Planning, Performance & Finance Committee

Tue 27 June 2023, 14:00 - 17:00

Virtual Via Teams

Agenda

14:00 - 14:00
0 min

1. PRELIMINARY MATTERS

1.1. Welcome and Introductions

Mel Jehu, Chair

1.2. Apologies for Absence

Mel Jehu, Chair

For Noting

1.3. Declarations of Interest

Mel Jehu, Chair

For Noting

14:00 - 14:00
0 min

2. CONSENT AGENDA

2.1. Items for Approval

2.1.1. Unconfirmed Minutes of the Meeting held on 4th May 2023

Mel Jehu, Chair

For Approval

2.1.1 Unconfirmed Minutes 4.5.23 PPF Committee 27 June 2023.pdf (11 pages)

2.1.2. Unconfirmed In Committee Minutes of the Meeting held on 4th May 2023

Mel Jehu, Chair

For Approval

2.1.2 Unconfirmed IC Minutes 4.5.23 PPF Committee 27 June 2023.pdf (2 pages)

2.1.3. Committee Annual Report 2022-23

Assistant Director of Governance & Risk

For Approval

2.1.3 Draft Annual Report 2022-23 Cover Report PPFC 27 June 2023.pdf (3 pages)
2.1.3a Appendix 1 Annual Report 2022-23 PPF Committee 27 June 2023.pdf (10 pages)
2.1.3b Appendix 2 Committee Terms of Reference Standing Orders - Schedule 3.6.pdf (8 pages)

2.2. Items for Noting

Mel Jehu, Chair

For Approval

2.2.1. Months 12, 1 & 2 Monitoring Returns to Welsh Government

Sally May, Director of Finance

For Noting

- 2.2.1a M12 - Monitoring Returns PPF Committee 27 June 2023.pdf (4 pages)
- 2.2.1b Annex A - Month 12 - CTM ULHB - Monitoring Narrative 2022-23- Final.pdf (13 pages)
- 2.2.1c Annex A - Month 12 - CTM ULHB - Monitoring Tables 2022-23.pdf (4 pages)
- 2.2.1d M1 - Monitoring Returns PPF Committee 27 June 2023.pdf (4 pages)
- 2.2.1e Annex A - Month 1 - CTM ULHB - Monitoring Narrative 2023-24- Final.pdf (12 pages)
- 2.2.1f Annex A - Month 1 - CTM ULHB - Monitoring Tables 2023-24.pdf (4 pages)
- 2.2.1g M2 - Monitoring Returns PPF Committee 27 June 2023.pdf (4 pages)
- 2.2.1h Annex A - Month 2 - CTM ULHB - Monitoring Narrative 2023-24- Final.pdf (18 pages)
- 2.2.1i Annex A - Month 2 - CTM ULHB - Monitoring Tables 2023-24.pdf (4 pages)

2.2.2. Action Log

Mel Jehu, Chair

For Noting

- 2.2.2 Action Log PPF Committee 27.06.23.pdf (6 pages)

14:00 - 14:00
0 min

3. MAIN AGENDA

3.1. Matters Arising not already discussed on the Action Log

Mel Jehu, Chair

14:00 - 14:00
0 min

4. GOVERNANCE

4.1. Organisational Risk Register

Cally Hamblyn, Assistant Director of Governance & Risk

For Discussion/Noting

- 4.1a Org Risk Register - May 23 - Cover Paper - June 23.pdf (4 pages)
- 4.1b Appendix 1 - Master Org Risk Register - May 23 - PPF June 23.pdf (2 pages)

14:00 - 14:00
0 min

5. IMPROVING CARE

5.1. Six Goals for Urgent Care

Gethin Hughes, Chief Operating Officer

For Discussion/Noting

- 5.1 Six Goals for Urgent and Emergency Care PPF Committee 27 June 2023.pdf (9 pages)

5.2. Integrated Performance Dashboard

Executive Directors

For Discussion/Noting

- 5.2 Integrated Performance Dashboard PPF Committee 27 June 2023.pdf (35 pages)

5.3. Mental Health 2023-24 Service Improvement Funding & Update on 2022-23

Julie Denley, Director of Primary, Community & Mental Health

For Discussion/Noting

- 5.3 Service Improvement Funding for Mental Health PPF Committee 17 June 2023.pdf (11 pages)

5.4. Ophthalmology Strategy & Cataracts Business Case

Linda Prosser, Director of Strategy & Transformation

Endorse for Board Approval

- 5.4 Ophthalmology Strategy and Cataracts Business Case Update PPF Committee 27 June 2023.pdf (7 pages)
- 5.4a Regional Cataracts Business Case PPF Committee 27 June 2023.pdf (152 pages)

14:00 - 14:00
0 min

6. SUSTAINING OUR FUTURE

6.1. Month 12 Movements from Forecast

Sally May, Director of Finance

For Discussion/Noting

- 6.1 M12 Movements from Forecast in 22-23- PPF Committee 27 June 2023.pdf (5 pages)
- 6.1a M12 Variances Annex A.pdf (4 pages)

6.2. Month 2 Finance Report

Sally May, Director of Finance

For Discussion/Noting

- 6.2 M2 Finance Report - Final PPF Committee 27 June 2023.pdf (23 pages)

6.3. Month 2 Finance Performance Report

Sally May, Director of Finance

For Discussion/Noting

- 6.3 M2 Finance Performance Report - Final PPF Committee 27 June 2023.pdf (19 pages)

6.4. Phase 2 All Wales RAAC Investigation - CTMUHB

Tim Burns

For Discussion/Noting

- 6.4 RAAC Investigation PPF Committee 27 June 2023.pdf (4 pages)
- 6.4.a Appendix A - RAAC summary PPf Committee 27 June 2023.pdf (1 pages)
- 6.4.b Appendix B RAAC Investigation PPF Committee 27 June 2023.pdf (1 pages)

14:00 - 14:00
0 min

7. OTHER MATTERS

7.1. Committee Highlight Report to Board

Mel Jehu, Chair

7.2. Committee Forward Work Plan

Mel Jehu, Chair

- 7.2 Forward Work Plan PPF Committee 27th June 2023.pdf (3 pages)

7.3. Any Other Urgent Business

Mel Jehu, Chair

7.4. How Did We Do today?

Mel Jehu, Chair

14:00 - 14:00
0 min

8. DATE AND TIME OF NEXT MEETING

22 August 2023 at 2.00 pm

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE PLANNING, PERFORMANCE & FINANCE COMMITTEE HELD ON 4 MAY 2023, AS A VIRTUAL MEETING WHICH WAS HELD VIA MICROSOFT TEAMS

PRESENT

Mel Jehu	-	Independent Member (Chair)
Nicola Milligan	-	Independent Member
Ian Wells	-	Independent Member
Carolyn Donoghue	-	Independent Member
Geraint Hopkins	-	Independent Member
Jonathan Morgan	-	Health Board Chair (Observing)

IN ATTENDANCE

Linda Prosser	-	Executive Director of Strategy & Transformation
Sally May	-	Executive Director of Finance & Procurement
Gethin Hughes	-	Chief Operating Officer
Sarah James	-	Deputy Chief Operating Officer (in-part)
Stuart Morris	-	Director of Digital
Sallie Davies	-	Deputy Medical Director
Lauren Edwards	-	Executive Director of Therapies & Health Sciences
Julie Denley	-	Director of Primary, Community & Mental Health
Emma Samways	-	Internal Audit and Assurance (Observing)
Paul Dalton	-	Internal Audit and Assurance (Observing)
Wendy Penrhyn-Jones	-	Head of Corporate Governance & Board Business
Kathrine Davies	-	Corporate Governance Manager (Meeting Secretariat)

PART 1. PRELIMINARY MATTERS

1.1.0 WELCOME AND INTRODUCTIONS

The Chair **welcomed** everyone to the meeting including Jonathan Morgan, Health Board Chair who was observing the meeting, Emma Samways and Paul Dalton, Internal Audit.

1.2.0 APOLOGIES FOR ABSENCE

Apologies were received from Dom Hurford, Medical Director.

1.3.0 DECLARATIONS OF INTERESTS

There were none declared.

PART 2. CONSENT AGENDA

2.1 FOR APPROVAL

2.1.1 'UNCONFIRMED' MINUTES OF THE PLANNING, PERFORMANCE & FINANCE COMMITTEE MEETING HELD ON 28 FEBRUARY 2023

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.2 'UNCONFIRMED' MINUTES OF THE PLANNING, PERFORMANCE & FINANCE IN COMMITTEE MEETING HELD ON 28 FEBRUARY 2023

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.3 'UNCONFIRMED' MINUTES OF THE EXTRA ORDINARY PLANNING, PERFORMANCE & FINANCE COMMITTEE MEETING HELD ON 22 MARCH 2023

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.4 'UNCONFIRMED' MINUTES OF THE EXTRA ORDINARY PLANNING, PERFORMANCE & FINANCE IN COMMITTEE MEETING HELD ON 22 MARCH 2023

Resolution: The minutes were **APPROVED** as a true and accurate record.

2.1.5 AMENDMENT TO THE STANDING ORDERS – REVISED TERMS OF REFERENCE

Resolution: The Revised Terms of Reference were **ENDORSED FOR BOARD APPROVAL**

2.2 FOR NOTING

2.2.1 MONTHLY MONITORING RETURNS TO WELSH GOVERNMENT

Resolution: The Committee **NOTED** the Monitoring Returns for Month 11.

2.2.2 ACTION LOG

P. Roseblade commented that there were a number of old completed actions on the log and suggested they were removed to leave a succinct note of current actions. The Chair agreed with this suggestion which would be processed for the next meeting.

Resolution: The Committee **NOTED** the Action Log.

Action: Action Log to be reviewed prior to next meeting.

3.0 MAIN AGENDA

3.1.0 MATTERS ARISING NOT PREVIOUSLY CONTAINED WITHIN THE ACTION LOG.

There were none.

4.0 GOVERANCE

4.1.0 ORGANISATIONAL RISK REGISTER

W. Penrhyn-Jones presented the report that outlined the high-level organisational risks that had been assigned to the Committee, and highlighted the management actions being taken to manage or mitigate these high-level risks.

N. Milligan noted the improvements and updates that had been made and referred to risk 4458, Emergency Department Metrics that had not been updated since November 2022. G. Hughes advised that they were currently updating their risks as part of the Targeted Intervention actions and therefore the risk would updated as part of that and therefore a current position would be available for the next meeting.

P. Roseblade referred to Risk 4772 regarding the Laundry and queried whether the software been updated successfully. G. Hughes agreed to verify this outside of the meeting and would share the update with the Committee.

C. Donoghue referred to Risk 4491 which referenced work being undertaken in April, May and June 2023 and suggested that this be updated to reflect the current position. G. Hughes advised that he would ensure this was updated in readiness for the next meeting.

I. Wells suggested that it would be helpful if updates were clearly identified by a heading of 'updates' for future iterations of this report.

P. Roseblade advised that the Audit & Risk Committee had noted that various risks required updating and there had been a commitment from the Executive Team that they would review the whole organisational risk register.

P. Roseblade commented that at the previous Board Development Session there had been a discussion on whether to introduce an issues log along side the risk register and she sought an update on this. W. Penrhyn-Jones advised that she would raise this outside of the meeting.

Resolution: The report was **NOTED**.

Action: Risks being undertaken as part of TI process to be updated for next meeting.
Action: Update required regarding Laundry Risk 4772 by the next meeting.
Action: Update required on risk 4491 by the next meeting.
Action: Consideration be given to the value of introducing an issues log alongside the Risk Register.

4.2.0 ENHANCED MONITORING & IMPROVING CARE

L. Prosser provided a presentation to the Committee on the current position with regard to Enhanced Monitoring and Improving Care.

Resolution: The presentation was **NOTED**.

5.0 IMPROVING CARE

5.1.0 PLANNED CARE RECOVERY PROGRAMME

G Hughes provided an update to the Committee on the overall progress, challenges, risks and operational schemes in relation to the Elective Recovery Portfolio of work including Cancer Performance.

The Committee noted that two significant changes had been made in relation to Cancer in that the Women's 'One Stop' Hub had opened in the Royal Glamorgan Hospital for a range of gynaecology conditions and that the Bridgend element of the 'One Stop' Breast service would relocate to the Snowdrop Centre on the Royal Glamorgan Hospital Site.

G. Hopkins queried whether, looking forward into the longer term when the Llantrisant Health Park opened, what the impact would be

on metrics that had been reported on. G. Hughes advised that it would make a huge impact. He added that in 2023/24 they were anticipating additional capacity which would help patients at stage two and stage three which would eradicate the backlog for CT and MRI scans. He advised that the theatre and endoscopy element would also come on stream in 2024-25 and the modelling had shown that a further six endoscopy rooms would be required, one in Prince Charles Hospital with the remainder based at the Llantrisant Health Park. They were also adopting new technology that would eradicate the need to carry out the scans in an endoscopy room.

I Wells referred to page five of the report where it referred to the Welsh Patient Administrative System (WPAS) and a plan being needed to take this forward. Ian Wells queried who would be undertaking that. G. Hughes advised that they were currently looking at the pooled lists on WPAS which worked well in outpatients and he was working with the digital team to progress this.

N. Milligan referred to page three and the section on the 'WISE' pain management services and requested an update on the success of the programme. G. Hughes advised that was an evaluation being done with the pain service and would bring this back to the Committee once finalised. He added that it had been possible to move a significant amount of patients up the waiting list since the WISE programme had commenced particularly for those with chronic/enduring pain and also those suffering pain due to the menopause. G. Hughes offered to discuss this further with Nicola Milligan outside the meeting.

N. Milligan referred to the mention of 'Cwm Taf' on page five which should be reflected as 'Cwm Taf Morgannwg'. G. Hughes confirmed that this would be amended.

N. Milligan referred to the recruitment issues in some areas and queried whether the opportunities for staff retention were being considered. G. Hughes confirmed that they were and that there were specific areas in terms of recruitment and retention to ensure they have the right workforce for the future. They were insourcing and trying to recruit and that insourcing was cost-effective.

N. Milligan referred to page two in the Appendix where it stated that they would be unable to recruit Operating Department Practitioners (ODPs) outside of the annual streamlining recruitment process in September and queried what the difficulty was with the funding. G. Hughes undertook to feedback outside the meeting.

N. Milligan referred to page six which referred to vacancy scrutiny panels, staff fatigue and that they were holding-up vacancies. G. Hughes advised that the vast majority of clinical posts did not go through vacancy panel and those that did were addressed every time. He added that he would review the text in this part of the report as this was misleading as the real issue lay with poor management of vacancies on the Trac system.

P. Roseblade referred to the Month 12 Finance Report where it stated that Planned Care had overspent by just over £1m and queried whether this had been due to industrial action. S. May confirmed that there had been some additional activity at the end of the year and they had adopted a pathway approach for outsourcing that had resulted in higher costs than initially expected.

P. Roseblade referred to the CT and MRI scanning and queried whether there would be additional staff employed to read the results. G. Hughes advised that the additional capacity would have to be managed with a service contract and would include the provision of some staff for reporting and also as part of the whole workload. He added that they were using additional outsourcing capacity for scanning and reporting. There was a small delay with reporting at this time and this was being addressed.

P. Roseblade commented that she recognised that this was an all-Wales service and queried whether the new equipment had been planned purchases. L. Prosser advised that this had all been contained within the Annual Plan and the budget for radiology and endoscopy had also been discussed with Welsh Government. She added that the planned care recovery fund had been top-sliced for regional delivery and all the trajectories were based on the assumption that they would receive those funds. In terms of the equipment, she advised that this was all part of the managed service.

M. Jehu commented that having read the report it was clear the complexity of the work and the enormity of the pressure upon the staff involved and he extended thanks to the team for all their hard work in this respect.

M. Jehu referred to the waiting times and queried whether they felt they were communicating effectively with the population as to the reasons for the long waiting times. G. Hughes responded that certain services were better than others in staying in touch with their cohorts but offered assurance that waiting list validation was constantly underway which was helping to provide an estimate to patients of the likely length of their waits. G. Hughes added that

when patients were offered the opportunity to go somewhere else to be seen sooner they do not always want to go to the alternative treatment site. As a consequence steps had been taken to remove the hospital name from the initial referral letter from the waiting list team so that it now just made reference to a service rather than a particular hospital site.

Resolution: The Report was **NOTED.**

Action: To query the issue with funding for ODPs.
Action: To discuss the Pain Service outside of the meeting.

5.2.0 INTEGRATED PERFORMANCE DASHBOARD

L. Prosser presented the report providing the Committee with a summary on performance against a number of key quality and performance indicators.

The Committee were advised that following the recent Board Development Workshop, a summary of what was discussed regarding the format and re-shaping of the Performance Dashboard had been sent out to members and feedback was awaited. The Chair urged colleagues to respond as soon as possible.

N. Milligan referred to page 26 in relation to the Child and Adolescent Mental Health Service (CAMHS) that was not meeting the required target. Nicola Milligan referred to an expected higher demand during the school exam period and queried whether patients were required to sit on the referral list for CAMHS or whether there an option to utilise other services for seasonal issues. J. Denley advised that there were alternative options within schools for children and wellbeing which was seeing early progress.

P. Roseblade referred to the immediate (ambulance) releases which was showing a vast improvement across all sites and congratulated the team.

M. Jehu referred to the ambulance handover compliance rates that had fallen and queried whether there were plans in place to mitigate this. In response, G. Hughes, advised that in terms of A&E four hour waits there was still lots more that needed to be done to improve. He said that he would circulate the figures for the last week of April 2023 which had decreased to 261. He added that they continued to see a downtrend in hours lost and would add the graph to the chat bar so Members could review.

C. Donoghue referred to stroke performance and commented that it was disappointing to see that no patients had been admitted within

four hours and queried when they would expect to see an impact with the work being undertaken on the mitigating actions. G. Hughes advised that they were hopeful that they would start to see improvements within the next six months. He added that they had made a commitment to invest in stroke as part of the Integrated Medium Term Plan (IMTP). He advised that the Princess of Wales Hospital was still in a challenging position but that they had seen greater coherence at Prince Charles Hospital in getting patients on to the stroke ward in a timely way.

C. Donoghue added that at the 'Safe to Start' meeting held the previous week she had been very impressed with the collaboration and team work which provided an insight into the challenges on every shift including ensuring appropriate beds for stroke patients.

Resolution: The report was **NOTED**

5.3.0 SPOTLIGHT: MENTAL HEALTH (Activity & Performance Data)

J. Denley presented the report providing the Committee with an update on the Mental Health and Learning Disabilities Care Group activity and performance.

M. Jehu thanked J. Denley for a very comprehensive report.

P. Roseblade referred to paragraph 2.2 and the 111 Press 2 service and queried whether they would have the capacity to deal with the patients who would be using this service and also would they be cross-referencing this with patients on the waiting lists.

In response, J. Denley, advised that lots of modelling had been undertaken and they had also been discussing the point of access with the Care Group so that they could move capacity into that space as 80 percent of patients did not need mental health services within the community and they could provide alternative options for them.

With regard to the waiting lists, J. Denley confirmed that they had not yet reviewed this but undertook to arrange this.

P. Roseblade referred to psychological therapies and queried whether harm reviews were carried out on patients waiting over six months. J. Denley undertook to look at this outside of the meeting.

P. Roseblade referred to the Child and Adolescent Mental Health Service (CAMHS) and queried the number of patients that did not attend (DNA). J. Denley advised that she did not have the number to hand but would request this following today's meeting.

N. Milligan referred to page 4 and the referrals for CAMHS which was an enormous task for the teams and advised that it was really helpful to see that when they scrutinise compliance that they could see the amount of volume of referrals.

M. Jehu thanked J. Denley and the team for the enormous amount of work being undertaken.

Resolution: The Committee:

- **NOTED** the processes in place to monitor and improve performance delivery within the Mental Health and Learning Disabilities Care Group.
- **NOTED** the challenges faced in reporting performance data due to the mixed approaches to recording information.
- **DISCUSSED** the need for additional or different information in order to be assured that the performance was measured and reported effectively.
- **DISCUSSED** the ongoing requirements for performance reports from the Care Group.

Action: To query whether harm reviews are undertaken for patients waiting over six months for psychological therapies.

Action: To query the DNA rate for the CAMHS Service.

6.0 SUSTAINING OUR FUTURE

6.1.0 MONTH 12 FINANCE REPORT & PERFORMANCE REPORT

S. May presented the report that highlighted the key messages in relation to the current month, year-to-date and forecast year-end financial position of the Health Board as at Month 10.

