARFOD:<br/>DATE OF MEETING:</b>      | 21 December 2023   |
| <b>CYFARFOD O:<br/>MEETING OF:</b>                   | Finance and Performance Committee  |
| <b>TEITL YR ADRODDIAD:<br/>TITLE OF REPORT:</b>      | Governance & Control Escalation – Operational Control Checklist October 2023 |
| <b>CYFARWYDDWR<br/>ARWEINIOL:<br/>LEAD DIRECTOR:</b> | Rob Holcombe<br>Executive Director of Finance, Procurement and VBHC          |
| <b>SWYDDOG ADRODD:<br/>REPORTING OFFICER:</b>        | Greg Bowen<br>Assistant Director of Finance – Hospital and Corp              |

|  |
|--|
| <b>Pwrpas yr Adroddiad (dewiswch fel yn addas)<br/>Purpose of the Report (select as appropriate)</b> |
| Er Sicrwydd/For Assurance  |

**ADRODDIAD SCAA  
SBAR REPORT**

**Sefyllfa / Situation**

Following a recent request for all Divisional budget holders to complete a Governance Operational Control Checklist for their respective areas, this report provides the Committee with an overall summary of the current reported situation as at the end of October 2023. The report demonstrates the proposed calculation method used to arrive at an overall Divisional Governance ‘score,’ and discusses options for how this is maintained and improved upon, on an ongoing basis. The Committee is asked to note the initial work that has been undertaken along with the initial scoring assessments and provide views on how this area of work is to be taken forward.

**Cefndir / Background**

In August 2023, following CEO request, all Divisional budget holders were asked to complete a Governance Operational Control Checklist for their respective Directorate. This requirement was for this to be service led to ensure ownership, but co-ordinated by the Divisional Finance teams, with a register of completion being maintained within each team.

The purpose of this exercise is that it is not a one-off, and in fact is an ongoing piece of work, with an updated assessment completed on a monthly basis with the intention of being able to demonstrate evidence of improved controls for the Executive Committee, the Board and for Welsh Government purposes.

## Asesiad / Assessment

The checklist, in Microsoft Excel format, required to be completed is below.

### ABUHB

### DIVISIONAL AND DIRECTORATE LEVEL CONTROL ASSESSMENT

Division:

Directorate:

Completed by:

|  |
|--|
|  |
|  |

#### OPERATIONAL CONTROL CHECKLIST

| SPEND AREA               | KEY ACTIONS   | IN PLACE? Y/N | RAG RATING | ACTIONS TO IMPLEMENT AND BY WHEN? |
|--------------------------|---|---------------|------------|-----------------------------------|
| BANK                     | Temporary staffing policy in place                                      |               |            |                                   |
|                          | Auto enrolment for new starters onto the bank                           |               |            |                                   |
|                          | Review pay rates and consider weekly pay as an incentive                |               |            |                                   |
|                          | Admin and clerical bank   |               |            |                                   |
| AGENCY                   | Clear process for agency booking (and compliance)                       |               |            |                                   |
|                          | Ensure appropriate deduction for agency staff breaks (lunch)            |               |            |                                   |
|                          | Review authorisation levels - seniority and consistency across sites    |               |            |                                   |
| ROSTERING                | E-rostering should be fully deployed                                    |               |            |                                   |
|                          | Annual leave, study leave should be closely managed throughout the year |               |            |                                   |
|                          | Posters should be approved six weeks in advance                         |               |            |                                   |
|                          | Contracted hours to be fully rostered                                   |               |            |                                   |
|                          | Sickness management   |               |            |                                   |
| OTHER PAY CONTROLS       | Line managers to notify HR of leaving dates                             |               |            |                                   |
|                          | Cease any early finish dates for leavers                                |               |            |                                   |
|                          | Enforce compliance with the All Wales Sickness policy                   |               |            |                                   |
|                          | Workforce/Vacancy control panel   |               |            |                                   |
| MEDICAL LOCUMS           | Implement medical bank  |               |            |                                   |
|                          | Proper process for booking medical agency (no direct approach)          |               |            |                                   |
|                          | Ensure appropriate deduction for agency staff breaks (lunch)            |               |            |                                   |
|                          | Ensure mileage claims are only for required intra site travel           |               |            |                                   |
| MEDICAL ROTAS            | Clear timeline for submission of rotas                                  |               |            |                                   |
|                          | Ensure alignment of rota to job plans                                   |               |            |                                   |
|                          | Review additional sessions allocated                                    |               |            |                                   |
|                          | Monitor medical annual leave  |               |            |                                   |
| WORKING LIST INITIATIVES | Ensure consistent process across organisation                           |               |            |                                   |
|                          | Require clear demonstration that existing PAs have been utilised        |               |            |                                   |
|                          | Ensure approval level is appropriate                                    |               |            |                                   |
| PROCUREMENT              | Address clinical preference variation in a targeted manner              |               |            |                                   |
|                          | Review and reduce those able to requisition and order                   |               |            |                                   |
|                          | Continue to enforce the 'No PO No Pay' policy                           |               |            |                                   |