C. Donoghue referred to the worsening of the £3.1m in the forecast and said it would be useful to see how that occurred. She also referred to the savings position which was of concern as it was not clear that there was a robust plan to deliver them and what the process around this entailed. S. May advised that they were having to backfill, there was some improvement in planned care which they were not expecting and the approach to outsourcing, so there were lessons to be learned and they would be doing some further work with teams on the accounting approaches. She also advised that they had been ambitious plans for the WISE service that had not been spent.

G. Hughes advised that they were developing the savings plans and the Project Management Office (PMO) were now working with the Care Groups with a complete focus on maturing their plans and

ensuring clear current schemes were all good with clarity on delivery and monitoring.

P. Roseblade referred to the contract and commission position and queried whether this had now settled and sought clarity as to whether they have the same budget. S. May confirmed that some of the movement were for areas such as Velindre where they had made assumptions. She advised that the team would need to work more closely with care providers to deliver more robust savings for next year.

P. Roseblade queried whether this was 'salami-slicing'. S. May confirmed that they had issued controlled totals based on forecast outturn at Month 10 and then set a 2% savings target for everybody.

N. Milligan referred to page 16 which referred to a nursing overspend of £3.9m and a £5m underspend on healthcare support workers (HCSW) and queried whether these were in fact agency HCSW. S. May advised that the overspend was, in the majority of cases, for HCSWs in unscheduled care. G. Hughes, stated that another part of the overspend was due to catering assistant cover on the wards. It was noted that in particular, there was difficulty in attracting people to take up HCSW posts in the Bridgend area.

N. Milligan referred to the pilot that had been undertaken with nutritionists and the amount of money that had been saved with early discharges and less medication prescribed and suggested that it might be worth looking into.

Resolution: The Committee **NOTED** the report.

7.0.0 OTHER MATTERS

7.1.0 HIGHLIGHT REPORT TO BOARD

Resolution: The Committee **AGREED** that the report would be prepared by the Governance Team following the meeting.

7.2.0 FORWARD WORK PLAN

The Chair asked Members of the Committee if they had any items that they would like to include for future meetings to let the Governance Team know.

Resolution: The Committee **NOTED** the Forward Work Plan

7.3.0 ANY OTHER URGENT BUSINESS

There was none.

7.4.0 HOW DID WE DO TODAY?

The Committee felt that an appropriate balance had been struck in terms of open discussions with a strategic focus as well as organisational values being taken into account.

The Chair advised that if anyone had any comments to feedback, they could do that outside of the meeting if they so wished.

7.5.0 CLOSE OF THE MEETING – DATE AND TIME OF NEXT MEETING:

The next full meeting of the Committee was scheduled to be held on 27th June 2023.

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

'UNCONFIRMED' MINUTES OF THE MEETING OF THE PLANNING, PERFORMANCE & FINANCE 'IN COMMITTEE' HELD ON 4 MAY 2023, AS A VIRTUAL MEETING WHICH WAS HELD VIA MICROSOFT TEAMS

PRESENT

Mel Jehu	-	Independent Member (Chair)
Carolyn Donoghue	-	Independent Member
Ian Wells	-	Independent Member
Nicola Milligan	-	Independent Member
Geraint Hopkins	-	Independent Member

IN ATTENDANCE

Linda Prosser	-	Executive Director of Strategy & Transformation
Sally May	-	Executive Director of Finance & Procurement
Victoria Wallace	-	Assistant Director of Strategy & Partnerships
Stuart Morris	-	Director of Digital
Lauren Edwards	-	Director of Therapies & Health Sciences
Gareth Cooke	-	National Programme Lead Digital Health Care Wales (DHCW) for 2.1.1 only
Grant Griffiths	-	Performance Manager (DHCW) for 2.1.1 only
Alison Maguire	-	Programme Lead (DHCW)for 2.1.1 only
John Collins	-	MSE Lead (DHCW) for 2.1.1 only
Joao Martins	-	Principal Project Manager (DHCW) for 2.1.1 only
Sally Bolt	-	Consultant Radiologist
Bronwen Bowen	-	Radiology Service Manager
Wendy Penrhyn-Jones	-	Head of Corporate Governance & Board Business
Kathrine Davies	-	Corporate Governance Manager (Meeting Secretariat)(in-part)

PART 1. PRELIMINARY MATTERS

1.1.0 WELCOME AND INTRODUCTIONS

The Chair **welcomed** everyone to the meeting including colleagues from Digital Health Care Wales and Radiology.

1.2.0 APOLOGIES FOR ABSENCE

Apologies for absence had been received from Dom Hurford, Medical Director.

1.3.0 DECLARATIONS OF INTERESTS

There were no declarations received.

PART 2. MAIN AGENDA

2.1 ITEMS FOR APPROVAL

2.1.1 RADIOTHERAPY INFORMATICS SYSTEM PROCUREMENT (RISP) BUSINESS CASE

L. Prosser, L. Edwards and colleagues from DCHW and Radiology provided a presentation regarding the business case.

Resolution: The Committee **NOTED** the detail on the Radiology Informatics System Procurement (RISP) Full Business Case and **ENDORSED FOR BOARD APPROVAL** the Full Business Case being received by the Board in May 2023.

Colleagues from DHCW were thanked for attending along with those from CTMUHB.

2.2 ITEMS FOR NOTING

2.2.1 UNCONFIRMED MINUTES OF THE IN COMMITTEE MEETING HELD ON THE 28 FEBRUARY 2023

Resolution:The Committee **NOTED** the Minutes as a true and accurate record.

2.2.2 UNCONFIRMED MINUTES OF THE EXTRA ORDINARY IN COMMITTEE MEETING HELD ON THE 22 MARCH 2023

Resolution:The Committee **NOTED** the Minutes as a true and accurate record.

3.0.0 OTHER MATTERS

3.1.0 ANY OTHER URGENT BUSINESS

There was none.

3.1.2 CLOSE OF THE MEETING – DATE AND TIME OF NEXT MEETING:

- 27TH June 2023 at 2:00 pm

AGENDA ITEM

PLANNING, PERFORMANCE & FINANCE COMMITTEE

PLANNING, PERFORMANCE & FINANCE COMMITTEE ANNUAL REPORT 2022-23

Date of meeting	28/06/2022
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Kathrine Davies, Corporate Governance Manager
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Director of Corporate Governance
Report purpose	ENDORSE FOR BOARD APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**

ACRONYMS	
PPFC	Planning, Performance & Finance Committee
CTMUHB	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

1.1 The purpose of this report is to highlight the activities and performance of the Planning, Performance & Finance (PPF) Committee during the year 2022-2023.

1.2 The Chair of the PPF Committee is required to present an annual report outlining PPF's business through the financial year to the Health Board to provide an assurance on the monitoring and scrutiny undertaken of Cwm Taf Morgannwg University Health Board (CTMUHB) performance in relation to Planning, Performance and Finance.

1.3 The Planning, Performance and Finance Committee's Annual Report for 2022-2023 is presented at **Appendix 1** for approval.

1.4 The revised Terms of Reference for the PPF Committee were last approved by the Board in May 2023 and are available on the Health Boards website via the following link: Standing Orders - Cwm Taf Morgannwg University Health Board (nhs.wales). The Committee are asked to review the Terms of Reference, as part of the Annual Cycle of Business as a separate item on the agenda.

1.5 An annual self-assessment questionnaire is also required to be undertaken and this will be completed by members outside of the meeting via Survey Monkey, the results of which will be reviewed at the August 2022 meeting.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Members of the Planning, Performance & Finance Committee are asked to approve the Annual Report for 2022-23.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The publication of the Annual Report demonstrates compliance with Standing Orders, which stipulates that each Board Committee is required to submit an annual report to the Board through the Chair within three months of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are being asked to:

5.2 **DISCUSS** and **ENDORSE** the Annual Report for submission to the Health Board.

5.3 **AGREE** to complete the Annual Self-Assessment questionnaire via Survey Monkey and review feedback at the August 2023 meeting of the Committee.

Appendix 1

Planning, Performance & Finance (PPF) Committee

Annual Report 2022/23

PLANNING, PERFORMANCE & FINANCE (PPF) COMMITTEE ANNUAL REPORT 2022/23

1. FOREWORD

I am pleased to present the Annual Report of the Cwm Taf Morgannwg UHB Planning, Performance & Finance (PPF) Committee for 2022-2023. The purpose of this report is to formally report on the work of the PPF Committee for the year ending 31 March 2023 in accordance with the Committee's Terms of Reference.

During the year my fellow Independent Members – Nicola Milligan, Ian Wells, Patsy Roseblade, Carolyn Donoghue and Geraint Hopkins once again offered their considerable knowledge and wide-ranging experience to the Committee.

I would like to express my thanks to all the officers of the Committee who have supported and contributed to the work carried out and for their commitment in meeting important targets and deadlines. I also wish to record my appreciation for the support and contribution given by the Independent Members.

In February 2023 the Committee extended a wider invitation to all Members of the Board who joined the meeting to ensure that there was a robust discussion and scrutiny of the Integrated Medium Term Plan and Annual Plan priorities.

The Annual Committee Cycle of Business was approved by the Committee at the meeting held in February 2023, which outlined the forward planning for the work of the Committee for 2023-2024.

I continue to advocate the promotion of a culture of continual improvement, and as usual look forward to the learning that will come from the self-assessment which is undertaken each year to reflect on the Committee's effectiveness.

Mel Jehu
Chair
Planning, Performance and Finance Committee

2. INTRODUCTION

The key function of the Planning, Performance & Finance Committee (PPF) is to provide scrutiny on behalf of the Board on all matters relating to Planning, Performance and Finance. The Committee provides a level of assurance to the Board that all appropriate actions are being taken to reduce risks in these areas.

The Committee meets on a bi-monthly basis following the Strategic Leadership Group where the initial management debate / scrutiny / action is taken. The Committee Chair presents exceptional issues to the Quality & Safety Committee. There is also the opportunity to refer key risks back to the Strategic Leadership Group or through reports from Committee Chair at full Health Board meetings.

All papers relating to the Committee (unless held 'in-committee') are available on the Health Board website. The Committee aims to meet up to six times per annum to scrutinise the Health Board's planning, performance and financial management aligned to its Integrated Medium Term Plan commitments.

Key areas of activity for the Committee during 2022-2023 are outlined below:

- Active involvement in the development and approach to the 2023-2026 Integrated Medium Term Plan and Annual Plan.
- Routinely reviewed and scrutinised the Health Board's integrated performance dashboard.
- Routinely, reviewed and scrutinised financial performance, such as the development of savings plans, budget setting, delivery of agreed savings plans including efficiency savings and the Monthly Monitoring Returns to Welsh Government.
- Routinely, reviewed and scrutinised the delivery of the Planned Care Elective Recovery Programme.
- Routinely, reviewed and scrutinised the organisational risks assigned to the Committee.
- Reviewed and scrutinised a report on the Budget Setting Arrangements.
- Reviewed and scrutinised a report on Child and Adolescent Mental Health Services (CAMHS) Performance Improvement.
- Received a Presentation on the Six Goals for Emergency Care
- Reviewed and scrutinised a report on the Stroke Action Plan.
- Reviewed and scrutinised a report on the Bridgend Transition.
- Reviewed and scrutinised a report on Winter Response Planning.

- Reviewed and scrutinised a report on the South East Wales Regional Collaborative.
- Reviewed and scrutinised a report on Nevill Hall Hospital Satellite Radiotherapy Unit
- Reviewed and noted a report on the Spinal Services Operational Delivery Network.
- Received a Presentation on Enhanced Monitoring Assurance Processes and Governance.
- Received a Presentation on Targeted Intervention and Improving Care.
- Reviewed and scrutinised a report on Sepsis Compliance Progress.
- Reviewed and scrutinised a report on Estates Performance.
- Endorsed for Board Approval the All Wales NHS Energy Procurement Proposal.
- Endorsed for Board Approval the new Velindre Cancer Centre Full Business Case.
- Endorsed for Board approval the following Policies:
    - Business Continuity & Emergency Preparedness Response & Recovery Policy
    - Transport, Travel and Car Parking Policy

3. MEMBERSHIP

Only the Independent Members are formal members of the Committee, however, they are joined at the meeting by Executive Directors and other Senior Officers as appropriate. Other Independent Members from other Health Boards, representatives from Internal Audit, Audit Wales and Welsh Government have also attended the meetings on occasions.

The role of the Independent Member of the Committee is to provide appropriate scrutiny and assurance to the Board independently of the management decision-making processes. The tables below outline the membership of the PPF Committee during 2022/23:

Table 1 – Composition of Independent Members

Independent Member
Mel Jehu (Chair)
Patsy Roseblade
Ian Wells
Nicola Milligan
Carolyn Donoghue
Geraint Hopkins

3.1 MEETING ATTENDANCE

The Planning, Performance & Finance Committee met on seven occasions during 2022/23. The meeting due to be held on the 20th December 2023 was stood down due to industrial action.

* Two Extra Ordinary meetings were called on the 20th September 2022 and the 22nd March 2023 for the Committee to receive an update on the progress in relation to the Integrated Medium Term Plan for 2023-26 and Endorse for Board Approval the Integrated Radiotherapy Solution and Satellite Radiotherapy Centre Full Business Case.

Name:	26/04/22	28/06/22	23/08/22	20/09/22*	25/10/22	28/02/23	22/03/23*
Core Membership							
Mel Jehu	√	√	√	√	√	√	√
Patsy Roseblade	X	√	√	√	√	X	√
Ian Wells	√	√	√	√	√	√	√
Nicola Milligan	√	√	√	√	√	√	√
Carolyn Donoghue	√	√	√	√	√	√	√
Geraint Hopkins	√	X	X	X	X	√	√

4. MAIN AREAS OF FINANCE PERFORMANCE & WORKFORCE COMMITTEE ACTIVITY

The agenda for each meeting follows a standard format as outlined below:

- Preliminary Matters
- Consent Agenda
- Governance (Including the Organisational Risk Register)
- Improving Care (Performance Activity)
- Sustaining our Future (Finance Update Reports & Estates Update Reports)
- Forward Work Programme, Highlight Report, How did we do today? and items to be referred to other Committees

PART 1
Preliminary Matters
This section provides the apologies for absence, welcome and introduction, declarations of interest, previous meeting minutes, matters arising and the action log.

PART 2 – MAIN AGENDA

Planning
This section of the meeting reviews and monitors the process for the development of the Integrated Medium Term Plan (IMTP), scrutinises strategic or major service plans, monitors and scrutinise the efficient prioritisation of capital schemes, capital plans, capital programmes and business cases.

Performance
This section of the meeting reviews the Integrated Performance Dashboard, which covers all Tier 1 targets set by the Welsh Government as well as critical, local targets.

The dashboard accompanied by a covering report highlights key performance areas which include those:

- under formal escalation with Welsh Government,
- where a cause for concern to the Committee has been raised due to fluctuations in performance levels being attained,
- demonstrating considerable improvements in performance.

The Dashboard is reviewed for changes from the previous month, trends throughout the year and determines the areas that will be discussed in more detail. The report highlights areas that will be brought forward onto the 'Forward Look', which is generally determined by those areas that have shown deterioration over two consecutive months. The Director of Strategy and Transformation or a suitably nominated deputy presents the Integrated Performance Dashboard. Key areas for further detailed discussion are then produced for exception reporting or are requested as part of a 'deep dive' financial presentation or for clinical efficiency review and discussion. Comparative information is also presented and discussed on a quarterly basis.

Finance
This section of the meeting monitors risk to financial delivery including mitigating actions to manage risk. Monitors the delivery of financial plans and savings programmes. Monitors activity and productivity including operational efficiency and effectiveness.

Items for exception reporting, information or update
Throughout the year, various high profile issues have been presented to the Committee by way of exception. These include reports produced by Wales Audit Office on an all-Wales basis.

Forward Work Programme and items to be referred to other Committees

Items for Information/Update
Items that have previously been presented may be placed on a future agenda for a written update or further information. These are received at this point by the Committee. In addition, papers of interest to members may be included in this section.

Forward Look
The 'Forward Look' plan for the Committee is reviewed at each meeting to ensure that it is still targeted at the appropriate risk areas. Issues raised during the Health Board's monthly meetings with Welsh Government's "Quality and Delivery Group" are presented as required.

Links with Other Committees/Boards
The Directors on the Committee provide this linkage to the Operational Management Board, Strategic Leadership Board and Executive Leadership Board. Key risk areas from the Planning, Performance & Finance Committee were highlighted at the Quality & Safety Committee and/or full Board meetings by the Committee Chair.

Key elements, including any patient specific risks, were also taken into account at the Quality and Safety Committee; an important link is made by the Chair of the Quality and Safety Committee and lead directors as appropriate.

The Committee Chair is able to refer items to other Board Committees as felt appropriate. There are three questions that the Committee are required to consider: What is the issue being referred? Why are the Committee seeking the referral? What is the outcome anticipated as a result of the referral.

During this period there were no referrals made.

5. ACTION LOG AND REPORTS TO BOARD

In order to monitor progress and any necessary follow up action, the Committee has developed an action log that captures all agreed actions. This has provided an essential element of assurance both to the Committee and

from the Committee to the Health Board. Following each meeting of the Committee a summary report is submitted to the next Board meeting to update all Board Members as to any decisions made, referrals to other committees or particular concerns the Committee had. These are available via our website.

6. GOVERNANCE

The Committee provides an essential element of the overall governance framework for the organisation and intends to develop its function still further in the forthcoming year. The Committee has an Annual Cycle of Business for each year which is approved at the first meeting of each year.

The Terms of Reference for the Committee were revised with minor amendments at the May 2023 Health Board Meeting (Attached at **Appendix 2**) and provide a robust commitment to monitor Planning, Performance and Finance via the following methodologies:

- a formal escalation protocol, which allows the Committee to deal with concerns in relation to key areas of performance, ultimately bringing a matter to the attention of the UHB Board if necessary;
- the presentation of the most recent data (even where this is an un-validated position) to allow the organisation's performance to be benchmarked where necessary;
- scrutiny of efficiency measures and targets on a quarterly basis.

7. COMMITTEE ANNUAL SELF-ASSESSMENT

The Committee is required to complete an annual self-assessment and the questionnaire is undertaken via Survey Monkey. This year's self-assessment will be completed following the June 2023 meeting and the outcome will be received at the August 2023 meeting.

8. CONCLUSION AND ASSURANCE TO THE BOARD

The Planning, Performance & Finance Committee wishes to assure the Board that on the basis of the work completed by the Committee during 2022/23 there are effective measures in place both to ensure the delivery of the key financial, planning and performance targets and to effectively scrutinise and monitor this important area. There are no outstanding issues that the Committee wishes to bring to the attention of the Board.

In terms of its financial responsibilities, the Health Board has reported a draft deficit of £24.5m for 2022/23 (subject to audit), which is a £2m improvement

from the planned deficit at the start of the year of £26.5m. The £24.5m draft deficit includes:

- A **Core plan** deficit of £24.4m.
- **Exceptional** costs of £17.3m compared with Welsh Government (WG) Allocation of £16.9m.
- **COVID** costs of £29.7m compared to a WG allocation of £30.0m.

The Health Board has therefore not achieved the financial duty to break even against its Revenue Resource Limit over the 3 year period 2020/21 to 2022/23 with a cumulative draft deficit of £24.2m.