Signed Off

Divisional Manager:

Divisional Director:

Date:

|  |
|--|
|  |
|  |
|  |

| Assessment | Outline Descriptor  |
|------------|---|
| Low        | identified controls in place are deemed inadequate with significant gaps identified which need to be addressed      |
| Medium     | identified controls in place are deemed adequate, however some gaps have been identified which need to be addressed |
| High       | identified controls in place are deemed robust  |

The process followed in order to complete the assessment was to assess each of the key actions by spend area and complete as below:

- Answer with a Y or N if it is felt that the key action is currently in place (or N/A if that is the case),
- Populate the template with any key actions identified for improvement, and proposed timeframe for implementation.

All Directorates were asked to complete this for their area and to return back to the relevant Divisional Finance team for registering, and consolidation into a Divisional template.

The Scheduled Care Divisional Finance team have proposed a mechanism for arriving at a Divisional Governance % score (for each key action, overall spend area; and the Division overall). The methodology also provides a RAG rating for each overall spend area and the Divisional overall, based on the % score and criteria set.

This proposal has also been discussed with the Chief Operating Officer (COO) & agreed with the Finance Director.

The Scheduled Care Division's completed assessment as at the end of October 2023 is shown below:

**ABUHB**

**DIVISIONAL AND DIRECTORATE LEVEL CONTROL ASSESSMENT**

Division:   
 Directorate:   
 Completed by:

**OPERATIONAL CONTROL CHECKLIST**

| SPEND AREA                                | KEY ACTIONS   | RAG RATING | Comments  | Score                                  | Max        | Compliance % |      |
|---|---|------------|---|--|------------|--------------|------|
| BANK                                      | Temporary staffing policy in place                                    | R          | Directorate contingency plans in place for temporary shortages                            | 1                                      | 3          | 11%          |      |
|   | Auto enrolment for new starters onto the bank                         |            | Dependant on experience   | 1                                      | 3          | 11%          |      |
|   | Review pay rates and consider weekly pay as an incentive              |            | 6   | 3                                      | 67%        |              |      |
|   | Admin and clerical bank   |            | 7   | 8                                      | 88%        |              |      |
|   |   |            |   | <b>15</b>                              | <b>35</b>  | <b>43%</b>   |      |
| AGENCY                                    | Clear process for agency booking (and compliance)                     | A          |   | 3                                      | 3          | 100%         |      |
|   | Ensure appropriate deduction for agency staff breaks (lunch) - Agency |            |   | 3                                      | 3          | 33%          |      |
|   | Review authorization levels - seniority and consistency across sites  |            | Senior nurse and above  | 8                                      | 3          | 83%          |      |
|   |   |            |   | <b>20</b>                              | <b>27</b>  | <b>74%</b>   |      |
| ROSTERING                                 | E-rostering should be fully deployed                                  | G          | implemented for nursing, medical staffing ongoing (T&O already in place)                  |  |            |              |      |
|   |   |            | New system to be rolled out across the division in 12 months                              | 4                                      | 3          | 44%          |      |
|   |   |            | Annual leave, study leave should be closely managed throughout the year                   |  |            |              |      |
|   |   |            | Rosters should be approved six weeks in advance   | 8                                      | 3          | 83%          |      |
|   |   |            | Contracted hours to be fully rostered   | nursing in place monitoring compliance | 3          | 3            | 100% |
|   |   |            | Sickness management   | 3                                      | 3          | 100%         |      |
|   |   |            |   | <b>39</b>                              | <b>45</b>  | <b>87%</b>   |      |
| OTHER PAY CONTROLS                        | Line managers to notify HR of leaving dates                           | G          |   | 3                                      | 3          | 100%         |      |
|   | Cease any early finish dates for leavers                              |            | Admin and clerical bank   | 6                                      | 3          | 67%          |      |
|   | Enforce compliance with the All Wales Sickness policy                 |            | review and share with DM and ensure compliance  | 3                                      | 3          | 100%         |      |
|   | Workforce/Vacancy control panel                                       |            | Weekly DMT Security panel in place  | 3                                      | 3          | 100%         |      |
|   |   |            |   | <b>33</b>                              | <b>36</b>  | <b>92%</b>   |      |
| MEDICAL LOCUMS                            | Implement medical bank  | A          | By directorate  | 2                                      | 8          | 25%          |      |
|   | Proper process for booking medical agency (no direct approach)        |            |   | 5                                      | 8          | 63%          |      |
|   | Ensure appropriate deduction for agency staff breaks (lunch) - Locum  |            | reinforce through DMs, remind of policy, (links in with Lisa Inglestone BPA workstream)   | 1                                      | 5          | 20%          |      |
|   | Ensure mileage claims are only for required intra site travel         |            | 5   | 5                                      | 100%       |              |      |
|   |   |            |   | <b>13</b>                              | <b>26</b>  | <b>50%</b>   |      |
| MEDICAL ROTAS                             | Clear timeline for submission of rotas                                | G          | Ensure up to date job plans / or date to review   | 3                                      | 3          | 100%         |      |
|   | Ensure alignment of rota to job plans                                 |            | Ensure up to date job plans / or date to review   | 3                                      | 3          | 100%         |      |
|   | Review additional sessions allocated                                  |            | additional activity panel in place weekly   | 8                                      | 3          | 83%          |      |
|   | Monitor medical annual leave  |            | as above (mtg in place)   | 3                                      | 3          | 100%         |      |
|   |   |            |   | <b>35</b>                              | <b>36</b>  | <b>97%</b>   |      |
| WORKING LIST INITIATIVES                  | Ensure consistent process across organization                         | G          | suspended, (except Breast), Policy in situ.   | 3                                      | 3          | 100%         |      |
|   | Require clear demonstration that existing PAs have been utilized      |            | suspended, Policy in place  | 3                                      | 3          | 100%         |      |
|   | Ensure approval level is appropriate                                  |            | Normally DM approves. Currently suspended.  | 3                                      | 3          | 100%         |      |
|   |   |            |   | <b>27</b>                              | <b>27</b>  | <b>100%</b>  |      |
| PROCUREMENT                               | Address clinical preference variation in a targeted manner            | R          | DMs to complete. Mon pay work ongoing. Once Patient / surgeon level initiated will review | 1                                      | 3          | 11%          |      |
|   | Review and reduce those able to requisition and order                 |            | Review cost codes and approval (Marion Williams can pull)                                 | 8                                      | 3          | 83%          |      |
|   | Continue to enforce the 'No PO No Pay' policy                         |            |   | 1                                      | 3          | 11%          |      |
|   |   |            |   | <b>10</b>                              | <b>27</b>  | <b>37%</b>   |      |
| <b>Signed Off</b>                         |   | <b>A</b>   |   | <b>384</b>                             | <b>518</b> | <b>74%</b>   |      |
| Divisional Manager: <input type="text"/>  |   |            |   |  |            |              |      |
| Divisional Director: <input type="text"/> |   |            |   |  |            |              |      |
| Date: <input type="text"/>                |   |            |   |  |            |              |      |

The methodology used for arriving at both the % score and the RAG rating is as follows:

- All Directorate responses consolidated on to one overall summary sheet for Divisional consolidation purposes,
- The 'Score' is determined by the number of Directorates within the Division that have assessed that the Key Action is in place, by including a 'Y' for the relevant key action in the checklist,
- The 'Max' is the number of Directorates within a particular Division where the Key Action is relevant (Please note that where it has been identified by the service that a particular Key Action is not applicable then it is not included in the scoring mechanism),
- Compliance % is the ratio between the Score and the Max score,
- The same methodology has been used for each Key Action, overall Spend Area, and the Division overall,
- The RAG rating is then determined from the Compliance % (Red < 50%, Amber 51% to 75%, Green > 75%)

The process described above has been repeated across all Divisions, and a snapshot of assessments is illustrated below:

| Division | Compliance | RAG Rating |
|----------|------------|------------|
| PCCS     | 87%        |            |
| CHC      | 88%        |            |
| MH & LD  | 79%        |            |
| SCH      | 74%        |            |
| MED      | 77%        |            |
| URG      | 93%        |            |
| F & T    | 83%        |            |
| CSS      | 69%        |            |
| E & F    | 92%        |            |

It is proposed that all budget holders highlight the top priority actions identified to improve controls and these can be reported through the Divisional Assurance meetings. In conjunction with this, all budget holders should return revised checklists to their Divisional Finance Business Partners during the month end reporting process, beginning in November 2023. This will allow the scoring (as described above) to be updated and compared on a month-on-month basis to demonstrate improved control.

Consideration should be given to identifying and sharing best practice across Divisions to drive overall continuous improvement. To assist with this, a matrix has also been developed which captures scores and RAG rating for each Spend Area by Division:

|                          | PCCS | CHC  | MH & LD | SCH  | MED  | URG  | F & T | CSS | E & F |
|--------------------------|------|------|---------|------|------|------|-------|-----|-------|
| Bank                     | 73%  | 100% | 31%     | 43%  | 62%  | 75%  | 49%   | 40% | N/A   |
| Agency                   | 88%  | 100% | 100%    | 74%  | 100% | 100% | 100%  | 86% | 100%  |
| Rostering                | 91%  | 91%  | 100%    | 87%  | 70%  | 100% | 92%   | 73% | 95%   |
| Other Pay Controls       | 98%  | 100% | 100%    | 92%  | 83%  | 100% | 87%   | 69% | 95%   |
| Medical Locums           | 89%  | N/A  | 55%     | 50%  | 68%  | 75%  | 85%   | 86% | N/A   |
| Medical Rotas            | 100% | N/A  | 67%     | 97%  | 71%  | 100% | 76%   | 75% | N/A   |
| Working List Initiatives | 100% | N/A  | 50%     | 100% | 100% | N/A  | 100%  | 60% | N/A   |
| Procurement              | 74%  | 50%  | 92%     | 37%  | 78%  | 100% | 85%   | 67% | 81%   |

An updated version of these reports will be presented monthly also.

### **Argymhelliad / Recommendation**

The Committee is asked to:



- Note the work completed to date on the initial Operational Control Checklist assessments and the initial scores.
- Note the future updates to be undertaken and reported to the Value & Sustainability Board.

| <b>Amcanion: (rhaid cwblhau)</b><br><b>Objectives: (must be completed)</b>   |   |
|--|---|
| Cyfeirnod Cofrestr Risg<br>Corfforaethol a Sgôr Cyfredol:<br>Corporate Risk Register<br>Reference and Score:                         |   |
| Safon(au) Gofal ac Iechyd:<br>Health and Care Standard(s):   | Governance, Leadership and Accountability<br>Choose an item.<br>Choose an item.<br>Choose an item.            |
| Blaenoriaethau CTCI<br>IMTP Priorities<br><br><a href="#">Link to IMTP</a>   | Choose an item.<br>Choose an item.<br>Governance.   |
| Galluogwyr allweddol o fewn y<br>CTCI<br>Key Enablers within the IMTP  | Governance  |
| Amcanion cydraddoldeb<br>strategol<br>Strategic Equality Objectives<br><br><a href="#">Strategic Equality Objectives<br/>2020-24</a> | Choose an item.<br>Improve the wellbeing and engagement of our<br>staff<br>Choose an item.<br>Choose an item. |

| <b>Gwybodaeth Ychwanegol:</b><br><b>Further Information:</b> |  |
|--|--|
| Ar sail tystiolaeth:<br>Evidence Base:                       |  |
| Rhestr Termau:<br>Glossary of Terms:                         |  |

|   |  |
|---|--|
| Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol:<br>Parties / Committees consulted prior to University Health Board: |  |
|---|--|