The Health Board's recurrent deficit position also deteriorated during 2022/23, with a forecast carried forward financial challenge at the end of 2022/23 of £79.6m. The key movements are summarised below:

C'fwd Challenge at the end of 22/23	**Total £m**
Recurrent deficit at 31 March 2020	17.6
Recurrent savings shortfalls 20/21	16.2
Recurrent savings shortfalls 21/22	11.1
Other recurrent underspends	-0.4
Recurrent Core plan deficit at start of 22/23	**44.5**
Forecast recurrent savings shortfalls 22/23	7.1
Other recurrent overspends	9.3
Ongoing local Covid response costs	10.0
Ongoing Exceptional energy costs	8.7
Forecast c'fwd financial challenge at the end of 22/23	**79.6**

The Health Board submitted its draft financial plan to WG at the end of March 2023 followed by a supplementary report at the end of May. It is important to note that the Health Board does not have a balanced financial plan for 2023/24. The revised Annual Plan, submitted to WG on 31st May 2023, is as follows:

	Recurrent £m	**Non Recurrent £m**	**Total plan £m**
Recurrent Core plan deficit at 31 March 2023	60.9		60.9
Recurrent ongoing COVID costs	10.0		10.0
Non Recurrent ongoing Exceptional energy costs		8.7	8.7
B'Fwd challenge at 31 March 2023	**70.9**	**8.7**	**79.6**
Allocation Adjustments	(17.4)	(12.5)	(29.9)
Cost Pressures & Investments:			
Inflationary Pressures	21.8	0	21.8
Demand Growth	12.3	0	12.3

	Recurrent £m	Non Recurrent £m	Total plan £m
Service Improvement – Local	4.3	2.8	7.0
COVID Programmes	0	11.7	11.7
Other Pressures & Investment	0.8	3.7	4.5
Savings Target	(27.3)	0	(27.3)
Total plan 23/24	**65.3**	**14.4**	**79.6**

Schedule 3.6

BOARD COMMITTEE ARRANGEMENTS

This Schedule forms part of, and shall have effect as if incorporated in the University Health Board Standing Orders

PLANNING, PERFORMANCE & FINANCE COMMITTEE

Terms of Reference & OPERATING ARRANGEMENTS

Reviewed April 2023 and Approved by Health Board on the 25th May 2023

INTRODUCTION

The Cwm Taf Morgannwg University Health Board's (CTMUHB) ~~UHB's~~ standing orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".

In accordance with Standing Orders (and the CTMUHB scheme of delegation), the Board shall nominate annually a committee to be known as the **Planning, Performance & Finance Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set out below.

CONSTITUTION AND PURPOSE

The Committee will allow appropriate scrutiny and review to a level of depth and detail not possible in Board meetings in respect of planning, performance and finance.

The Committee will ensure that evidence based and timely interventions are implemented to drive forward improved performance thereby allowing the Health Board to achieve the requirements and standards determined for the NHS in Wales, and as outlined within the Board's 3 Year Integrated Medium Term Plan.

SCOPE AND DUTIES

The Committee will; in response of its provision of advice and assurance:

Planning

- Monitor the process for the development of the IMTP
- Scrutinise strategic or major service plans
- Monitor and scrutinise the efficient prioritisation of capital schemes
- Scrutinise Capital Plans and Business Cases in accordance with the Scheme of Delegation
- Monitor the delivery of the Capital Programme;
- Ensure systems are in place to scrutinise business cases in line

with authorised financial limits.

Performance

- Monitor in-year performance against the capital finance limit and activity targets that support the relevant metrics agreed by the Board
- Monitor overall performance against the UHB's IMTP;
- Monitor Estates and Facilities Performance

Organisational Risk Register

- Regularly review risks included on the organisational Risk Register and assigned to the Committee by the Board.

Finance

- Monitor risk to financial delivery including mitigating actions to appropriately manage the risks;
- Robustly challenge and support progress against delivery of savings plans to achieve financial plans to ensure consideration of impact on services;
- Scrutinise investments in line with SFIs and the Scheme of Delegation prior to submission to Board for approval;
- Monitor activity and productivity including operational efficiency and effectiveness;
- Monitor delivery of financial plans and delivery of savings programmes.
- Scrutinise financial savings plans

The committee, in monitoring and scrutinising the above areas, will discuss and agree corrective action where necessary. This will include cost improvement and other productivity improvement programmes.

The Committee will monitor the development of appropriate Key Performance Indicators (KPIs) across all parts of the organisation.

Where necessary, the Committee will undertake detailed "deep dives" of specific areas. These reviews will be supported by appropriate benchmarking information to ensure all Cwm Taf Morgannwg services are striving to achieve "best in class" levels of performance.

DELEGATED POWERS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for

ensuring the quality and safety of healthcare for its citizens through the effective governance of its organisation.

The Committee has a key role in assisting the Board to fulfil its oversight responsibilities in areas such as the Health Board's Planning, Performance and Financial strategies to ensure it is operating appropriately and effectively.

AUTHORITY

The Committee is authorised by the Board to:

- investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the CTMUHB. It can seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee;

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements;

- by giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- approve policies relevant to the business of the Committee as delegated by the Board.

MEMBERSHIP

Members:

A minimum of (4) members, comprising

Chair	Independent Member of the Board
Vice Chair	Independent Member of the Board
Members	Two Independent Members of the Board (one of which should be a member of the Quality & Safety Committee).

Attendees:

- Executive Director of Planning, Performance & Partnerships (Executive Lead for the Committee)
- Executive Director of Finance & Procurement
- Deputy Chief Operating Officer (in their absence nominated Care Group Lead)
- The Director of Governance / Board Secretary or representative will routinely attend meetings ensuring governance support and advice is available to the Committee Chair.

By Invitation:

- Other Directors / Health Board Officers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that Director.

- The Committee may also co-opt additional independent external members from outside the organisation to provide specialist skills, knowledge and experience.

Secretariat

The Director of Governance / Board Secretary will determine the secretarial and support arrangements for the Committee.

Member Appointments

The membership of the Committee shall be determined by the Chair of the Board, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

The Board shall ensure succession planning arrangements are in place.

Support to Committee Members

The Director of Governance / Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to committee members on any aspect related to the conduct of their role, and

- Co-ordinate the provision of a programme of organisational development for committee members as part of the overall Health

Board's Organisational Development programme developed by the Executive Director of Workforce & Organisational Development

COMMITTEE MEETINGS

QUORUM

A quorum shall be two Independent Members one of whom must be the Chair or in the absence of the Chair, the Vice Chair or an Independent Member who will be nominated to Chair the Committee.

FREQUENCY OF MEETINGS

Meetings shall be held no less than four times a year, and otherwise as the Chair of the Committee deems necessary. ~~Meetings shall be held on a monthly basis (apart from August and December).~~

The Committee will arrange meetings to fit in with key statutory requirements during the year consistent with the CTMUHB's annual plan of Board Business.

Withdrawal of Individuals in Attendance

The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

Circulation of Papers

The Director of Governance / Board Secretary will ensure that all papers are distributed at least 7 calendar days in advance of the meeting.

REPORTING AND ASSURANCE ARRANGEMENTS

The Committee Chair shall:

– report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent / critical matters that may affect the operation and / or reputation of the Health Board;

The Committee shall provide a written, annual report to the Board on its work in support of the Annual Governance Statement specifically commenting on the adequacy of the assurance arrangement, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committees self-assessment and evaluation.

The Board may also require the Committee Chair to report upon the activities at public meetings or to community partners and other stakeholders, where this is considered appropriate e.g. where the Committee's assurance role relates to a joint or shared responsibility.

The Director of Governance / Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES / GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.

The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business: and

- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the CTMUHB Standing Orders are equally applicable to the operation of the Committee, except in the area relating to the Quorum.

CHAIR'S ACTION ON URGENT MATTERS

There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

REVIEW

These Terms of Reference shall be adopted by the Planning, Performance & Finance Committee at its first meeting and subject to review at least on an annual basis thereafter, with approval ratified by the Board.

Reviewed 23rd June 2022 by the PPF Committee and no changes made.

AGENDA ITEM
2.2.1a

PLANNING, PERFORMANCE & FINANCE COMMITTEE

MONTH 12 MONITORING RETURNS TO WELSH GOVERNMENT

Date of meeting	27/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Thomas, Deputy Director of Finance
Presented by	Sally May, Director of Finance & Procurement
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Welsh Government	02/05/2023	NOTED

ACRONYMS	
WG	Welsh Government
M1 etc	Month 1 etc
PPFC	Planning, Performance & Finance Committee
LHB	Local Health Board

MONTH 12 MONITORING RETURNS TO WELSH GOVERNMENT

1. SITUATION/BACKGROUND

1.1 In addition to our normal internal Finance reports there is a WG requirement for a Committee of the Board to receive the monthly Monitoring Return submissions to WG (narrative report plus certain tables) in order to provide the Committee with transparency on the submission made to WG.

1.2 The purpose of this report is to provide the PPFC with information from the M12 Financial Monitoring Return submission to Welsh Government.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The HB, SHA & Trust Monthly Financial Monitoring Return Guidance was issued on 26 April 2022. This guidance refers to the monitoring return spreadsheet and accompanying narrative that LHBs will need to complete to report their 2022/23 financial performance, together with the following requirements:

The Day 9 submission to WG must be agreed and the narrative signed by both the Director of Finance and Chief Executive before the submission is made to WG. The Board governance, regarding the arrangements for when the Director of Finance and/or Chief Executive is not available, should be set out at the start of the year and shared with the Head of NHS Financial Management.

2.2 An additional statement must be included in the narrative each month to clarify the date and main Committee of the Board which will receive that Month's Financial Monitoring return (consisting of the Narrative, Table A and Tables C, C1, C2 & C3) in order to provide the Committee with , transparency on the submission made to WG.

The following information is provided at Annex A:

Annex A
M12 Narrative report
Table A - Movement
Tables C, C1, C2 & C3

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 All information made available to WG should be consistent with that provided to the Board. The detailed commentary in the Monitoring Returns must include a statement confirming that the financial information reported in the Monitoring Return aligns to the financial details included with the internal Board papers.

3.2 The key information included in the M12 Financial Monitoring returns is summarised below:

	M12 Actual	M12 YTD	M12 Forecast	M11 Forecast	Financial Plan
	£m	£m	£m	£m	£m
Core plan deficit	**1.9**	**24.4**	**24.5**	**24.5**	**26.5**
Exceptional items:					
National insurance changes	0.0	3.1	3.1	3.1	5.0
Energy inflation	1.6	11.8	11.4	11.4	11.6
Real Living Wage for Social Care Workers	0.2	2.4	2.4	2.4	2.4
Anticipated funding	(1.5)	(16.9)	(16.9)	(16.9)	(19.0)
Total	**0.4**	**0.4**	**0**	**0**	**0**
Covid response costs:					
Programme	1.0	13.8	13.6	13.6	15.6
Other	1.1	15.9	16.1	16.1	16.7
Anticipated funding	(2.4)	(30.0)	(29.7)	(29.7)	(32.3)
Total	**(0.3)**	**(0.3)**	**0**	**0**	**0**
Grand total	**2.0**	**24.5**	**24.5**	**24.5**	**26.5**

3.3 The M12 YTD position is a £24.5m deficit. This represents a breakeven position compared to the forecast £24.5m Core plan deficit.

3.4 It is important to note that M12 internal reporting within the Health Board is reporting a M12 YTD savings consistent with the breakeven position reported in this Monitoring Return.

	Monitoring Return Table C	Internal HB reporting
	£m	£m
Annual Plan	17.3	17.3
Year to date Plan	17.3	17.3
Year to date actual	(17.3)	(17.3)
Year to date Variance	**(0.0)**	**(0.0)**

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The paper is directly relevant to the allocation and utilisation of resources.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the contents of the Month 12 Monitoring Returns submitted to Welsh Government for 2022/23.

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD
MONITORING RETURNS – MARCH 2023
FINANCIAL COMMENTARY

Introduction

These returns outline the financial position for Cwm Taf Morgannwg (CTM) UHB for the period ended 31 March 2023.

The tables attached to this commentary **do not** include the income, expenditure and balances of the Welsh Health Specialised Services Committee (WHSSC) or the Emergency Ambulance Services Committee (EASC) which is being financially managed via WHSSC. They do however include the Cwm Taf Morgannwg element of transactions between the parties.

1. Financial Plan, Year to Date and Forecast position

1.1 Financial Plan for 2022/23

In accordance with Welsh Government (WG) guidance, our financial plan is set out into three parts:

- Core Plan
- Exceptional Cost Pressures
- Ongoing Covid response costs

Our draft Annual Plan, submitted to WG on 29 April 2022, is as follows:

	Core plan £m	Exceptional items £m	Covid response costs £m
Recurrent deficit as at 31 March 2020	17.6		
Recurrent savings shortfalls 2020/21	16.2		
Forecast recurrent savings shortfalls 2021/22	11.1		
Other recurrent underspends	(0.4)		
Forecast recurrent deficit as at 31 March 2022	**44.5**	**0**	**0**
Planned surplus on Core plan	-18.0		
National insurance changes		5.0	
Energy inflation		11.6	
Real Living Wage for Social Care Workers		2.4	
Ongoing Covid response costs (Programme costs and Other response costs)			32.3
Total	**26.5**	**19.0**	**32.3**

1.2 Actual YTD and Forecast 22-23 (Table A)

	M12 Actual	M12 YTD	M11 Forecast	Financial Plan
	£m	£m	£m	£m
Core plan deficit	**1.9**	**24.4**	**24.5**	**26.5**
Exceptional items:				
National insurance changes	0.0	3.1	3.1	5.0
Energy inflation	1.6	11.8	11.4	11.6
Real Living Wage for Social Care Workers	0.2	2.4	2.4	2.4
Anticipated funding	(1.5)	(16.9)	(16.9)	(19.0)
Total	**0.4**	**0.4**	**0**	**0**
Covid response costs:				
Programme	1.0	13.8	13.6	15.6
Other	1.1	15.9	16.1	16.7
Anticipated funding	(2.4)	(30.0)	(29.7)	(32.3)
Total	**(0.3)**	**(0.3)**	**0**	**0**
Grand total	**2.0**	**24.5**	**24.5**	**26.5**

The key issues to highlight are as follows:

- **Core Plan -** The M12 YTD position is a £24.4m deficit. This represents a £0.1m underspend position compared to the forecast £24.5m Core plan deficit**.**

- **Covid costs and Exceptional Items –** The M12 exceptional energy costs have exceeded the funded position by £0.4m. Conversely, COVID costs have reduced by £0.3m compared to the funded position.

- **Pay award funding**- The M12 position recognises the recent pay circulars for the 1.5% non consolidated and 1.5% consolidated pay awards. In line with WG initial advice the further pay offer for 2022/23 recently announced by WG has not been reflected in this M12 position. This position will be reviewed between draft and final accounts.

1.3 Material income and expenditure category movements between the current period actual and the previous month forecast (Table B)

	March			Year End Forecast		
	Act £'000	F/Cast £'000	Movement £'000	M12 £'000	M11 £'000	Movement £'000
RRL	196,936	163,519	33,418	1,340,283	1,306,866	33,417
Donation/Grants	1,608	52	1,556	1,706	150	1,556
Welsh HBs & NHST	8,209	7,464	745	88,089	87,344	745
WHSSC	1,109	1,074	35	12,791	12,756	35
WG Income	1,587	57	1,530	1,783	253	1,530
Other Income	4,212	2,928	1,284	39,849	38,565	1,284
Income Total	**213,661**	**175,093**	**38,568**	**1,484,501**	**1,445,933**	**38,568**
PC Contractor	12,824	13,896	(1,072)	150,782	151,853	(1,071)
PC - Drugs	8,440	8,750	(310)	97,754	98,064	(310)
Pay	91,311	50,100	41,211	665,015	623,804	41,211
Non Pay	16,835	9,327	7,508	123,884	116,376	7,508
SC - Drugs	4,627	4,671	(44)	48,280	48,324	(44)
H/C Other NHS	22,738	21,600	1,138	259,172	258,034	1,138
Non H/C Other NHS	343	294	49	3,516	3,467	49
CHC & FNC	4,983	4,447	536	59,082	58,546	536
Private & Vol	3,620	2,686	934	17,717	16,783	934
Joint & Other	2,035	4,362	(2,327)	4,901	7,228	(2,327)
DEL	2,283	2,469	(186)	32,804	32,990	(186)
AME	45,672	54,541	(8,869)	46,152	55,021	(8,869)
Res & Cont	0	0	0	0	0	0
P&L on Disposal	(17)	0	(17)	(76)	(59)	(17)
Cost - Total	**215,694**	**177,143**	**38,551**	**1,508,983**	**1,470,433**	**38,550**

The actual expenditure for M12 was £38.55m more than the £177.1m forecast. This movement was mainly driven by new Welsh Government allocations with the final variance from resource limit being a £18k improvement compared to the M11 forecast.

As M12 is the final period in the financial year the movements in month are equal to the movement in forecast outturn. The most significant movements between the M12 forecast and M11 actuals were as follows:

- **Donation/Grants - £1.6m Favourable** – Recognition of revaluation of a donated asset. This is neutralised with a corresponding WG allocation adjustment.
- **WG Income - £1.5m Favourable** – Adjustments to final non cash limited expenditure and income drawn down.
- **Other Income - £1.3m Favourable** – Impact of grossing up netted off income with expenditure. See Provider Non Pay.

- **Primary Care Contractors - £1.1m Favourable –** Categorisation adjustment between primary care contractors and provider Non Pay. See Provider Non Pay.
- **Provider Pay - £41.2m Adverse** – The pay position reflects the new enhanced pay awards of 1.5% consolidated (£8.9m) and 1.5% non consolidated (£6.7m). A further pension adjustment of £25.8m was also recognised in M12. The remaining £0.2m favourable variance was due to a greater than expected release of annual leave accrual (£0.8m) offset by worse than anticipated pay expenditure (£0.6m).
- **Provider Non Pay - £7.5m Adverse** – The M12 position reflects the grossing of expenditure and income noted above (£1.3m). There were also categorisation changes between the forecast and actuals for Primary Care contractors of £1.1m and RPB expenditure of £2.5m. The remaining adverse variance of £2.6m reflects year end stock adjustments and higher than anticipated non pay expenditure.
- **Healthcare NHS - £1.1m Adverse –** The increase is attributed to new WG allocations for EASC & WHSSC of £1.7m together with the pension adjustment for WHSSC of £0.27m. The remaining favourable variance of £1.0m was due to further LTA under performance.
- **CHC & FNC - £0.5m Adverse** – The increase in M12 expenditure was partly due to the recognition of the impact of the recent pay awards upon the FNC & CHC rates £0.3m together with increased retrospective CHC provision £0.2m.
- **Private & Voluntary - £0.9m Adverse –** The increase relates to additional planned care recovery activity with the independent sector.
- **Joint & Other - £2.3m Favourable** – As noted in Provider Non Pay above, there has been a categorisation change between the forecast and actuals of £2.5m.

1.4 Pay Expenditure (Table B2- Sections A, B&C)

The M12 Pay expenditure was £95.0m and the monthly trend is summarised below.

	M12	M11	M10	M9	M8	M7	M6	M5	M4	M3
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
A&C	13.1	7.1	7.3	7.2	7.1	7.1	8.5	6.7	6.6	6.8
Medical	22.8	13.8	14.1	14.2	14.0	13.5	16.3	13.1	12.9	13.6
Nursing	30.1	17.1	16.3	17.1	16.9	17.1	19.9	15.1	16.5	16.7
ACS	12.6	7.3	8.1	6.9	7.2	7.1	8.9	6.5	6.8	6.6
Other	16.4	8.9	9.1	9.0	9.1	9.0	11.0	9.3	8.4	8.5
Total	**95.0**	**54.2**	**54.9**	**54.4**	**54.3**	**53.8**	**64.6**	**50.7**	**51.2**	**52.2**

The Key issues to highlight are as follows:

- The M12 pay position recognises the recent pay circulars implementing the 1.5% non consolidated (£6.7m) & 1.5% consolidated (£8.9m) pay awards together with the pension adjustment for the additional 6.3% centrally funded element (£25.8m). As planned additional annual leave accruals of £3.9m were also written back in M12. After allowing for these specific M12 adjustments, the M12 position was £3.0m higher than the average of recent months, this reflected increased agency expenditure, bank expenditure and increased overtime and ADHs in M12.

The M12 agency expenditure was £5.6m and the monthly trend (excluding accountancy gains) is summarised below.

	M12	M11	M10	M9	M8	M7	M6	M5	M4	M3
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Medical	1.8	1.8	1.8	1.8	1.8	1.5	1.7	1.1	1.4	1.7
Nursing	2.0	1.9	1.4	2.6	2.1	2.3	2.3	2.3	2.4	2.4
Other	1.8	1.1	2.2	1.2	1.4	0.8	0.9	1.2	1.0	1.0
Total	**5.6**	**4.8**	**5.4**	**5.6**	**5.3**	**4.9**	**4.9**	**4.6**	**4.8**	**5.1**

Agency costs have returned to levels experienced in M09 & M10 and is £0.3m higher than the average of the last 4 months. The most significant increases are within AHPs.

1.4 Covid analysis (Table B3)

A summary of the additional revenue costs being classified as Covid is provided below:

	M12 Actual	M12 YTD	M11 Year-end forecast	Financial Plan- 30 April	Movement between M12 and M11 Forecasts
Programme costs	**£m**	**£m**	**£m**	**£m**	**£m**
TTP	0.4	5.7	5.7	6.5	0
Mass Vaccination	0.5	6.5	6.3	7.4	0.2
PPE	0.1	1.6	1.6	1.6	0
Sub total	**1.0**	**13.8**	**13.6**	**15.6**	**0.2**
Other Covid costs:					
Cleaning Standards	0.1	1.6	1.7	2.3	(0.1)
Capacity & Facilities costs	0.2	3.7	3.7	3.0	0
Prescribing costs	0	0.4	0.4	2.1	0
Dental income losses	0.2	2.0	2.0	2.5	0
Increased workforce costs	0.3	4.6	4.6	2.6	0
Services supporting Covid response:					
Long Covid	0.2	0.8	0.8	0.8	0
Flu extension	0.1	1.1	1.1	0.6	0
Discharge support	0.0	0.3	0.3	0.6	0
Other Covid Response	0.1	1.4	1.5	2.3	(0.1)
Sub total	**1.1**	**15.9**	**16.1**	**16.7**	**(0.2)**
Total Covid costs	**2.1**	**29.7**	**29.7**	**32.3**	**0**
Anticipated funding	**(2.4)**	**(30.0)**	**(29.7)**	**(32.3)**	**(0.3)**
Total	**(0.3)**	**(0.3)**	**0**	**0**	**(0.3)**

There are no significant movements in the In month expenditure.

There are no significant movements between the M12 position and the M11 forecast.

2. Month 11 - Forecast recurrent position (Table A)

The B'fwd recurrent deficit at the end of 21/22 was £44.5m.

As at M12 we are reporting a forecast Underlying deficit of £79.6m (M11: £88.7m). This is consistent with the IMTP submitted on the 31st March 2023.

	M12	M11	Comment
	£m	£m	
Core Plan	60.9	60.9	See below
Ongoing local Covid response costs	10.0	10.0	
Ongoing Exceptional energy costs	8.7	17.8	Latest estimates provided by NWSSP/BG.
Total	**79.6**	**88.7**	

The forecast Core plan recurrent deficit of £60.9m (M11: £60.9m) represents a £16.4m deterioration from the B'fwd recurrent deficit at the start of the year and a £32.9m deterioration from the planned recurrent deficit of £28m. This deterioration from plan includes:

- Forecast recurrent shortfalls in savings delivery (£8.1m)- see Section 6.
- Forecast recurrent overspends (£11.0m)- Our Integrated Locality Groups (ILGs) and Directorates identified bought forward cost pressures of circa £11m at the start of 22/23.These cost pressures were excluded from the financial plan and the risk has been managed non recurrently in 22/23. The latest forecast recurrent cost pressures from the Care Groups and directorates now exceed the original £11m this has now been reflected forecast recurrent position for next year.
- A deterioration in Primary care prescribing during 22/23 leading to an estimated recurrent overspend of circa £9.4m.
- Recurrent shortfall in Pay award funding (£1.9m)- see above.

3. Risk Management (Table A2)

The M12 position is consistent with the draft accounts awaiting audit review.

In line with WG advice, the recent WG announcement on a further 2022/23 pay offer of an average of a 3% non consolidated payment has not been recognised within the M12 position. This position will be kept under review between draft accounts and final accounts.

4. Ring Fenced Allocations (Tables N&O)

The additional ringfenced template has been completed to provide further information on requested Ring-Fenced allocations.

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

See section 1.4.

6. Saving (inc Accountancy gains) Plans (Tables C, C1, C2, C3)

The financial plan for 2022/23 includes a £17.3m recurring savings target.

	Month 12			Month 11		
	M12 YTD	**22/23**	**Rec**	**M11 YTD**	**22/23**	**Rec**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
Planned savings		14.1			14.1	
Planned income generation		0.2			0.2	
Plans to be finalised		3.0			3.0	
Savings target as at M12	**17.3**	**17.3**	**17.3**	**15.7**	**17.3**	**17.3**
Actual and Forecast Savings	(17.3)	(17.3)	(9.2)	(16.1)	(17.1)	(10.1)
Total	**0**	**0**	**8.1**	**(0.4)**	**0.2**	**7.2**

The recurrent savings forecast has reduced from £10.1m to £9.2m in M12.

It is important to note that M12 internal reporting within the Health Board is reporting a M12 YTD savings consistent with the breakeven position reported in this Monitoring Return.

	Monitoring Return Table C	Internal HB reporting
	£m	£m
Annual Plan	17.3	17.3
Year to date Plan	17.3	17.3
Year to date actual	(17.3)	(17.3)
Year to date Variance	**0**	**0**

7. Income Assumptions 2022/23 (Tables D & E)

Table D has been completed from information within the M12 Agreement of Balances exercise.

The financial plan also includes provision for additional costs arising from the WRP risk sharing arrangement of £3.3m, which is consistent with the information provided by NWSSP.

8. Health Care agreements

All the LTA agreements with other Welsh NHS bodies have been agreed and signed.

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

9.1 Significant month on month balance sheet movements

Non-current assets (PP&E) have increased significantly from M11. This is mainly due to the change in accounting treatment for IFRS16 Right of Use Assets, which has led to £23m of leased assets being shown on the Balance sheet. There is an equivalent movement in lease liability shown in Payables.

There are further movements on non-current assets which largely offset each other, of which £32m has been taken to the Revaluation Reserve. This has resulted in the change in the Revaluation Reserve and General Fund between m11 and M12.

Non-Current Receivables increased by £4.4m, which is mainly due to the increase in WRP debtors at year end.

Payables have increased due to the lease liability relating to IFRS16, as detailed above. Other payables have also increased significantly, including £8.5m accrual in relation to 2022-23 consolidated pay award, and several NHS year end accruals.

Provisions has increased mainly due to an increase in the quantum relating to a number of claim cases.

9.2 Details of any aged receivables/payables (over 11 weeks old) and disputed invoice information

In relation to aged receivables, there was one NHS invoice greater than 11 weeks old as at the 31st March. This invoice has now been paid.

The analysis of Welsh NHS receivables in Table F includes Welsh NHS and WG invoices.

10. Cash Flow Forecast (Table G)

The closing cash balance at year end was £1.348m.

As agreed, £2.48m available Revenue cash was not drawn down.

This accounts for the validation error on Table G – Cashflow.

11. Public Sector Payment Compliance (Table H)

The percentage for the number of non-NHS invoices paid within the 30-day target within the final quarter of 2022-23 was 96.2% (value 93%), with a year-to-date percentage of 95.4% (94.3% in value terms).

The performance target of 95% was therefore achieved in 2022-23.

For the final quarter of 2022-23 a total of 70.4% of NHS invoices were paid within 30 days (95.1% in value terms), with year-to-date percentage of 80.9% (96.6% in value terms).

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

The final CRL as issued on the 13th April 2023 is £73.025m. After adjusting for donated assets and asset disposals £72.982m has been charged against the CRL leaving a small underspend of £0.043m.

The latest CRL has been adjusted for a number of the under and overspends that were managed through discretionary capital in year. The table below details some of the remaining differences in spend compared to allocation

Scheme	Over/Underspend	Explanation
Centralising decontamination at POW	Overspend £0.076m	Fees on this project are more than the CRL, this is currently being funded from discretionary capital with a plan to recover as part of the business case when submitted.
Anti Ligature Works	Overspend £0.131m	Scope of scheme expanded to include works at Ty Lydiard resulting in overspending against CRL. This approach was agreed earlier in the year with WG and the shortfall has been funded from discretionary capital
Electrical Infrastructure Modernisation at RGH	Overspend £0.068m	Scheme extended due to delays and additional work. Overspend funded from discretionary capital.

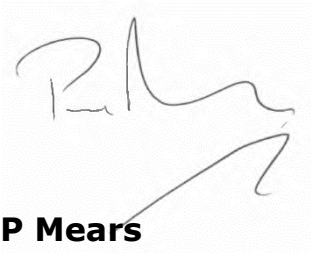
Disposals
11 Cedar Wood Drive has been disposed in year for £0.215m. The net book value of this, £0.210m, has been added to the available spend as per the usual process along with £0.017m relating to equipment disposals.

13. Other Issues

The financial position reported within this monitoring return aligns to the financial details included within the internal Board papers.

The M12 Financial Monitoring Return (consisting of the Narrative, Table A, Table B3, Tables C,C1,C2,C3 and Table F) will be reported to the next meeting of the Planning, Performance and Finance Committee in May.

14. Authorisation



P Mears
Chief Executive

S May
Director of Finance

Date: 02 May 2023

Action Points arising from Month 11 Response

Action Point	WG Comment	CTM Response
11.1	As we approach year-end, Health Boards should retain any remaining underspends (spend is not being restricted within the area, in the hope that these minor underspends can be utilised within the overall Operational position). We have communicated previously that Health Boards should also now manage any movements on the Covid and Energy funding positions. If slippage cannot be utilised, then it will form part of your final outturn.	Noted.
11.2	**Movement of Opening Financial Plan to Forecast Outturn (Table A)** It is noted that the outturn position did not improve this month despite the additional release (from Opportunities) of the Annual Leave Accrual, which improved the in-month position, as an increase in the March cost pressures (line 26) has offset the benefit. This appears to be linked to the £2.2m non pay expenditure increase in the SoCNE (which is described as 'known plans for M12'). I will look to your final submission for a supporting explanation of the actual cost pressure incurred in March.	Noted.
10.5	**Underlying Position (Table A1)** I acknowledge your response that explains the difference between the MMR (£88.7m) and 'Touch Point' presentation (£70.9m). I trust that you are currently refining the position in preparation for the March Plan submission and that a final c/f underlying position will be reported at Month 12.	Revised underlying deficit position was reported in the IMTP submission of £79.6m
11.3	**Capital (Tables I & J)** I note that you are currently forecasting a balanced position against the reported CRL; although, there are a few schemes assessed as either high or medium risk. I trust that you are liaising with colleagues in the Capital Team regarding the year-end delivery.	Yes regular discussion with the WG capital team however position always planned to be managed by the Health Board across AWCP and Discretionary Capital
7.5	**Movement of Opening Financial Plan to Forecast Outturn (Table A)** I refer to your latest response to Action Point 7.5 where you confirm the intention to include Accountancy Gains in the 23/24 opening plan and are therefore continuing to phase Accountancy Gains in future months within this financial year. This approach is not compliant with Welsh Health Circular (2022) 013 which confirms that opening planned Accountancy Gains are not acceptable and that the release of in-year Accountancy Gains must be phased into the period in which they are reported as supporting the forecast outturn position. Please ensure you comply with the WG expectation going forward. For the Plans, this may	Our IMTP submission included planning assumptions for accountancy gains.

	mean that you include an aspiration in your March Plan, described as 'plans still to be finalised', which may eventually be achieved via in-year Accountancy Gains in 23/24 (which is likely to be after the Audit is complete).	
11.4	**Monthly Positions (Table B) & Pay Analysis (Table B2)** I note that the keyboard character dash (-) has been entered into Table B (Cell N33) and Table B2 (Cells I36 and M36) instead of zero values. When uploading into our all-Wales database, the dash is not being recognised and is creating errors. Within future returns, please ensure these are amended to reflect whole values only, as instructed within the guidance.	Noted.
11.5	**Key Dates:** **11th April 23** – Month 12 Day 5 Submission (Please also confirm on this day, any outstanding RRL adjustments due for your organisation).	Noted
11.6	**14th April 23** – Final non-cash adjustments including IFRS 16 and please confirm final IFRS 16 total interest value (complete and submit the table below).	Submitted as requested
11.7	**2nd May 23** – Month 12 (Full) Return due by midday. If there are any material movements to the outturn position between Day 5 and the Final submission, please inform me as soon as possible.	Noted.

Cwm Taf Morgannwg ULHB **Period : Mar 23**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

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

		In Year Effect	Non Recurring	Recurring	FYE of Recurring		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
		£'000	£'000	£'000	£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-44,500	0	-44,500	-44,500	1	-3,708	-3,708	-3,708	-3,708	-3,708	-3,708	-3,708	-3,708	-3,708	-3,708	-3,708	-3,708	-44,500	-44,500
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-98,911	-936	-97,975	-97,975	2	-8,243	-8,243	-8,243	-8,243	-8,243	-8,243	-8,243	-8,243	-8,243	-8,243	-8,243	-8,243	-98,911	-98,911
3	Planned Expenditure For Covid-19 (Negative Value)	-35,676	-35,676	0	0	3	-5,054	-4,673	-4,409	-2,492	-2,492	-2,497	-2,262	-2,298	-2,296	-2,397	-2,404	-2,402	-35,676	-35,676
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	93,159	2,456	90,703	90,703	4	7,763	7,763	7,763	7,763	7,763	7,763	7,763	7,763	7,763	7,763	7,763	7,763	93,159	93,159
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	35,676	35,676	0	0	5	5,054	4,673	4,409	2,492	2,492	2,497	2,262	2,298	2,296	2,397	2,404	2,402	35,676	35,676
6	Planned Provider Income (Positive Value)	6,430	0	6,430	6,430	6	536	536	536	536	536	536	536	536	536	536	536	536	6,430	6,430
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0	7	677	-103	60	-226	-260	-194	33	29	29	88	87	-220	0	0
8	Planned (Finalised) Savings Plan	14,104	7,683	6,422	7,088	8	766	1,520	1,367	1,318	1,351	1,285	1,058	1,062	1,062	1,003	1,003	1,310	14,104	14,104
9	Planned (Finalised) Net Income Generation	247	0	247	253	9	0	27	17	22	23	23	23	23	23	23	24	24	247	247
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0	10													0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0			11													0	0
12		0	0			12													0	0
13	Planning Assumptions still to be finalised at Month 1	2,971	0	2,971	10,001	13				330	330	330	330	330	330	330	330	330	2,971	2,971
14	**Opening IMTP / Annual Operating Plan**	**-26,500**	**9,202**	**-35,702**	**-28,000**	14	**-2,208**	**-2,208**	**-2,208**	**-2,208**	**-2,208**	**-2,208**	**-2,208**	**-2,208**	**-2,208**	**-2,208**	**-2,208**	**-2,208**	**-26,500**	**-26,500**
15	Reversal of Planning Assumptions still to be finalised at Month 1	-2,971	0	-2,971	-10,001	15	0	0	0	-330	-330	-330	-330	-330	-330	-330	-330	-330	-2,971	-2,971
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive	0	0			16													0	0
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0			17													0	0
18	Other Movement in Month 1 Planned & In Year Net Income Generation	-119	0	-119	-253	18	0	-27	15	-11	-12	-12	-12	-12	-12	-12	-13	-13	-119	-119
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-4,039	-350	-3,689	-4,065	19	0	-631	-464	-376	-606	181	-229	-295	-354	-360	-335	-570	-4,039	-4,039
20	Additional In Year Identified Savings - Forecast	7,185	946	6,239	6,193	20	0	697	434	453	466	1,865	581	508	515	512	552	602	7,185	7,185
21	Variance to Planned RRL & Other Income	395	395			21	1	-38	14	175	482	-1,104	-67	-16	82	85	32	750	395	395
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 (Positive Value - additional)	-5,713	-5,713			22	-154	-1,910	-1,938	72	-583	-101	190	-180	4	-434	-639	-39	-5,713	-5,713
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0			23													0	0
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	5,982	5,982			24	154	1,910	1,938	-72	583	101	-190	180	-4	434	639	308	5,982	5,982
25	In Year Accountancy Gains (Positive Value)	5,389	5,389	0	0	25	0	0	0	889	0	3,900	100	100	100	100	100	100	5,389	5,389
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	-519	-519		-22,874	26	-154	-108	-123	-346	-254	1,216	883	552	541	-1,016	1,932	-3,642	-519	-519
27	Release of Annual Leave Accrual over £6m plan	3,100	3,100	0	0	27	0	0	0	0	0	0	0	0	0	0	0	3,100	3,100	3,100
28	Reverse Accountancy Gain included in IMTP	-4,500	-4,500			28						-4,500							-4,500	-4,500
29	Remove COVID Funding Assumption included in IMTP	-2,873	-2,873			29		-555	-277	-247	-247	-247	-217	-217	-217	-217	-217	-215	-2,873	-2,873
30	Energy Price Pressures (Pre Energy Benefit Relief Scheme for 23/24)	0	0		-8,700	30													0	0
31	New Pressure Provision for Primary Care Out of Hours dispute - Holiday Pay	-800	-800			31				-800									-800	-800
32	Shortfall in Payaward anticipated allocation	-1,900	-1,900		-1,900	32							-1,108	-158	-158	-158	-158	-158	-1,900	-1,900
33	Retention of Dental Underspend & Other non recurrent benefits	1,600	1,600			33								1,267	-1,267	1,333	133	133	1,600	1,600
34	Change in discount rate	1,800	1,800			34										1,500	150	150	1,800	1,800
35	COVID-19 Continuing Expenditure supported with N/R allocations in 22/23	0	0		-10,000	35													0	0
36	**Forecast Outturn (- Deficit / + Surplus)**	**-24,482**	**11,759**	**-36,242**	**-79,600**	36	**-2,362**	**-2,871**	**-2,609**	**-2,801**	**-2,709**	**-1,239**	**-2,608**	**-809**	**-3,310**	**-771**	**-362**	**-2,032**	**-24,482**	**-24,482**
37	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**269**				37	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**269**	**269**	**269**

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

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	CHC and Funded Nursing Care	Budget/Plan	16	47	47	32	32	32	32	32	32	27	27	27	378	378		378	0			
2		Actual/F'cast	16	349	183	183	183	183	183	183	183	183	183	183	2,192	2,192	100.00%	2,192	0	192	2,000	2,000
3		Variance	0	303	136	151	151	151	151	151	151	156	156	156	1,814	1,814	*479.26%*	1,814	0			
4	Commissioned Services	Budget/Plan	15	15	15	45	45	45	40	40	40	40	40	40	422	422		377	45			
5		Actual/F'cast	15	15	15	15	15	1,461	91	141	116	116	116	116	2,231	2,231	100.00%	2,231	0	121	2,110	2,261
6		Variance	0	(0)	(0)	(30)	(30)	1,416	51	101	76	76	76	76	1,810	1,810	*429.25%*	1,855	(45)			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	0	210	210	235	235	235	243	244	243	244	244	244	2,586	2,586		2,461	125			
8		Actual/F'cast	0	8	8	(17)	0	687	116	121	121	121	121	121	1,411	1,411	100.00%	1,411	0	265	1,146	1,146
9		Variance	0	(201)	(201)	(252)	(235)	452	(127)	(122)	(121)	(122)	(122)	(122)	(1,175)	(1,175)	*(45.45%)*	(1,050)	(125)			
10	Non Pay	Budget/Plan	396	418	445	442	491	467	346	349	343	343	343	643	5,025	5,025		4,834	192			
11		Actual/F'cast	396	694	565	807	641	617	599	510	470	420	511	601	6,831	6,831	100.00%	6,831	0	3,851	2,981	3,116
12		Variance	0	277	120	365	150	149	253	161	127	77	168	(41)	1,806	1,806	*35.93%*	1,997	(192)			
13	Pay	Budget/Plan	340	831	651	564	548	506	397	397	404	350	350	356	5,693	5,693		5,425	268			
14		Actual/F'cast	340	519	567	407	373	384	420	319	332	315	290	320	4,585	4,585	100.00%	4,585	0	3,849	736	693
15		Variance	0	(312)	(84)	(157)	(174)	(122)	23	(78)	(72)	(35)	(60)	(36)	(1,108)	(1,108)	*(19.46%)*	(839)	(268)			
16	Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	766	1,520	1,367	1,318	1,351	1,285	1,058	1,062	1,062	1,003	1,003	1,310	14,104	14,104		13,474	630			
20		Actual/F'cast	766	1,586	1,337	1,395	1,212	3,331	1,409	1,275	1,222	1,155	1,221	1,342	17,250	17,250	100.00%	17,250	0	8,278	8,972	9,216
21		Variance	0	66	(30)	77	(139)	2,046	351	213	161	152	218	32	3,146	3,146	*22.31%*	3,776	(630)			
22	Variance in month		0.00%	4.34%	(2.20%)	5.85%	(10.31%)	159.18%	33.23%	20.05%	15.13%	15.12%	21.68%	2.47%	22.31%							
23	In month achievement against FY forecast		4.44%	9.19%	7.75%	8.09%	7.02%	19.31%	8.17%	7.39%	7.09%	6.69%	7.08%	7.78%								