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



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board

# Informatics Programme Cost Analysis

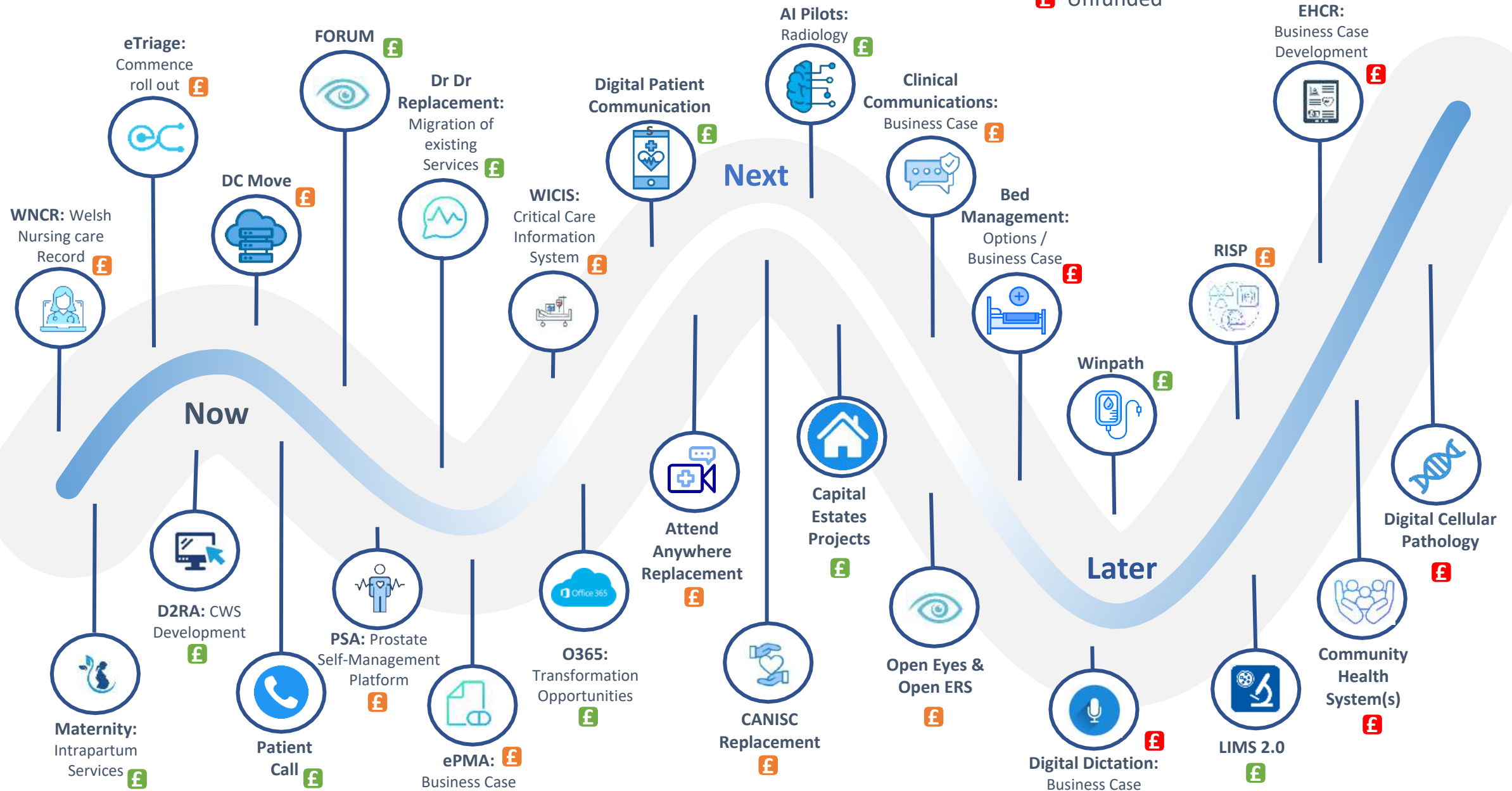
Finance & Performance Committee

# Introduction

- Several critical programmes of work are underway across the Health Board to support digital transformation & initiatives.
- Typical the source of these is one of three routes:
  - Health Board instigated – new services or replacement for end of life.
  - Digital Health & Care Wales led – delivered nationally as part of NHS Wales strategic programmes.
  - Welsh Government instigated – associated with national care boards such as planned care and led by the NHS Wales Executive.
- These programmes have been split into three categories:
  - Fully funded – both capital and revenue funding has been secured.
  - Part funded – internal / external funding is supporting the initiative but does not cover the full costs.
  - Unfunded – no funding streams have yet been identified.

# Digital Programme Plan: 24/25 – 25/26

£ Fully Funded  
£ Funding at risk  
£ Unfunded



# Funded Schemes

## Maternity

- Implementation of Badgernet, now live in Antenatal and going live in postpartum in the new year.
- £105k capital and £84k ongoing revenue

## D2RA (Discharge To Recover and Assess)

- Internal development of solution in CWS 2.0 to support.
- £70k revenue in 2023/2024 has supported the development through external resources.
- No additional revenue expected in 2024/2025 however depends on future development requirements.

## Patient Call

- Upgrades associated with Outpatient check-in and calling for Tredegar, Ysbyty Aneurin Bevan and Ysbyty Ystrad Fawr
- Additional costs funded from Tredegar scheme.

## Patient Communications

- Patient communications platform to support replacement of DrDoctor and PSL print contract.
- Support patient reminders and hybrid mail (digital letters)
- £430k per annum revenue however will deliver cost savings over and above existing revenue and paper presented to Board.

## WinPath

- Replacement for Blood Transfusion system due to go live Q3/Q4 in 2024.
- £1.4m capital funding and £93k per annum revenue

## Data Centre Move

- Relocation of Data Centre from Mamhilad to The Grange
- Due to complete Q1 2024