Cwm Taf Morgannwg ULHB **Period : Mar 23**

Table C1- Savings Schemes Pay Analysis

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Changes in Staffing Establishment	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	16	44	43	41	13	9	9	7	1	1	1	185	185	100.00%	185	0	185	0	0
3		Variance	0	16	44	43	41	13	9	9	7	1	1	1	185	185		185	0			
4	Variable Pay	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Locum	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Agency / Locum paid at a premium	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Changes in Bank Staff	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16	Other (Please Specify)	Budget/Plan	340	831	651	564	548	506	397	397	404	350	350	356	5,693	5,693		5,425	268			
17		Actual/F'cast	340	503	522	364	333	370	411	311	325	314	289	320	4,400	4,400	100.00%	4,400	0	3,664	736	693
18		Variance	0	(328)	(129)	(200)	(215)	(136)	14	(87)	(79)	(36)	(61)	(37)	(1,293)	(1,293)	*(22.71%)*	(1,025)	(268)			
19	Total	Budget/Plan	340	831	651	564	548	506	397	397	404	350	350	356	5,693	5,693		5,425	268			
20		Actual/F'cast	340	519	567	407	373	384	420	319	332	315	290	320	4,585	4,585	100.00%	4,585	0	3,849	736	693
21		Variance	0	(312)	(84)	(157)	(174)	(122)	23	(78)	(72)	(35)	(60)	(36)	(1,108)	(1,108)	*(19.46%)*	(839)	(268)			

Table C2- Savings Schemes Agency/Locum Paid at a Premium Analysis

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Reduced usage of Agency/Locums paid at a premium	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Non Medical 'off contract' to 'on contract'	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medical - Impact of Agency pay rate caps	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Other (Please Specify)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Total	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			

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This Table is currently showing 51 errors

Table C3 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	766	1,520	1,367	1,318	1,351	1,285	1,058	1,062	1,062	1,003	1,003	1,310	14,104	14,104	7,683	6,422	666	7,088
	Month 1 - Actual/Forecast	766	889	903	942	745	1,466	829	767	707	643	669	740	10,065	10,065	7,332	2,733	290	3,023
	Variance	0	(631)	(464)	(376)	(606)	181	(229)	(295)	(354)	(360)	(335)	(570)	(4,039)	(4,039)	(350)	(3,689)	(376)	(4,065)
	In Year - Plan	0	700	433	445	410	1,064	568	498	498	498	498	497	6,111	6,111	410	5,701	75	5,776
	In Year - Actual/Forecast	0	697	434	453	466	1,865	581	508	515	512	552	602	7,185	7,185	946	6,239	(46)	6,193
	Variance	0	(3)	0	8	56	801	12	10	17	14	54	105	1,074	1,074	536	538	(121)	417
	Total Plan	766	2,220	1,801	1,763	1,761	2,349	1,626	1,560	1,560	1,501	1,501	1,807	20,215	20,215	8,092	12,123	741	12,864
	Total Actual/Forecast	766	1,586	1,337	1,395	1,212	3,331	1,409	1,275	1,222	1,155	1,221	1,342	17,250	17,250	8,278	8,972	244	9,216
	Total Variance	0	(634)	(463)	(368)	(550)	982	(217)	(285)	(337)	(346)	(280)	(465)	(2,964)	(2,964)	186	(3,150)	(497)	(3,648)
Net Income Generation	Month 1 - Plan	0	27	17	22	23	23	23	23	23	23	24	24	247	247	0	247	6	253
	Month 1 - Actual/Forecast	0	0	32	11	11	11	11	11	11	11	11	11	128	128	0	128	(128)	0
	Variance	0	(27)	15	(11)	(12)	(12)	(12)	(12)	(12)	(12)	(13)	(13)	(119)	(119)	0	(119)	(134)	(253)
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	0	27	17	22	23	23	23	23	23	23	24	24	247	247	0	247	6	253
	Total Actual/Forecast	0	0	32	11	11	11	11	11	11	11	11	11	128	128	0	128	(128)	0
	Total Variance	0	(27)	15	(11)	(12)	(12)	(12)	(12)	(12)	(12)	(13)	(13)	(119)	(119)	0	(119)	(134)	(253)
Accountancy Gains	In Year - Plan	0	0	0	889	0	0	0	0	0	0	0	0	889	889	889	0	0	0
	In Year - Actual/Forecast	0	0	0	889	0	0	0	0	0	0	0	0	889	889	889	0	0	0
	Variance	0	0	0	(0)	0	0	0	0	0	0	0	0	(0)	(0)	(0)	0	0	0
Total	Month 1 - Plan	766	1,547	1,384	1,339	1,373	1,308	1,080	1,085	1,084	1,026	1,027	1,333	14,351	14,351	7,683	6,669	672	7,341
	Month 1 - Actual/Forecast	766	889	935	953	756	1,477	839	777	718	654	679	750	10,193	10,193	7,332	2,861	162	3,023
	Variance	0	(658)	(448)	(386)	(618)	169	(241)	(307)	(366)	(372)	(347)	(583)	(4,158)	(4,158)	(350)	(3,808)	(510)	(4,318)
	In Year - Plan	0	700	433	1,334	410	1,064	568	498	498	498	498	497	7,000	7,000	1,299	5,701	75	5,776
	In Year - Actual/Forecast	0	697	434	1,342	466	1,865	581	508	515	512	552	602	8,074	8,074	1,835	6,239	(46)	6,193
	Variance	0	(3)	0	8	56	801	12	10	17	14	54	105	1,074	1,074	536	538	(121)	417
	Total Plan	766	2,247	1,817	2,673	1,784	2,372	1,649	1,583	1,582	1,524	1,524	1,830	21,351	21,351	8,982	12,370	747	13,117
	Total Actual/Forecast	766	1,586	1,369	2,294	1,222	3,342	1,420	1,286	1,233	1,166	1,231	1,353	18,267	18,267	9,167	9,100	116	9,216
	Total Variance	0	(661)	(448)	(379)	(561)	970	(229)	(297)	(349)	(358)	(293)	(478)	(3,084)	(3,084)	185	(3,269)	(631)	(3,901)

AGENDA ITEM
2.2.1d

PLANNING, PERFORMANCE & FINANCE COMMITTEE

MONTH 1 MONITORING RETURNS TO WELSH GOVERNMENT

Date of meeting	27/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Thomas, Deputy Director of Finance
Presented by	Sally May, Director of Finance & Procurement
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Welsh Government	13/05/2023	NOTED

ACRONYMS	
WG	Welsh Government
M1 etc	Month 1 etc
PPFC	Planning, Performance & Finance Committee
LHB	Local Health Board

MONTH 1 MONITORING RETURNS TO WELSH GOVERNMENT

1. SITUATION/BACKGROUND

1.1 In addition to our normal internal Finance reports there is a WG requirement for a Committee of the Board to receive the monthly Monitoring Return submissions to WG (narrative report plus certain tables) in order to provide the Committee with transparency on the submission made to WG.

1.2 The purpose of this report is to provide the PPFC with information from the M1 Financial Monitoring Return submission to Welsh Government.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The HB, SHA & Trust Monthly Financial Monitoring Return Guidance was issued on 26 April 2023. This guidance refers to the monitoring return spreadsheet and accompanying narrative that LHBs will need to complete to report their 2023/24 financial performance, together with the following requirements:

The Day 9 submission to WG must be agreed and the narrative signed by both the Director of Finance and Chief Executive before the submission is made to WG. The Board governance, regarding the arrangements for when the Director of Finance and/or Chief Executive is not available, should be set out at the start of the year and shared with the Head of NHS Financial Management.

2.2 An additional statement must be included in the narrative each month to clarify the date and main Committee of the Board which will receive that Month's Financial Monitoring return (consisting of the Narrative, Table A and Tables C, C1, C2, C3 & C4) in order to provide the Committee with, transparency on the submission made to WG.

The following information is provided at Annex A:

Annex A
M1 Narrative report
Table A - Movement
Tables C, C1, C2, C3 & C4

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 All information made available to WG should be consistent with that provided to the Board. The detailed commentary in the Monitoring Returns must include a statement confirming that the financial information reported in the Monitoring Return aligns to the financial details included with the internal Board papers.

3.2 The key information included in the M1 Financial Monitoring returns is summarised below:

	M1 Actual	M1 YTD	M1 Forecast	Financial Plan
	£m	£m	£m	£m
Core plan deficit	**5.9**	**5.9**	**70.9**	**70.9**
Exceptional Energy inflation	**0.7**	**0.7**	**8.7**	**8.7**
Covid Programme costs:				
Health Protection	0.5	0.5	9.1	9.1
PPE	0.1	0.1	1.0	0
Adferiad	0.0	0.0	1.0	0
Nosocomial	0.0	0.0	0.6	0
Anticipated Funding	0.6	0.6	(11.7)	(9.1)
Total	**0**	**0**	**0**	**0**
Grand total	**6.6**	**6.6**	**79.6**	**79.6**

3.3 The M1 YTD position is a £6.6m deficit. This represents a breakeven position compared to 1/12th of the £79.6m planned deficit.

3.4 The financial plan for 2023/24 includes a £27.3m recurring savings target.

	Month 1		
	M1 YTD	**23/24**	**Rec**
	£m	**£m**	**£m**
Savings target as at M1	**2.3**	**27.3**	**27.3**
Actual and Forecast Savings	(0.3)	(9.0)	(9.3)
Total	**2.0**	**18.3**	**18.0**

3.5 Further work is ongoing to develop robust plans to close the forecast gap of £18.3m In year and £18.0m recurrently.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The paper is directly relevant to the allocation and utilisation of resources.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the contents of the Month 1 Monitoring Returns submitted to Welsh Government for 2023/24.

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD
MONITORING RETURNS – APRIL 2023
FINANCIAL COMMENTARY

Introduction

These returns outline the financial position for Cwm Taf Morgannwg (CTM) UHB for the period ended 30 April 2023.

The tables attached to this commentary **do not** include the income, expenditure and balances of the Welsh Health Specialised Services Committee (WHSSC) or the Emergency Ambulance Services Committee (EASC) which is being financially managed via WHSSC. They do however include the Cwm Taf Morgannwg element of transactions between the parties.

1. Financial Plan, Year to Date and Forecast position

1.1 Financial Plan for 2023/24

Our draft Annual Plan, submitted to WG on 31st March 2023, is as follows:

	Recurrent £m	Non Recurrent £m	Core plan £m
Recurrent Core plan deficit at 31 March 2023	60.9		60.9
Recurrent ongoing COVID costs	10.0		10.0
Non Recurrent ongoing Exceptional energy costs		8.7	8.7
B'Fwd challenge at 31 March 2023	**70.9**	**8.7**	**79.6**
Allocation Adjustments	(17.4)	(9.9)	(27.3)
Cost Pressures & Investments:			
Inflationary Pressures	21.8	0	21.8
Demand Growth	12.3	0	12.3
Service Improvement – Local	4.3	2.8	7.0
COVID Programmes	0	9.1	9.1
Other Pressures & Investment	0.8	3.7	4.5
Savings Target	(27.3)	0	(27.3)
Total plan 23/24	**65.3**	**14.4**	**79.6**

1.2 Actual YTD and Forecast 23-24 (Table A)

	M1 Actual	M1 YTD	M1 Forecast	Financial Plan
	£m	£m	£m	£m
Core plan deficit	**5.9**	**5.9**	**70.9**	**70.9**
Exceptional Energy inflation	**0.7**	**0.7**	**8.7**	**8.7**
Covid Programme costs:				
Health Protection	0.5	0.5	9.1	9.1
PPE	0.1	0.1	1.0	0
Adferiad	0.0	0.0	1.0	0
Nosocomial	0.0	0.0	0.6	0
Anticipated Funding	0.6	0.6	(11.7)	(9.1)
Total	**0**	**0**	**0**	**0**
Grand total	**6.6**	**6.6**	**79.6**	**79.6**

The key issues to highlight at M1 are as follows:

- **Core plan YTD position**

The M1 position is a £6.6m deficit. This represents a breakeven position compared to 1/12th of the £79.6m deficit in the draft plan submitted to WG on 31 March. The M1 position includes a £2m shortfall against the M1 savings target of £2.3m but this is currently being offset by positive operating variances across the Care Groups and directorates.

- **Core plan forecast**

As at M1 we are maintaining a forecast Core plan deficit of £79.6m for 23/24 which is consistent with the draft financial plan.

The draft plan includes several significant risks which are summarised in Section 3, most notably the savings plan position is currently £18.3m short of the £27.3m savings target. Urgent work is ongoing to develop robust savings plans and to de-risk the financial plan for 23/24.
The draft financial plan also, includes several significant funding assumptions which are summarised in Section 7. Any further clarification on these funding assumptions would be helpful to inform the submission of our supplementary paper to WG on 31 May.

- **Exceptional energy costs**

As at M1 the HB is reporting energy expenditure of £1.4m with a forecast of £15.6m. This represents a forecast cost pressure of £8.7m which is consistent with the draft financial plan.

- **COVID Programme costs**

As at M1 the HB is reporting COVID Programme expenditure of £0.6m with a forecast of £11.7m. In line with the WG guidance, the HB is anticipating that the COVID Programme costs will be fully funded.

1.3 Material income and expenditure category movements between the current period actual and the previous month forecast (Table B & B1)

Commentary on movements to be provided from M2 onwards.

The forecast has been profiled using latest plans and information and will continue to be refined throughout the year. The pay expenditure includes an estimate for the 1.5% consolidated pay award with a matching anticipated allocation. The position does not assume the recent pay settlement offer for 2023/24 which is assumed to be fully funded by WG.

The profile for M6 includes the anticipated accountancy gains included in our draft financial plan for Non Pay and CHC.

M12 includes £13.3m of committed reserves for Planned Care programmes and Regional Integration Fund (RIF), pending finalisation of spend profiles.

1.4 Pay Expenditure (Table B2)

The M1 Pay expenditure was £54.1m and the monthly trend is summarised below.

	M1	M12	M11	M10	M9
	£m	£m	£m	£m	£m
A&C	7.3	13.1	7.1	7.3	7.2
Medical	13.5	22.8	13.8	14.1	14.2
Nursing	17.1	30.1	17.1	16.3	17.1
ACS	7.2	12.6	7.3	8.1	6.9
Other	9.0	16.4	8.9	9.1	9.0
Total	**54.1**	**95.0**	**54.2**	**54.9**	**54.4**

The Key issues to highlight are as follows:

- The M12 pay position recognised the recent pay circulars implementing the 1.5% non-consolidated (£6.7m) & 1.5% consolidated (£8.9m) pay awards together with the pension adjustment for the additional 6.3% centrally funded element (£25.8m). Planned additional annual leave accruals of £3.9m were also written back in M12. The M12 cost excluding these one-off items was £57.5m.

- The M1 position includes the 1.5% consolidated pay settlement equivalent to £0.75m. After allowing for this inflationary increase of £0.75m the adjusted M1 position (£53.4m) is reporting a reduction of circa £1.0m compared to the average of M9, M10 & M11 (£54.5m).

The M1 agency expenditure was £4.3m and the monthly trend (excluding accountancy gains) is summarised below.

	M1	M12	M11	M10	M9
	£m	£m	£m	£m	£m
Medical	1.1	1.8	1.8	1.8	1.8
Nursing	2.2	2.0	1.9	1.4	2.6
Other	1.0	1.8	1.1	2.2	1.2
Total	**4.3**	**5.6**	**4.8**	**5.4**	**5.6**

Agency Costs in M1 have also reduced by circa £1.0m compared to the average of M9, M10 & M11(£5.3m). The main areas of reduction are Medical Staff and ACS staff.

1.5 Covid analysis (Table B3)

A summary of the additional revenue costs being classified as Covid Programme is shown below.

	M1 Actual	M1 YTD	M1 Year-end forecast	Financial Plan- 31 March	Movement between M1 and the Financial Plan
Programme costs	**£m**	**£m**	**£m**	**£m**	**£m**
Public Health Response - TTP	0.1	0.1	2.7	2.7	0
Public Health Response - Mass Vaccination	0.4	0.4	6.4	6.4	0
PPE	0.1	0.1	1.0	0	1.0
Adferiad (Long COVID)	0.0	0.0	1.0	0	1.0
Nosocomial Investigation	0.0	0.0	0.6	0	0.6
Anticipated funding	**(0.6)**	**(0.6)**	**(11.7)**	**(9.1)**	**(2.6)**
Total	**0**	**0**	**0**	**0**	**0**

The key points to note are as follows:

- Public Health response – Plans continue to progress to address the interim Public Health response for both Vaccination and TTP and to

develop a more integrated sustainable approach. Pending finalisation of the 2023/24 plans, the M1forecast is based on the indicative allocation noted in Sioned Rees's correspondence dated 22 Dec 2022.

- In line with the MMR guidance, the additional costs of PPE have been assumed to be fully funded and an anticipated allocation is included in these Returns. The additional PPE costs have been assessed using the NWSSP stock list of PPE items expenditure compared to 2019/20 actual costs as baseline.
- Adferiad (Long COVID) – In line with the MMR guidance, the additional costs of Adferiad have been assumed to be fully funded. An anticipated allocation has also been included in these Returns.
- Nosocomial Investigation - In line with the MMR guidance, the additional costs of the Nosocomial investigation have been assumed to be fully funded with an anticipated allocation being recognised.

2. Month 1 - Forecast recurrent position (Table A)

The B'fwd recurrent deficit at the end of 22/23 was £70.9m.

As at M1 we are reporting a forecast Underlying deficit at the end of 23/24 of £65.3m. This is consistent with the IMTP submitted on the 31st March 2023.

	M1	**Draft financial plan**	**Comment**
	£m	**£m**	
Core Plan B/F	60.9	60.9	
Ongoing local Covid response costs B/F	10.0	10.0	Any reduction in these costs will be treated as a saving in 23/24
Ongoing Exceptional energy costs	tbc	tbc	The ongoing impact of exceptional energy costs into 24 25, will be reassessed during 23/24.
B/Fwd Total	**70.9**	**70.9**	
2023/24 Planned Improvement	-5.6	-5.6	The planned improvement in the underlying deficit of £5.6m assumes the full recurrent delivery of the £27.3m recurrent savings target. As at M1 this is a significant risk with only £9.3m of plans identified.
Total	**65.3**	**65.3**	

3. Risk Management (Table A2)

The key financial risks and opportunities for 22/23 are noted in Table A2 and are summarised below:

	Month 1 £m	IMTP £m	Comment
Savings delivery risks:			
Shortfall against planned savings delivery of £27.3m.	9.1	7.5	The latest shortfall at M1 is £18.3m and the risk has been estimated at 50%.
Forecast recurrent overspends in Care Groups not recognised in the plan. Risk of not delivering the £7.0m of NR benefits in 22/23 again in 23/24.	3.5	3.5	
Funding risks:			
Assumed WG funding for dental – 30% abatement of the dental income target	1.0	1.0	Further clarification needed on funding assumptions for 23/24
Assumed funding for the impact of RLW in 23/24	1.2	1.2	Further clarification needed on funding assumptions for 23/24.
Assumed funding for Regional Planned care Recovery solutions	3.8	3.8	Further clarification needed on funding assumptions for 23/24.
Risk of the 23/24 pay award not being fully funded given the £1.9m recurrent shortfall in 22/23	1.0	1.0	Further clarification needed on funding assumptions for 23/24.
Risk of the additional costs for the extra bank holiday in 23/24 not being fully funded	0.6	0.6	Further clarification needed on funding assumptions for 23/24.
Cost pressure risks:			
Return to pre Covid Cost & Volume LTA arrangements in 23/24	1.0	1.0	
Contracting risks with other Health Boards	3.1	1.5	See Section 8 re specific risk re ABUHB.
Provider and commissioner relationship for exceptional inflationary cost pressures such as energy – WAST and Velindre	0	Tbc	WAST and Velindre not assuming extra funding for energy cost pressures in their draft LTAs.
Primary care prescribing – inflation and volume growth different to plan assumptions	Tbc	Tbc	Prescribing data is 2m in arrears and we will not have Q1 data until August 2023.
Significant uncertainty surrounding the expected energy cost pressure	Tbc	Tbc	
NICE costs exceed planned growth of £3.0m	Tbc	Tbc	
Non Pay Inflation exceeds the £4.9m provision made in the plan (4.9%)	0	Tbc	
Pension changes – Increased pension costs if staff opt back in following changes to the 1995 scheme	0.75	0.75	
Winter plans – All schemes funded non recurrently in 22/23 need to stop by 31 March	0.75	0.75	
Total Risks	**25.8**	**22.6**	
Contingencies / Opportunities			
Further balance sheet review within 22/23	(2.5)	(2.5)	
Retrospective vat recoveries – Primary care and Microsoft contract	(0.5)	(0.5)	

	Month 1	IMTP	Comment
Provision for an adverse movement in discount rates in 23/24 (following a positive movement in 22/23) not required	(1.0)	(1.0)	
Potential to recharge NWSSP for increased energy costs for laundry	0	(0.6)	The M1 position and forecast assume that the recharge is made and recovered.
Total Opportunities	**(4.0)**	**(4.6)**	
Total	**21.8**	**18.0**	

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

Tables N & O will be completed Quarterly from Q2 (M6) and Table P will be completed from M3 onwards.