- £800k of capital

## Attend Anywhere

- Replacement of national platform with Microsoft Teams
- Expected to be fully funded from Welsh Government



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board

# Part Funded Schemes

## Welsh Nursing Care Record

- National solution for digitisation of nursing documentation.
- £328k capital funding to support equipment.
- £184k charge on DHCW Service Level Agreement is an ongoing cost pressure.

## E-Triage

- Welsh Government programme to support effective triage in unscheduled and urgent care.
- £265k costs of the pilot funded.
- Cost pressure of circa £299k - £746k per annum, pending benefits work to identify efficiency savings.

## WICIS

- Intensive Care digital system to support paperless department led by NHS Executive.
- £66k of capital funded from Welsh Government.
- £154k on-going revenue will be an ongoing cost pressure.

## RISP

- PACS / Radiology Information System replacement.
- Capital costs associated with national infrastructure and licences funded (circa £2.1m).
- Revenue of £176k from Welsh Government but net impact to Health Board of ????????

## EPMA

- Hospital E-Prescribing and Medicines Administration programme.
- £383k revenue from Welsh Government supporting programme development of Business Case.
- Procurement nearing completion and business case to be submitted in the new year.



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board



# Part Funded Schemes

## OpenEyes / OpenERS

- National solution for digitisation of nursing documentation.
- £328k capital funding to support equipment.
- £184k charge on DHCW Service Level Agreement is an ongoing cost pressure.

## Office 365

- Welsh Government programme to support effective triage in unscheduled and urgent care.
- £265k costs of the pilot funded.
- Cost pressure of circa £299k - £746k per annum, pending benefits work to identify efficiency savings.

## PSA

- My Medical Record self-management platform to support patients with prostate cancer.
- National funding coming to an end.
- £5k per annum revenue charges which will be an ongoing cost pressure.

## CANISC

- Replacement of CANISC with solution based on Welsh Clinical Portal and Welsh Patient Administration System.
- Expecting an increase on the WPAS Service Level Agreement for 2024/2025.