	Total Allocation	Forecast	Comment
	£m	£m	
Confirmed Allocations (Initial Allocation letter 23/24)			
Planned Care Recovery Funding	18.5	24.0	Includes £5.5m of additional investment above the WG allocation.
Value Based Healthcare	2.1	2.1	
Regional Integration Fund	22.3	22.3	Assumes anticipated allocations of £2m consistent with Shelley Davies's letter dated 31st March.
Genomics Strategy	1.4	1.4	
Critical Care Funding	2.7	2.7	
In Year Allocations (Initial Allocation letter 23/24)			
Urgent Emergency Care	3.0	3.0	Anticipated allocation
Mental Health (SIF)	0.8	0.8	Anticipated 23/24 allocation
Planned Care	0.6	0.6	Anticipated allocation
Value Based Healthcare	0.7	0.7	Anticipated allocation for approved schemes.
Recovery	7.7	7.7	Anticipated allocations for Regional Plans
Total	**59.8**	**65.3**	

The Dental position will be reviewed in Q2. In the meantime, further clarification on whether there will additional funding to support shortfalls in patient charges in 23/24 and the position on retention/recovery of dental underspends would be appreciated.

The Health Board can confirm that there are no concerns at M1 on any other ring-fenced budgets.

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

See section 1.4.

6. Saving (inc Accountancy gains) Plans (Tables C, C1, C2, C3)

The financial plan for 2023/24 includes a £27.3m recurring savings target.

	Month 1		
	M1 YTD	**23/24**	**Rec**
	£m	**£m**	**£m**
Savings target as at M1	**2.3**	**27.3**	**27.3**
Actual and Forecast Savings	(0.3)	(9.0)	(9.3)
Total	**2.0**	**18.3**	**18.0**

Further work is ongoing to develop robust plans to close the forecast gap of £18.3m In year and £18.0m recurrently.

The financial plan for 2023/24 also includes planned accountancy gains of £3.0m.

7. Income Assumptions 2023-24 (Tables D & E)

Table D has been completed and agreed with all other organisations.

The financial plan also includes provision for additional costs arising from the WRP risk sharing arrangement of £3.5m which is consistent with the information provided by NWSSP. This provision has been included as an anticipated allocation adjustment in Table E.

Table E shows the anticipated allocations assumed within our M1 position. The table below summaries the more material items:

Description	£'000	Comments
1.5% consolidated pay award	8,900	Estimated requirement
Regional Planned Care Recovery	7,700	Planning Assumption to be confirmed
Real Living Wage	4,800	Estimated requirement
Substance Misuse	3,909	Awaiting APB approval
Urgent & Emergency Care	2,960	Planning Assumption to be confirmed
2022/23 MH Investment	3,301	Planning Assumption to be confirmed.
Dental Income Abatement	2,000	Planning Assumption to be confirmed.
Dementia Funding (RIF)	1,242	Approved RIF funding
Public Health Wales Transfer	1,387	Approved transfer funding
Planned Care – OP Transformation & Eyecare	619	Planning Assumption to be confirmed.
Hosted Value in Health Team	2,227	Estimated requirement
Health Protection – Mass Vaccination	6,400	Indicative allocation to be claimed on actual costs
Health Protection - TTP	2,700	Indicative allocation to be claimed on actual costs
Adferiad	972	Indicative allocation to be claimed on actual costs
PPE	1,000	Indicative allocation to be claimed on actual costs
Noscomial	596	Indicative allocation to be claimed on actual costs
WRP Deduction	-3,482	Indicative Adjustment
Invest to Save Repayments	-1,200	Agreed repayment profile
Other Allocations	6,543	
Total Anticipated Allocations	**52,574**	

8. Health Care agreements

The Health Board is working with other Welsh NHS bodies to ensure all contracts are agreed and signed by 30th June 2023.

The Health Board is assuming that LTA arrangements for 23/24 will follow the recommendation accepted by the majority view at the Directors of Finance meeting on the 17th March 2023.

The HB has received a letter dated 10th May from ABUHB indicating that they do not accept this position and are intending to reduce the CTM provider LTA value by circa £6m in 23/24. We do not agree with this assessment, and we have suggested a way forward to ABUHB to fairly address the change in patient flows since 19/20. Correspondence between DoFs and Commissioning teams since November 2022 have failed to resolve the differences and it will now be escalated to Chief Executives

before an official arbitration request is submitted. The risk to our draft plan is £3.1m.

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

9.1 Significant month on month balance sheet movements

An update is not required for this return.

9.2 Details of any aged receivables/payables (over 11 weeks old) and disputed invoice information

In relation to aged receivables, there was one NHS invoice greater than 17 weeks and two greater than 11 weeks old as at the 30th April 2023. All invoices were agreed as part of the M12 Agreement of Balances and there are no disputes. Organisations have been contacted and confirmation of payment dates requested.

10. Cash Flow Forecast (Table G)

An update is not required for this return.

11. Public Sector Payment Compliance (Table H)

An update is not required for this return.

In relation to NHS invoices, the Health Board continues to look for improvements in the process, but several areas of the process are outside the Health Board's control (i.e. the invoicing organisation and the process through Accounts Payable). The plan to improve the payment of NHS invoices includes:

- Review of regular NHS invoices missing the PSPP date.
- Use of Power BI dashboard analysis to escalate unpaid invoices.
- Reviewing the current application of the No PO No Pay policy in relation to NHS invoices in CTMUHB, and what alternatives could be used to improve the rate of payment.
- Continuing to work with the All-Wales P2P group and Agreement of Balances sub-group to make improvements between organisations.

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

An update is not required for this return.

Non-cash requirements have been matched to existing baselines for M1. These will be updated in M3 with revised estimates for the year following the submission of the first non-cash return at the end of June.

13. Other Issues

The financial position reported within this monitoring return aligns to the financial details included within the internal Board papers.

The M1 Financial Monitoring Return (consisting of the Narrative, Table A, Tables C,C1,C2,C3 and C4) will be reported to the next meeting of the Planning, Performance and Finance Committee in June 2023.

14. Authorisation

P Mears
Chief Executive

S May
Director of Finance

Date: 15 May 2023

Action Points arising from Month 12 Response

Action Point	WG Comment	CTM Response
	I note the reporting of a year-end deficit, subject to audit, of £24.482m. This position assumes the retention of a material underspend (c£4m) on the ring-fenced Dental allocation, which was higher than the approved retention surplus of £1.6m. I trust you will continue to liaise with the Dental Policy Lead to ensure actions are taken in 23/24, to fully utilise the funding on the purpose it has been awarded.	Primary care colleagues will liaise with Dental Policy lead during 23/24 to agree assumptions and slippage plans. Please see Section 4 above re further clarification needed on funding assumptions and slippage rules if not have an approved IMTP.
	It is disappointing that the NHS payment performance (80.6%) has not materially improved compared to 21/22 (80.0%). The narrative does not make reference to planned actions for improvement; therefore, please ensure these details are provided in the M1 MMR submission as part of the expected assurance that the Health Board will achieve the minimum best practice performance of 95% in 23/24.	Please see Section 11.
	I note your response to Action Point 7.5 stating that the 23/24 IMTP submission includes assumptions relating to the benefits of Accountancy Gains. I reiterate that the Welsh Health Circular prohibits the reliance of 'finalised' Accountancy Gains as part of the opening planned position. At the date of your Month 1 submission in which the Health Board will be reporting the opening plan position, the audit of your 22/23 position will still be ongoing. Accountancy Gains must be treated as unplanned in-year benefits and once finalised, phased into the period when they are reported as supporting the forecast outturn position.	Accountancy gains have been included in our IMTP plan and have been noted in Table A line 12.

Cwm Taf Morgannwg ULHB **Period : Apr 23**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

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

		In Year Effect	Non Recurring	Recurring	FYE of Recurring
		£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-70,900	0	-70,900	-70,900
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-57,200	-18,100	-39,100	-39,100
3	Planned Expenditure For Covid-19 (Negative Value)	-11,841	-11,841		
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	18,200	800	17,400	17,400
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	11,841	11,841		
6	Planned Provider Income (Positive Value)	0	0		
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0
8	Planned (Finalised) Savings Plan	8,781	495	8,286	9,253
9	Planned (Finalised) Net Income Generation	202	202	0	0
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
12	Planned Accountancy Gain	3,000	3,000		
13	Planning Assumptions still to be finalised at Month 1	18,318	271	18,047	18,047
14	**Opening IMTP / Annual Operating Plan**	**-79,600**	**-13,332**	**-66,268**	**-65,300**
15	Reversal of Planning Assumptions still to be finalised at Month 1	-18,318	-271	-18,047	-18,047
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive	0	0		
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
18	Other Movement in Month 1 Planned & In Year Net Income Generation	0	0	0	0
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	0	0	0	-1
20	Additional In Year Identified Savings - Forecast	0	0	0	0
21	Variance to Planned RRL & Other Income	0	0		
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 plus virements (Positive Value - additional)	-174	-174		
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0		
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	174	174		
25	In Year Accountancy Gains (Positive Value)	0	0	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	2,008	2,008		0
27	Anticipated Improvement in Savings plans	16,310	0	16,310	18,048
28		0	0		
29		0	0		
30		0	0		
31		0	0		
32		0	0		
33		0	0		
34		0	0		
35		0	0		
36		0	0		
37		0	0		
38		0	0		
39		0	0		
40	**Forecast Outturn (- Deficit / + Surplus)**	**-79,600**	**-11,595**	**-68,005**	**-65,300**
41	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**			
42	**Operational - Forecast Outturn (- Deficit / + Surplus)**	**-79,600**			
43					

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	-5,908	-5,908	-5,909	-5,908	-5,908	-5,909	-5,908	-5,908	-5,909	-5,908	-5,908	-5,909	-5,908	-70,900
2	-4,767	-4,767	-4,766	-4,767	-4,767	-4,766	-4,767	-4,767	-4,766	-4,767	-4,767	-4,766	-4,767	-57,200
3	-987	-987	-987	-987	-987	-987	-987	-987	-987	-987	-987	-988	-987	-11,841
4	1,517	1,517	1,516	1,517	1,517	1,516	1,517	1,517	1,516	1,517	1,517	1,516	1,517	18,200
5	987	987	987	987	987	987	987	987	987	987	987	988	987	11,841
6													0	0
7												0	0	0
8	267	756	625	750	718	766	797	807	763	843	822	867	267	8,781
9	0	18	18	18	18	18	18	18	18	18	18	18	0	202
10													0	0
11	250	250	250	250	250	-2,750	250	250	250	250	250	250	250	0
12						3,000							0	3,000
13	2,008	1,501	1,632	1,507	1,539	1,491	1,459	1,449	1,494	1,414	1,434	1,389	2,008	18,318
14	**-6,633**	**-6,633**	**-6,634**	**-6,633**	**-6,633**	**-6,634**	**-6,633**	**-6,633**	**-6,634**	**-6,633**	**-6,633**	**-6,634**	**-6,633**	**-79,600**
15	-2,008	-1,501	-1,632	-1,507	-1,539	-1,491	-1,459	-1,449	-1,494	-1,414	-1,434	-1,389	-2,008	-18,318
16													0	0
17													0	0
18	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21													0	0
22	-340	-457	-460	-455	-481	-480	361	398	398	418	427	498	-340	-174
23													0	0
24	340	457	460	455	481	480	-361	-398	-398	-418	-427	-498	340	174
25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	2,027											-19	2,027	2,008
27		1,501	1,633	1,507	1,539	1,492	1,459	1,449	1,494	1,414	1,434	1,386	0	16,310
28													0	0
29													0	0
30													0	0
31													0	0
32													0	0
33													0	0
34													0	0
35													0	0
36													0	0
37													0	0
38													0	0
39													0	0
40	**-6,614**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,656**	**-6,614**	**-79,600**
41	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
42	**-6,614**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,656**	**-6,614**	**-79,600**

TABLE A : Movement of Opening Financial Plan to Forecast Outturn

Monthly Positions (- Deficit / + Surplus) reconciles to Table B Monthly Positions	**Ok**
Recurring & Non Recurring Analysis of In Year items is not greater than In Year items	**Ok**
FYE of Recurring items are greater than, or equal to, the In Year Recurring amount	**Ok**
FYE of Recurring items only reported against Recurring items	**Ok**
Has Organisation name being selected	**Ok**

Cwm Taf Morgannwg ULHB

Period : Apr 23

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

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %aae of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	CHC and Funded Nursing Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Commissioned Services	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	0	161	167	173	173	173	173	173	173	173	173	173	0	1,887		548	1,339			
8		Actual/F'cast	0	161	167	173	173	173	173	173	173	173	173	173	0	1,887	0.00%	548	1,339	0	1,887	1,887
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Non Pay	Budget/Plan	19	192	108	112	113	116	129	129	129	201	136	136	19	1,520		565	956			
11		Actual/F'cast	19	192	108	112	113	116	129	129	129	201	136	136	19	1,520	1.26%	565	956	245	1,275	1,368
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
13	Pay	Budget/Plan	248	403	349	465	432	476	495	505	460	469	513	523	248	5,338		3,597	1,741			
14		Actual/F'cast	248	403	349	465	432	476	495	505	460	469	513	523	248	5,338	4.64%	3,597	1,741	250	5,088	5,569
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
16	Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	36	0	36		0	36			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	36	0	36	0.00%	0	36	0	36	428
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	267	756	625	750	718	766	797	807	763	843	822	867	267	8,781		4,710	4,071			
20		Actual/F'cast	267	756	625	750	718	766	797	807	763	843	822	867	267	8,781	3.04%	4,710	4,071	495	8,286	9,252
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
22		Variance in month	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%							
23		In month achievement against FY forecast	3.04%	8.60%	7.11%	8.54%	8.17%	8.72%	9.08%	9.19%	8.69%	9.60%	9.36%	9.88%								

Cwm Taf Morgannwg ULHB

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Table C1- Savings Schemes Pay Analysis

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Changes in Staffing Establishment	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Variable Pay	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Locum	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Agency / Locum paid at a premium	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Changes in Bank Staff	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16	Other (Please Specify)	Budget/Plan	248	403	349	465	432	476	495	505	460	469	513	523	248	5,338		3,597	1,741			
17		Actual/F'cast	248	403	349	465	432	476	495	505	460	469	513	523	248	5,338	4.64%	3,597	1,741	250	5,088	5,569
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
19	Total	Budget/Plan	248	403	349	465	432	476	495	505	460	469	513	523	248	5,338		3,597	1,741			
20		Actual/F'cast	248	403	349	465	432	476	495	505	460	469	513	523	248	5,338	4.64%	3,597	1,741	250	5,088	5,569
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			

Table C2- Savings Schemes Agency/Locum Paid at a Premium Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Reduced usage of Agency/Locums paid at a premium	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Non Medical 'off contract' to 'on contract'	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medical - Impact of Agency pay rate caps	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Other (Please Specify)	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Total	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			

Table C3- Savings Schemes SoCNE/SCNI Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
1	Pay	Budget/Plan		248	403	349	465	432	476	495	505	460	469	513	523	248	5,338
2		Actual/F'cast		248	403	349	465	432	476	495	505	460	469	513	523	248	5,338
3		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Non Pay	Budget/Plan		19	192	108	112	113	116	129	129	129	201	136	136	19	1,520
5		Actual/F'cast		19	192	108	112	113	116	129	129	129	201	136	136	19	1,520
6		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	Primary Care Drugs	Budget/Plan		0	131	137	143	143	143	143	143	143	143	143	143	0	1,558
8		Actual/F'cast		0	131	137	143	143	143	143	143	143	143	143	143	0	1,558
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	Secondary Care Drugs	Budget/Plan		0	30	30	30	30	30	30	30	30	30	30	30	0	329
8		Actual/F'cast		0	30	30	30	30	30	30	30	30	30	30	30	0	329
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	CHC/FNC	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
11		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	Primary Care Contractor	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	36	0	36
14		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	36	0	36
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Healthcare Services Provided by Other NHS Bodies	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
17		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
18		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Non Healthcare Services Provided by Other NHS Bodies	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
20		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
21		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
22	Other Private & Voluntary Sector	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
23		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
24		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
25	Joint Financing & Other	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
26		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
27		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
28	Total	Budget/Plan		267	756	625	750	718	766	797	807	763	843	822	867	267	8,781
29		Actual/F'cast		267	756	625	750	718	766	797	807	763	843	822	867	267	8,781
30		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0

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This Table is currently showing 34 errors

Table C4 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	267	756	625	750	718	766	797	807	763	843	822	867	267	8,781	495	8,286	968	9,253
	Month 1 - Actual/Forecast	267	756	625	750	718	766	797	807	763	843	822	867	267	8,781	495	8,286	966	9,252
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2)	(1)
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	267	756	625	750	718	766	797	807	763	843	822	867	267	8,781	495	8,286	968	9,253
	Total Actual/Forecast	267	756	625	750	718	766	797	807	763	843	822	867	267	8,781	495	8,286	966	9,252
	Total Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2)	(1)
Net Income Generation	Month 1 - Plan	0	18	18	18	18	18	18	18	18	18	18	18	0	202	202	0	0	0
	Month 1 - Actual/Forecast	0	18	18	18	18	18	18	18	18	18	18	18	0	202	202	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	0	18	18	18	18	18	18	18	18	18	18	18	0	202	202	0	0	0
	Total Actual/Forecast	0	18	18	18	18	18	18	18	18	18	18	18	0	202	202	0	0	0
	Total Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Accountancy Gains	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Month 1 - Plan	267	774	643	768	736	784	816	826	781	861	841	886	267	8,982	697	8,286	968	9,253
	Month 1 - Actual/Forecast	267	774	643	768	736	784	816	826	782	861	841	886	267	8,982	697	8,286	966	9,252
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2)	(1)
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	267	774	643	768	736	784	816	826	781	861	841	886	267	8,982	697	8,286	968	9,253
	Total Actual/Forecast	267	774	643	768	736	784	816	826	782	861	841	886	267	8,982	697	8,286	966	9,252
	Total Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2)	(1)

AGENDA ITEM
2.2.1g

PLANNING, PERFORMANCE & FINANCE COMMITTEE

MONTH 2 MONITORING RETURNS TO WELSH GOVERNMENT

Date of meeting	27/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Thomas, Deputy Director of Finance
Presented by	Sally May, Director of Finance & Procurement
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Welsh Government	13/06/2023	NOTED

ACRONYMS	
WG	Welsh Government
M1 etc	Month 1 etc
PPFC	Planning, Performance & Finance Committee
LHB	Local Health Board

MONTH 2 MONITORING RETURNS TO WELSH GOVERNMENT

1. SITUATION/BACKGROUND

1.1 In addition to our normal internal Finance reports there is a WG requirement for a Committee of the Board to receive the monthly Monitoring Return submissions to WG (narrative report plus certain tables) in order to provide the Committee with transparency on the submission made to WG.

1.2 The purpose of this report is to provide the PPFC with information from the M2 Financial Monitoring Return submission to Welsh Government.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The HB, SHA & Trust Monthly Financial Monitoring Return Guidance was issued on 26 April 2023. This guidance refers to the monitoring return spreadsheet and accompanying narrative that LHBs will need to complete to report their 2023/24 financial performance, together with the following requirements:

2.2 The Day 9 submission to WG must be agreed and the narrative signed by both the Director of Finance and Chief Executive before the submission is made to WG. The Board governance, regarding the arrangements for when the Director of Finance and/or Chief Executive is not available, should be set out at the start of the year and shared with the Head of NHS Financial Management.

2.3 An additional statement must be included in the narrative each month to clarify the date and main Committee of the Board which will receive that Month's Financial Monitoring return (consisting of the Narrative, Table A and Tables C, C1, C2, C3 & C4) in order to provide the Committee with, transparency on the submission made to WG.

2.4 The following information is provided at Annex A:

Annex A
M2 Narrative report
Table A - Movement
Tables C, C1, C2, C3 & C4

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 All information made available to WG should be consistent with that provided to the Board. The detailed commentary in the Monitoring Returns must include a statement confirming that the financial information reported in the Monitoring Return aligns to the financial details included with the internal Board papers.