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board

# Unfunded Schemes

## Bed Management / Flow

- Options being explored for digital system to support electronic bed management and supporting patient flow across the system.
- Will include options appraisal of existing systems in the Health Board, custom development and third-party suppliers.

## Electronic Health Care Record

- Focused initially on the replacement / redevelopment of CWS.
- Includes wider requirements for replacement of WCCIS and to provide digital solutions for community.
- Business case will be developed in conjunction with consultancy partner.

## Digital Dictation / Speech Recognition

- Replacement for G2, investigations underway for AI based Cloud Service.

## Digital Cellular Pathology

- Awaiting national direction for the Digital Cellular Pathology programme.
- LIMS 2.0 and upgrade of current system being developed by national programme.

## Clinical Communications

- Approach agreed by Executive Committee, procurement will shortly start for a modern platform for the Health Board to replace Vocera, Paging. Business Case to be developed.

# Summary (1)

- Schemes funded / part funded

| 2023/2024 and 2024/2025                           |                          |                          |                          |                             |                   |
|---|--------------------------|--------------------------|--------------------------|-----------------------------|-------------------|
| Funded / Part Funded                              | Capital<br>23/24<br>'000 | Revenue<br>23/24<br>'000 | Revenue<br>24/25<br>'000 | Existing<br>Funding<br>'000 | Shortfall<br>'000 |
| Welsh Nursing Care Record                         | £ 328                    | £ 184                    | £ 184                    | £ -                         | -£ 184            |
| eTriage   | £ -                      | £ 265                    | £ 299                    | £ -                         | -£ 299            |
| Data Centre Move                                  | £ 800                    | £ -                      | £ -                      | £ -                         | £ -               |
| WinPath   | £ 1,400                  | £ -                      | £ 279                    | £ 279                       | £ -               |
| DrDoctor Replacement                              | £ -                      | £ -                      | £ 430                    | £ 428                       | -£ 2              |
| Welsh Intensive Care Information System           | £ 66                     | £ -                      | £ 154                    | £ -                         | -£ 154            |
| Maternity   | £ 105                    | £ -                      | £ 84                     | £ 84                        | £ -               |
| D2RA  | £ -                      | £ 70                     | £ -                      | £ -                         | £ -               |
| Patient Call                                      | £ 72                     | £ 4                      | £ 9                      | £ 9                         | £ 0               |
| PSA   | £ -                      | £ 5                      | £ 5                      | £ -                         | -£ 5              |
| Electronic Prescribing & Medicines Administration | £ -                      | £ 383                    | £ -                      | £ -                         | £ -               |
| Office 365  | £ -                      | £ 3,700                  | £ 3,700                  | £ 3,380                     | -£ 320            |
| Attend Anywhere                                   | £ -                      | £ 750                    | £ 750                    | £ 750                       | £ -               |
| CANISC Replacement                                | £ -                      | £ 186                    | £ 195                    | £ 186                       | -£ 9              |
| OpenEyes / Open ERS                               | £ -                      | £ -                      | £ 400                    | £ -                         | -£ 400            |
| <b>Total</b>                                      | £ 2,771                  | £ 5,547                  | £ 6,489                  | £ 5,116                     | -£ 1,373          |



Bwrdd Iechyd Prifysgol  
Aneurin Bevan  
University Health Board

# Summary (2)

- Schemes currently under development

| Unfunded                                     | Capital<br>'000 | Revenue<br>'000 |  | Existing Funding<br>'000 | Shortfall |
|--|-----------------|-----------------|--|--------------------------|-----------|
| Clinical Communications                      | £ -             | £ -             |  | £ 161                    | £ -       |
| Bed Management                               | £ -             | £ -             |  | £ -                      | £ -       |
| Radiology Information System Programme       | £ 5,706         | £ 8,867         |  | £ 7,149                  | -£ 1,718  |
| Electronic Health & Care Record              | £ -             | £ -             |  | £ 834                    | £ -       |
| Digital Cellular Pathology                   | £ -             | £ -             |  | £ -                      | £ -       |
| Laboratory Information Management System 2.0 | £ -             | £ -             |  | £ 762                    | £ -       |
| Digital Dictation                            | £ -             | £ -             |  | £ 33                     | £ -       |