3.2 The key information included in the M2 Financial Monitoring returns is summarised below:

	M2 Actual	M2 YTD	M2 Forecast	Financial Plan
	£m	£m	£m	£m
Core plan deficit	**6.1**	**11.9**	**70.9**	**70.9**
Exceptional Energy inflation	**0.7**	**1.5**	**8.7**	**8.7**
Covid Programme costs:				
Health Protection	0.4	0.9	9.1	9.1
PPE	0.0	0.1	0.3	1.0
Adferiad	0.0	0.1	1.0	1.0
Nosocomial	0.0	0.1	0.6	0.6
Anticipated Funding	(0.5)	(1.1)	(11.0)	(11.7)
Total	**0**	**0**	**0**	**0**
Grand total	**6.8**	**13.4**	**79.6**	**79.6**

3.3 The M2 YTD position is a £13.4m deficit. This represents an adverse £0.1m position compared to 2/12th of the £79.6m planned deficit.

3.4 The financial plan for 2023/24 includes a £27.3m recurring savings target.

	Month 2			**Month 1**		
	M2 YTD	**23/24**	**Rec**	**M1 YTD**	**23/24**	**Rec**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
Savings target as at M2	**4.6**	**27.3**	**27.3**	**2.3**	**27.3**	**27.3**
Actual and Forecast Savings	(2.2)	(19.9)	(20.7)	(0.3)	(9.0)	(9.3)
Total	**2.3**	**7.4**	**6.6**	**2.0**	**18.3**	**18.0**

3.5 Further work is ongoing to develop robust plans to close the forecast gap of £7.4m In year and £6.6m recurrently.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The paper is directly relevant to the allocation and utilisation of resources.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the contents of the Month 2 Monitoring Returns submitted to Welsh Government for 2023/24.

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD
MONITORING RETURNS – MAY 2023
FINANCIAL COMMENTARY

Introduction

These returns outline the financial position for Cwm Taf Morgannwg (CTM) UHB for the period ended 31 May 2023.

The tables attached to this commentary **do not** include the income, expenditure and balances of the Welsh Health Specialised Services Committee (WHSSC) or the Emergency Ambulance Services Committee (EASC) which is being financially managed via WHSSC. They do however include the Cwm Taf Morgannwg element of transactions between the parties.

1. Financial Plan, Year to Date and Forecast position

1.1 Financial Plan for 2023/24

Our revised Annual Plan, submitted to WG on 31st May 2023, is as follows:

	Recurrent £m	Non Recurrent £m	Total plan £m
Recurrent Core plan deficit at 31 March 2023	60.9		60.9
Recurrent ongoing COVID costs	10.0		10.0
Non Recurrent ongoing Exceptional energy costs		8.7	8.7
B'Fwd challenge at 31 March 2023	**70.9**	**8.7**	**79.6**
Allocation Adjustments	(17.4)	(12.5)	(29.9)
Cost Pressures & Investments:			
Inflationary Pressures	21.8	0	21.8
Demand Growth	12.3	0	12.3
Service Improvement – Local	4.3	2.8	7.0
COVID Programmes	0	11.7	11.7
Other Pressures & Investment	0.8	3.7	4.5
Savings Target	(27.3)	0	(27.3)
Total plan 23/24	**65.3**	**14.4**	**79.6**

1.2 Actual YTD and Forecast 23-24 (Table A)

	M2 Actual	M2 YTD	M2 Forecast	Financial Plan
	£m	£m	£m	£m
Core plan deficit	**6.1**	**11.9**	**70.9**	**70.9**
Exceptional Energy inflation	**0.7**	**1.5**	**8.7**	**8.7**
Covid Programme costs:				
Health Protection	0.4	0.9	9.1	9.1
PPE	0.0	0.1	0.3	1.0
Adferiad	0.0	0.1	1.0	1.0
Nosocomial	0.0	0.1	0.6	0.6
Anticipated Funding	(0.5)	(1.1)	(11.0)	(11.7)
Total	**0**	**0**	**0**	**0**
Grand total	**6.8**	**13.4**	**79.6**	**79.6**

The key issues to highlight at M2 are as follows:

- **Core plan YTD position**

The M2 position is a £13.4m deficit. This represents a £0.1m adverse variance compared to 2/12th of the £79.6m deficit in the draft plan submitted to WG on 31 March. The M2 position includes a £2.3m shortfall against the M2 savings target of £4.5m but this is currently being offset by the following positive operating variances:

- Dental performance £0.4m
- Pay improvements £0.4m
- Non Pay Improvements £0.2m
- Corporate Functions £0.5m
- Release of Planning Contingency £0.2m
- Other £0.5m

- **Core plan forecast**

As at M2 we are maintaining a forecast Core plan deficit of £79.6m for 23/24 which is consistent with the draft financial plan.

The draft plan includes several significant risks which are summarised in Section 3, most notably the savings plan position is currently £7.4m short of the £27.3m savings target. Urgent work is ongoing to develop robust savings plans and to de-risk the financial plan for 23/24.

The draft financial plan also, includes several significant funding assumptions which are summarised in Section 7. Any further clarification on these funding assumptions would be helpful to remove uncertainty and inform our forecast position for 23/24.

- **Exceptional energy costs**

As at M2 the HB is reporting energy expenditure of £2.6m with a forecast of £15.6m. This represents a forecast cost pressure of £8.7m which is consistent with the draft financial plan.

- **COVID Programme costs**

As at M2 the HB is reporting COVID Programme expenditure of £1.1m with a forecast of £11.0m. In line with the WG guidance, the HB is anticipating that the COVID Programme costs will be fully funded.

- **Real Living Wage for Health & Social Care Workers**

In accordance with WG policy, the fee rates for patient care placements within the private/independent sector have been uplifted to reflect the impact of paying Real Living Wage for Health & Social Care workers. The impact of continuing this policy in 2023/24 has been estimated at £2.4m in addition to the £2.4m impact in 2022/23. An anticipated allocation of £4.8m has therefore been recognised in our plan.

1.3 Material income and expenditure category movements between the current period actual and the previous month forecast (Table B & B1)

	May			Year End Forecast		
	Act £'000	F/Cast £'000	Movement £'000	M2 £'000	M1 £'000	Movement £'000
RRL	102,123	101,931	192	1,234,354	1,231,056	3,298
Donation/Grants	0	23	(23)	100	276	(176)
Welsh HBs & NHST	6,904	7,410	(506)	84,814	85,320	(506)
WHSSC	997	1,018	(21)	12,195	12,216	(21)
WG Income	(570)	10	(580)	(460)	120	(580)
Other Income	3,394	3,455	(61)	41,399	41,460	(61)
Income Total	**112,848**	**113,847**	**(999)**	**1,372,402**	**1,370,448**	**1,954**
PC Contractor	11,918	12,670	(752)	151,388	154,140	(2,752)
PC - Drugs	9,370	8,572	798	103,884	103,086	798
Pay	52,205	52,550	(345)	633,755	634,100	(345)
Non Pay	9,324	10,683	(1,359)	120,827	124,567	(3,740)
SC - Drugs	5,213	4,997	216	54,732	54,516	216
H/C Other NHS	20,588	21,827	(1,239)	257,085	258,324	(1,239)
Non H/C Other NHS	293	322	(29)	3,806	3,835	(29)
CHC & FNC	5,588	5,630	(42)	65,518	65,560	(42)
Private & Vol	1,511	940	571	11,816	11,245	571
Joint & Other	150	269	(119)	16,319	16,438	(119)
DEL	3,449	2,010	1,439	32,753	24,117	8,636
AME	10	10	0	122	120	2
Res & Cont	0	0	0	0	0	0
P&L on Dispoal	(3)	0	(3)	(3)	0	(3)
Cost - Total	**119,617**	**120,480**	**(863)**	**1,452,002**	**1,450,048**	**1,954**

The actual expenditure for M2 was £0.9m (0.7%) less than the £120.5m forecast. The most significant movements between the M2 forecast and M2 actuals were as follows:

- **Welsh HB & NHST Income - £506k Adverse** – The reduction in forecast income is mainly attributed to LTA variances pending signed LTA's.
- **WG Income - £580k Adverse -** The reduction in WG income reflects estimated Non-Cash Limited adjustments.
- **Primary Care Contractors - £752k Favourable** – The reduction in expenditure is mainly attributed to Non-Cash Limited adjustments.
- **Primary Care Drugs - £798k Adverse** – The position at M2 still reflects estimates pending actual data for M1. Given the deterioration in the final quarter of 22/23 the M2 position reflects the increased baseline costs with minimal savings achievement due to the absence of any M1 data.
- **Provider Non-Pay - £1,359k Favourable** – The level of non-pay expenditure incurred year to date is lower than anticipated across

many areas. Further investigation is underway to determine if this trend will continue or correct in future periods.

- **Healthcare NHS - £1,239k Favourable** – As with NHS Income, further work is ongoing pending signed LTAs. An adjustment has been made in M2 to recognise the transfer of NICE Drugs from SBU.
- **Private & Voluntary Sector - £571k Adverse** – The increase in expenditure is mainly related to increased Planned Care Recovery outsourcing/insourcing.

The year-end forecast expenditure at M2 has increased by £1.9m to £1,452m offset by a corresponding increase in the income forecast. The most significant changes between the M2 and M1 year-end forecasts are as follows:

- **Welsh HB & NHST Income - £506k Adverse** – Reflects current month movements, see above.
- **WG Income - £580k Adverse –** Reflects current month movements, see above.
- **Primary Care Contractors - £2,752k Favourable** – The reduction in expenditure is mainly attributed recognition of Dental underspends and Non-Cash Limited adjustments as noted in the current month movements.
- **Primary Care Drugs - £798k Adverse** – Reflects current month movements, see above.
- **Provider Non-Pay - £3,740k Favourable** – The change in forecast reflect £2.4m recognising the IFRS 16 adjustment together with the current month movement noted above.
- **Healthcare NHS - £1,239k Favourable** – Reflects current month movements, see above.
- **Private & Voluntary Sector - £571k Adverse** – Reflects current month movements, see above.

The forecast has been profiled using latest plans and information and will continue to be refined throughout the year. The pay expenditure includes the 1.5% consolidated pay award with a matching anticipated allocation. The position does not assume the recent pay settlement offer for 2023/24 which is assumed to be fully funded by WG.

The profile for M6 includes the anticipated accountancy gains included in our draft financial plan for Non-Pay and CHC.

M12 includes £13.3m of committed reserves for Planned Care programmes and Regional Integration Fund (RIF), pending finalisation of the spend profiles.

1.4 Pay Expenditure (Table B2)

The M2 Pay expenditure was £54.4m and the monthly trend is summarised below.

	M2	M1	M12	M11	M10	M9
		£m	£m	£m	£m	£m
A&C	7.3	7.3	13.1	7.1	7.3	7.2
Medical	14.2	13.5	22.8	13.8	14.1	14.2
Nursing	16.6	17.1	30.1	17.1	16.3	17.1
ACS	7.1	7.2	12.6	7.3	8.1	6.9
Other	9.2	9.0	16.4	8.9	9.1	9.0
Total	**54.4**	**54.1**	**95.0**	**54.2**	**54.9**	**54.4**

The Key issues to highlight are as follows:

- The M12 pay position recognised the recent pay circulars implementing the 1.5% non-consolidated (£6.7m) & 1.5% consolidated (£8.9m) pay awards together with the pension adjustment for the additional 6.3% centrally funded element (£25.8m). Planned additional annual leave accruals of £3.9m were also written back in M12. The M12 cost excluding these one-off items was £57.5m.

- The M1 position includes the 1.5% consolidated pay settlement equivalent to £0.75m. After allowing for this inflationary increase of £0.75m the adjusted M1 position (£53.4m) is reporting a reduction of circa £1.0m compared to the average of M9, M10 & M11 (£54.5m).
- The M2 position increased slightly compared to M1 which reflects the Easter Bank Holidays. Allowing for the 1.5% pay settlement, the adjusted M2 position of £53.7m (£54.4m less £0.75m pay inflation) is still reporting a favourable position of £0.8m compared to the average of M9, M10 & M11 (54.5m).

The M2 agency expenditure was £4.5m and the monthly trend (excluding accountancy gains) is summarised below.

	M2	M1	M12	M11	M10	M9
		£m	£m	£m	£m	£m
Medical	1.6	1.1	1.8	1.8	1.8	1.8
Nursing	1.7	2.2	2.0	1.9	1.4	2.6
Other	1.2	1.0	1.8	1.1	2.2	1.2
Total	**4.5**	**4.3**	**5.6**	**4.8**	**5.4**	**5.6**

Agency Costs in M2 have slightly increased compared to M1 but remain £0.8m less than the average of M9, M10 & M11(£5.3m). M2 has reported £0.5m increase in medical agency costs compared to M1 but this is offset by a £0.5m reduction in Nursing costs.

1.5 Covid analysis (Table B3)

A summary of the additional revenue costs being classified as Covid Programme is shown below.

	M2 Actual	**M2 YTD**	**M2 Year-end forecast**	**Financial Plan- 31 May**	**Movement between M2 and the Financial Plan**
Programme costs	**£m**	**£m**	**£m**	**£m**	**£m**
Public Health Response - TTP	0.1	0.1	2.7	2.7	0
Public Health Response - Mass Vaccination	0.4	0.4	6.4	6.4	0
PPE	0.0	0.1	0.3	1.0	(0.7)
Adferiad (Long COVID)	0.0	0.0	1.0	1.0	0
Nosocomial Investigation	0.0	0.0	0.6	0.6	0
Anticipated funding	**(0.6)**	**(0.6)**	**(11.0)**	**(11.7)**	**(0.7)**
Total	**0**	**0**	**0**	**0**	**0**

The key points to note are as follows:

- Public Health response – Plans continue to progress to address the interim Public Health response for both Vaccination and TTP and to develop a more integrated sustainable approach. Pending finalisation of the 2023/24 plans, the M2 forecast is based on the indicative allocation noted in Sioned Rees's correspondence dated 22 Dec 2022. This represents a potential financial opportunity and has been included in our Risk table in Section 3.

- In line with the MMR guidance, the additional costs of PPE have been assumed to be fully funded and an anticipated allocation is included in these Returns. The additional PPE costs have been assessed using the NWSSP stock list of PPE items expenditure compared to 2019/20 actual costs as baseline.

- Adferiad (Long COVID) – In line with the MMR guidance, the additional costs of Adferiad have been assumed to be fully funded. An anticipated allocation has also been included in these Returns.

- Nosocomial Investigation - In line with the MMR guidance, the additional forecast costs of the Nosocomial investigation have fully funded through an allocation letter, and movement on this position will noted with an adjustment to anticipated allocations.

2. Month 2 - Forecast recurrent position (Table A)

The B'fwd recurrent deficit at the end of 22/23 was £70.9m.

As at M2 we are reporting a forecast Underlying deficit at the end of 23/24 of £65.3m (excluding ongoing exceptional energy costs). This is consistent with the revised IMTP submitted on 31 May 2023.

	M2	**Draft financial plan**	**Comment**
	£m	**£m**	
Core Plan B/F	60.9	60.9	
Ongoing local Covid response costs B/F	10.0	10.0	Any reduction in these costs will be treated as a saving in 23/24
Ongoing Exceptional energy costs	tbc	tbc	The ongoing impact of exceptional energy costs into 24 25, will be reassessed during 23/24.
B/Fwd Total	**70.9**	**70.9**	
2023/24 Planned Improvement	-5.6	-5.6	The planned improvement in the underlying deficit of £5.6m assumes the full recurrent delivery of the £27.3m recurrent savings target. As at M2 this is a significant risk with only £20.7m of recurrent plans identified. The forecast recurrent savings shortfall at M2 is £6.6m.
Total	**65.3**	**65.3**	

3. Risk Management (Table A2)

The key financial risks and opportunities for 22/23 are noted in Table A2 and are summarised below:

	M2 £m	31 May submission £m	Comment
Savings delivery risks:			
Shortfall against planned savings delivery of £27.3m.	7.4	8.6	The latest forecast shortfall at M2 is £7.4m.
Forecast recurrent overspends in Care Groups not recognised in the plan. Risk of not delivering the £7.0m of NR benefits in 22/23 again in 23/24.	0	0	
Funding risks:			
Assumed WG funding for dental – 30% abatement of the dental income target	0	0	Please see section 4 below.
Assumed funding for the impact of RLW in 23/24	1.2	1.2	Further clarification needed on funding assumptions for 23/24.
Assumed funding for Regional Planned care Recovery solutions	3.8	3.8	Further clarification needed on funding assumptions for 23/24. In the meantime, the potential risk has been estimated at 50% of the assumed Regional allocation.
Risk of the 23/24 pay award not being fully funded given the £1.9m recurrent shortfall in 22/23	1.0	1.0	Further clarification needed on funding assumptions for 23/24.
Risk of the additional costs for the extra bank holiday in 23/24 not being fully funded	0	0	Funding risk removed following confirmation of the WG funding position.
Cost pressure risks:			
Return to pre Covid Cost & Volume LTA arrangements in 23/24	1.0	1.0	
Contracting risks with other Health Boards	3.1	3.1	See Section 8 re specific risk re ABUHB.
Primary care prescribing – inflation and volume growth different to plan assumptions	Tbc	Tbc	Prescribing data is 2m in arrears and we will not have Q1 data until August 2023.
Significant uncertainty surrounding the expected energy cost pressure	Tbc	Tbc	
NICE costs exceed planned growth of £3.0m	Tbc	Tbc	
Non-Pay Inflation exceeds the £4.9m provision made in the plan (4.9%)	0	0	
Pension changes – Increased pension costs if staff opt back in following changes to the 1995 scheme	0.75	0.75	
Winter plans – All schemes funded non recurrently in 22/23 need to stop by 31 March	0.75	0.75	
Total Risks	**19.0**	**20.2**	
Contingencies / Opportunities			
Further balance sheet review within 22/23	(2.5)	(2.5)	
Retrospective vat recoveries – Primary care and Microsoft contract	(0.5)	(0.5)	
Provision for an adverse movement in discount rates in 23/24 (following a positive movement in 22/23) not required	(1.0)	(1.0)	
Potential opportunity if the HB can reduce expenditure for TTP/vaccination below the notified	(2.0)	(2.0)	Further clarification needed on funding assumptions for 23/24.

	M2	31 May submission	Comment
allocation amount – and be allowed to retain any slippage.			
Total Opportunities	**(6.0)**	**(6.0)**	
Total	**13.0**	**14.2**	

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

Tables N & O will be completed Quarterly from Q2 (M6) and Table P will be completed from M3 onwards.

	Total Allocation	Forecast	Comment
	£m	£m	
Confirmed Allocations (Initial Allocation letter 23/24)			
Planned Care Recovery Funding	18.5	24.0	Includes £5.5m of additional investment above the WG allocation.
Value Based Healthcare	2.1	2.1	
Regional Integration Fund	22.3	22.3	Assumes anticipated allocations of £2m consistent with Shelley Davies's letter dated 31st March.
Genomics Strategy	1.4	1.4	
Critical Care Funding	2.7	2.7	
In Year Allocations (Initial Allocation letter 23/24)			
Urgent Emergency Care	3.0	3.0	Anticipated allocation
Mental Health (SIF)	0.8	0.8	Anticipated 23/24 allocation
Planned Care	0.6	0.6	Anticipated allocation
Value Based Healthcare	0.7	0.7	Anticipated allocation for approved schemes.
Recovery	7.7	7.7	Anticipated allocations for Regional Plans
Total	**59.8**	**65.3**	

We note the WG response that funding for Dental Patient Charge Income shortfalls should not be assumed. As at M2 we have removed the anticipated allocation and are assuming that any shortfall will be managed within the Dental Ringfenced allocation. It is possible that the Health Board will underspend on the Dental Ringfenced allocation in 23/24 and we would

welcome clarification on whether any underspends can be retained by the Health Board. The Dental position will be reviewed in Q2.

The Health Board can confirm that there are no concerns at M2 on any other ring-fenced budgets.

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

See section 1.4.

6. Saving (inc Accountancy gains) Plans (Tables C, C1, C2, C3)

The financial plan for 2023/24 includes a £27.3m recurring savings target.

	Month 2			Month 1		
	M2 YTD	**23/24**	**Rec**	**M1 YTD**	**23/24**	**Rec**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
Savings target as at M2	**4.6**	**27.3**	**27.3**	**2.3**	**27.3**	**27.3**
Actual and Forecast Savings	(2.2)	(19.9)	(20.7)	(0.3)	(9.0)	(9.3)
Total	**2.3**	**7.4**	**6.6**	**2.0**	**18.3**	**18.0**

Further work is ongoing to develop robust plans to close the forecast gap of £7.4m In year and £6.6m recurrently.

7. Income Assumptions 2023-24 (Tables D & E)

Table D has been completed and agreed with all other organisations. See Section 8 for specific comments regarding a dispute with Aneurin Bevan UHB.

The financial plan also includes provision for additional costs arising from the WRP risk sharing arrangement of £3.5m which is consistent with the information provided by NWSSP. This provision has been included as an anticipated allocation adjustment in Table E.

Table E shows the anticipated allocations assumed within our M2 position. The table below summaries the more material items:

Description	M2	M1	Comments
	£k	£k	
1.5% consolidated pay award	8,900	8,900	Estimated requirement
Regional Planned Care Recovery	7,700	7,700	Planning Assumption to be confirmed
Real Living Wage	4,800	4,800	Estimated requirement
Substance Misuse	3,909	3,909	Awaiting APB approval
Urgent & Emergency Care	2,960	2,960	Planning Assumption to be confirmed
2022/23 MH Investment	3,301	3,301	Planning Assumption to be confirmed.
Dental Income Abatement	0	2,000	See section 4 above.
Dementia Funding (RIF)	1,242	1,242	Approved RIF funding
Public Health Wales Transfer	1,387	1,387	Approved transfer funding
Planned Care – OP Transformation & Eyecare	619	619	Planning Assumption to be confirmed.
Hosted Value in Health Team	2,227	2,227	Estimated requirement
Health Protection – Mass Vaccination	6,400	6,400	Indicative allocation to be claimed on actual costs
Health Protection - TTP	2,700	2,700	Indicative allocation to be claimed on actual costs
Adferiad	984	972	Indicative allocation to be claimed on actual costs
PPE	300	1,000	Indicative allocation to be claimed on actual costs
Nosocomial	0	596	Allocation confirmed in M2.
WRP Deduction	-3,482	-3,482	Indicative Adjustment
IFRS 16 Adjustment	-2,410	0	Indicative IFRS adjustment
Invest to Save Repayments	-1,200	-1,200	Agreed repayment profile
Other Allocations	5,542	6,543	
Total Anticipated Allocations	**45,879**	**52,574**	

8. Health Care agreements

The Health Board is working with other Welsh NHS bodies to ensure all contracts are agreed and signed by 30th June 2023.

The Health Board is assuming that LTA arrangements for 23/24 will follow the recommendation accepted by the majority view at the Directors of Finance meeting on the 17th March 2023.

The HB has received a letter dated 10th May from ABUHB indicating that they do not accept this position and are intending to reduce the CTM provider LTA value by circa £6m in 23/24. We do not agree with this assessment, and we have suggested a way forward to ABUHB to fairly address the change in patient flows since 19/20. Correspondence between DoFs and Commissioning teams since November 2022 have failed to resolve the differences and it will now be escalated to Chief Executives before an official arbitration request is submitted. The risk to our draft plan is £3.1m.

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

9.1 Significant month on month balance sheet movements

An update is not required for this return.

9.2 Details of any aged receivables/payables (over 11 weeks old) and disputed invoice information

In relation to aged receivables, there was one NHS invoice greater than 17 weeks (which has since been paid) and six greater than 11 weeks old as at the 31st May 2023. All invoices were agreed as part of the M12 Agreement of Balances and there are no disputes. Organisations have been contacted and confirmation of payment dates requested for the remainder of the unpaid invoices.

10. Cash Flow Forecast (Table G)

The Cash Flow forecast shows a current surplus of £5.4m at the end of M2.

The forecast Cash Flow position to year end shows a projected deficit of £79.6m. This reflects the current plan deficit and will require future strategic cash support. Without cash support there will be a cash shortfall in the latter months of the financial year.

11. Public Sector Payment Compliance (Table H)

An update is not required for this return.

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

The M2 CRL is £64.5m, issued on the 25 May 2023. As at M2, £10.9m has been charged against the CRL mainly in relation to Prince Charles Hospital Refurbishment - Phase 2 and 3.

The table below details some of the forecast over and underspends this year. These are identified as medium or high risks in Table J.

Scheme	Over/Underspend	Explanation
PCH G&FF Floor Phase 2 and 3	Medium – Risk of overspend in financial year currently estimated at £2.5m	The current forecast from the contractor estimates that the scheme will overspend against the in year allocation. This was a planned position as the allocation requested by the Health Board was initially c£4m below the contractor's forecast to allow for slippage on the scheme. The gap has already been reduced in the first 2 months. This will be monitored over the next few months to establish if further funding is required and will be discussed regularly with Welsh Government
Bridgend Health and Wellbeing Centre (Sunnyside)	Medium – Slippage £0.76m	As previously reported the scheme remains on hold pending the appointment of a new contractor. Until a contractor is appointed the spending for 23/24 cannot be forecast.
EFAB – Infrastructure, Fire and Decarbonisation	Medium - Slippage	High number of schemes covered within this allocation and all at are early stages, hence the programme has not yet been confirmed. The assumption is that allocations in year can be managed across the 3 areas and high-level indications have been included in the return.

Disposals

Llwyn Yr Eos is planned for disposal in year as well as a small amount of equipment.

Non-cash requirements have been matched to baselines for M2. These will be updated in M3 with revised estimates for the year following the submission of the first non-cash return at the end of June.

13. Other Issues

The financial position reported within this monitoring return aligns to the financial details included within the internal Board papers.

The M2 Financial Monitoring Return (consisting of the Narrative, Table A, Tables C,C1,C2,C3 and C4) will be reported to the next meeting of the Planning, Performance and Finance Committee in June 2023.

14. Authorisation

P Mears
Chief Executive

S May
Director of Finance

Date: 13 June 2023

Action Points arising from Month 1 Response

Action Point	WG Comment	CTM Response
1.1	**Table A** – It is disappointing to note again this year that, contrary to the WHC, the HB is including a quantified assumption of Accountancy Gains as part of your Opening Financial Plan. A value of £3.0m has been reported on free text line (12) of Table A, which you describe as relating to Non Pay and CHC areas and these are forecast to be phased into your position at Month 6. There is a clear concern, that so close to submitting your Draft Accounts, you feel confident to report such benefits. Accountancy Gains must be treated as unplanned in-year benefits in the next version of your Plan, due 31st May, and within the M2 MMR Table A on line 13 (Planning Assumptions still to be finalised). As a secondary issue, the current treatment to show these on line 12 of Table A means they do not reverse out at the start of the year and therefore, when the HB records them in the Tracker at M6, this will cause a double count. The HB will not be able to amend the Opening Plan section as it will have been fixed at M2 and therefore you would have to enter a contra entry within the in-year section to fix the double count. This is because the templates have been specifically constructed to align to the WHC guidance, to only recognise Accountancy Gains as in-year benefits. Should the Month 2 MMR submission not be revised as requested, it will likely not be accepted. **(Action Point 1.1)**	Noted and adjusted in M2.
1.2	**Table A** – Please provide further details of the M1 (non-recurring) favourable 'Care Group and directorates operating variances' (line 26), totalling c. £2.0m. **(Action Point 1.2)**	Please see Section 1.2 for details of the more significant M2 YTD operating variances.

1.3	**Table A2** – The narrative confirms that you have adopted a similar approach to prior years, wherein the Opening Plan excludes forecast 'Care Group' recurrent overspends totalling £7.000m. These are forecast to mitigate these via in-year non-recurring benefits (an associated assessment of risk is reported as £3.5m within Table A2). As raised last year, the management of such a material issue outside of the Plan and key tables of the MMR, is of concern. Given the assessment of risk at M1, of not being able to fully mitigate these pressures and that this will be via a non-current actions, please consider including these recurring costs and any identified mitigating actions within the next version of your MDS Tables and within future MMR Table A submissions. You may wish to discuss your treatment further, with FDU colleagues, before the 31st May MDS is submitted. **(Action Point 1.3)**	Please see updated risk table at Section 3.
1.4	**Table A2 –** I note the potential LTA dispute with Aneurin Bevan which is quantified as a £3.1m financial risk. Please be reminded that the deadline to agree and sign-off the NHS Wales 23/24 LTA/SLA's is the 30th of June 2023. Any requirement to activate the arbitration process should be regarded as a last resort; therefore, the submission of cases will be viewed as a failure of organisations to deal with the matter locally in a prompt and professional manner. **(Action Point 1.4)**	Noted
1.5	**Table A2** - Please continue to refine the Risks and Opportunities each month, ensuring a 'balanced' assessment is always taken. **(Action Point 1.5)**	Noted
1.6	**Table E** – Please remove the assumed funding for "abatement of dental income target- £2.0m". Should additional funding be confirmed later in the year, only at that point should it be included in your assumptions. **(Action Point 1.6).**	Actioned
1.7	**Table E** – Please include the latest annual forecast IFRS16 Revenue Recovery value (negative) on Line 14 and a best estimate for the IFRS 16 WBC request (Line 62). **(Action Point 1.7)**	Actioned
1.8	**Table E** – Also, please report the RLW (care homes) anticipated funding on the designated line (15) of Table E. **(Action Point 1.8)**	Actioned

Cwm Taf Morgannwg ULHB **Period : May 23**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

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

		In Year Effect	Non Recurring	Recurring	FYE of Recurring
		£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-70,900	0	-70,900	-70,900
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-49,450	-7,400	-42,050	-42,050
3	Planned Expenditure For Covid-19 (Negative Value)	-11,668	-11,668	0	0
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	16,300	0	16,300	17,500
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	11,668	11,668	0	0
6	Planned Provider Income (Positive Value)	2,850	0	2,850	2,850
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0
8	Planned (Finalised) Savings Plan	17,678	341	17,337	18,268
9	Planned (Finalised) Net Income Generation	1,217	217	1,000	1,000
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0	0	0
12	Correction of Energy N/R underlying Deficit	-8,700	-8,700	0	0
13	Planning Assumptions still to be finalised at Month 1	11,405	3,373	8,032	8,032
14	**Opening IMTP / Annual Operating Plan**	**-79,600**	**-12,169**	**-67,431**	**-65,300**
15	Reversal of Planning Assumptions still to be finalised at Month 1	-11,405	-3,373	-8,032	-8,032
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive	0	0		
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
18	Other Movement in Month 1 Planned & In Year Net Income Generation	3	3	0	0
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-1,502	-251	-1,251	-928
20	Additional In Year Identified Savings - Forecast	2,471	574	1,896	2,384
21	Variance to Planned RRL & Other Income	0	0		
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 plus virements (Positive Value - additional)	-688	-688		
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0		
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	688	688		
25	In Year Accountancy Gains (Positive Value)	0	0	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	2,063	2,063	0	0
27	Anticipated Improvement in Savings plans	8,370	1,794	6,576	6,576
28		0	0		
29		0	0		
30		0	0		
31		0	0		
32		0	0		
33		0	0		
34		0	0		
35		0	0		
36		0	0		
37		0	0		
38		0	0		
39		0	0		
40	**Forecast Outturn (- Deficit / + Surplus)**	**-79,600**	**-11,358**	**-68,241**	**-65,300**
41	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**			
42	**Operational - Forecast Outturn (- Deficit / + Surplus)**	**-79,600**			
43					

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	-5,908	-5,908	-5,908	-5,908	-5,908	-5,908	-5,908	-5,908	-5,908	-5,908	-5,908	-5,908	-11,817	-70,900
2	-4,121	-4,121	-4,121	-4,121	-4,121	-4,121	-4,121	-4,121	-4,121	-4,121	-4,121	-4,119	-8,242	-49,450
3	-972	-972	-972	-972	-972	-972	-972	-972	-972	-972	-972	-972	-1,945	-11,668
4	1,358	1,358	1,359	1,358	1,358	1,359	1,358	1,358	1,359	1,358	1,358	1,359	2,716	16,300
5	972	972	972	972	972	972	972	972	972	972	972	972	1,945	11,668
6	237	238	237	238	237	238	237	238	237	238	237	238	475	2,850
7												0	0	0
8	268	936	915	2,699	843	890	2,745	930	886	2,807	946	2,816	1,204	17,678
9	0	37	18	351	101	102	101	101	102	101	101	102	37	1,217
10													0	0
11	250	250	250	250	250	-2,750	250	250	250	250	250	250	500	0
12	-725	-725	-725	-725	-725	-725	-725	-725	-725	-725	-725	-725	-1,450	-8,700
13	2,007	1,302	1,342	-775	1,331	4,283	-571	1,244	1,287	-633	1,228	-643	3,309	11,405
14	**-6,634**	**-6,633**	**-6,633**	**-6,633**	**-6,634**	**-6,632**	**-6,634**	**-6,633**	**-6,633**	**-6,633**	**-6,634**	**-6,630**	**-13,268**	**-79,600**
15	-2,007	-1,302	-1,342	775	-1,331	-4,283	571	-1,244	-1,287	633	-1,228	643	-3,309	-11,405
16													0	0
17													0	0
18	0	-37	37	0	0	0	0	0	0	0	0	0	-37	3
19	-1	872	694	-1,406	442	504	-1,313	422	466	-1,367	504	-1,319	871	-1,502
20	0	295	191	199	210	220	230	252	216	221	218	218	295	2,471
21													0	0
22	-326	-513	-513	-535	-539	-472	-307	34	375	375	375	1,355	-839	-688
23													0	0
24	326	513	513	535	539	472	307	-34	-375	-375	-375	-1,355	839	688
25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	2,028	35											2,063	2,063
27			420	431	679	3,558	513	570	605	513	507	573	0	8,370
28													0	0
29													0	0
30													0	0
31													0	0
32													0	0
33													0	0
34													0	0
35													0	0
36													0	0
37													0	0
38													0	0
39													0	0
40	**-6,614**	**-6,770**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,515**	**-13,384**	**-79,600**
41	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
42	**-6,614**	**-6,770**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,633**	**-6,515**	**-13,384**	**-79,600**

TABLE A : Movement of Opening Financial Plan to Forecast Outturn

Monthly Positions (- Deficit / + Surplus) reconciles to Table B Monthly Positions	**Ok**
Recurring & Non Recurring Analysis of In Year items is not greater than In Year items	**Ok**
FYE of Recurring items are greater than, or equal to, the In Year Recurring amount	**Ok**
FYE of Recurring items only reported against Recurring items	**Ok**
Has Organisation name being selected	**Ok**

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

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %aae of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	CHC and Funded Nursing Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Commissioned Services	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	0	317	177	183	183	183	183	183	183	183	183	183	317	2,141		1,514	627			
8		Actual/F'cast	0	0	482	181	182	182	182	182	182	182	182	182	0	2,118	0.00%	1,474	643	0	2,118	2,146
9		Variance	0	(317)	305	(2)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(317)	(23)	*(100.00%)*	(40)	16			
10	Non Pay	Budget/Plan	20	139	80	83	84	87	98	98	98	185	105	105	159	1,186		667	519			
11		Actual/F'cast	19	18	125	65	67	69	81	86	86	166	86	86	37	953	3.91%	403	550	80	873	1,030
12		Variance	(1)	(121)	45	(19)	(17)	(18)	(18)	(13)	(13)	(20)	(20)	(20)	(122)	(233)	*(76.54%)*	(264)	31			
13	Pay	Budget/Plan	248	480	658	2,432	575	619	2,463	648	604	2,438	657	2,491	728	14,315		12,281	2,034			
14		Actual/F'cast	248	2,085	1,192	1,246	1,246	1,363	1,400	1,336	1,300	1,313	1,400	1,411	2,333	15,541	15.01%	13,563	1,977	584	14,956	16,120
15		Variance	(0)	1,605	534	(1,186)	671	744	(1,064)	688	696	(1,125)	743	(1,080)	1,605	1,225	*220.45%*	1,282	(57)			
16	Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	36	0	36		0	36			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	36	0	36	0.00%	0	36	0	36	428
18		Variance	0	0	0	0	0	0	0	0	0	0	0	(0)	0	(0)		0	(0)			
19	Total	Budget/Plan	268	936	915	2,699	843	890	2,745	930	886	2,807	946	2,816	1,204	17,678		14,462	3,216			
20		Actual/F'cast	267	2,103	1,800	1,492	1,495	1,614	1,662	1,603	1,567	1,661	1,667	1,714	2,370	18,647	12.71%	15,441	3,206	664	17,982	19,724
21		Variance	(1)	1,167	885	(1,206)	653	724	(1,083)	674	682	(1,146)	722	(1,101)	1,166	969	*96.86%*	979	(10)			
22		Variance in month	(0.37%)	124.70%	96.75%	(44.70%)	77.45%	81.41%	(39.45%)	72.45%	76.97%	(40.83%)	76.31%	(39.11%)	96.86%							
23		In month achievement against FY forecast	1.43%	11.28%	9.65%	8.00%	8.02%	8.66%	8.91%	8.60%	8.41%	8.91%	8.94%	9.19%								

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Table C1- Savings Schemes Pay Analysis

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Changes in Staffing Establishment	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	10	42	21	28	28	28	31	31	31	31	31	10	313	3.24%	313	0	0	313	369
3		Variance	0	10	42	21	28	28	28	31	31	31	31	31	10	313		313	0			
4	Variable Pay	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	42	39	49	52	52	62	62	62	67	64	64	42	615	6.77%	595	20	270	345	459
6		Variance	0	42	39	49	52	52	62	62	62	67	64	64	42	615		595	20			
7	Locum	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Agency / Locum paid at a premium	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Changes in Bank Staff	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16	Other (Please Specify)	Budget/Plan	248	480	658	2,432	575	619	2,463	648	604	2,438	657	2,491	728	14,315		12,281	2,034			
17		Actual/F'cast	248	2,033	1,112	1,177	1,165	1,282	1,309	1,243	1,207	1,215	1,305	1,316	2,281	14,612	15.61%	12,655	1,957	314	14,298	15,292
18		Variance	(0)	1,553	454	(1,256)	590	663	(1,154)	595	603	(1,223)	648	(1,175)	1,553	297	*213.33%*	374	(78)			
19	Total	Budget/Plan	248	480	658	2,432	575	619	2,463	648	604	2,438	657	2,491	728	14,315		12,281	2,034			
20		Actual/F'cast	248	2,085	1,192	1,246	1,246	1,363	1,400	1,336	1,300	1,313	1,400	1,411	2,333	15,541	15.01%	13,563	1,977	584	14,956	16,120
21		Variance	(0)	1,605	534	(1,186)	671	744	(1,064)	688	696	(1,125)	743	(1,080)	1,605	1,225	*220.45%*	1,282	(57)			

Table C2- Savings Schemes Agency/Locum Paid at a Premium Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Reduced usage of Agency/Locums paid at a premium	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Non Medical 'off contract' to 'on contract'	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medical - Impact of Agency pay rate caps	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Other (Please Specify)	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Total	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			

Table C3- Savings Schemes SoCNE/SCNI Analysis

			Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
				£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000		
1	Pay	Budget/Plan		248	480	658	2,432	575	619	2,463	648	604	2,438	657	2,491	728	14,315
2		Actual/F'cast		248	2,085	1,192	1,246	1,246	1,363	1,400	1,336	1,300	1,313	1,400	1,411	2,333	15,541
3		Variance		(0)	1,605	534	(1,186)	671	744	(1,064)	688	696	(1,125)	743	(1,080)	1,605	1,225
4	Non Pay	Budget/Plan		20	139	80	83	84	87	98	98	98	185	105	105	159	1,186
5		Actual/F'cast		19	18	125	65	67	69	81	86	86	166	86	86	37	953
6		Variance		(1)	(121)	45	(19)	(17)	(18)	(18)	(13)	(13)	(20)	(20)	(20)	(122)	(233)
7	Primary Care Drugs	Budget/Plan		0	268	147	153	153	153	153	153	153	153	153	153	268	1,792
8		Actual/F'cast		0	0	421	152	152	152	152	152	152	152	152	152	0	1,792
9		Variance		0	(268)	274	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(268)	0
7	Secondary Care Drugs	Budget/Plan		0	49	30	30	30	30	30	30	30	30	30	30	49	349
8		Actual/F'cast		0	0	61	29	29	29	29	29	29	29	29	29	0	325
9		Variance		0	(49)	31	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(49)	(24)
10	CHC/FNC	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
11		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
12		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	Primary Care Contractor	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	36	0	36
14		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	36	0	36
15		Variance		0	0	0	0	0	0	0	0	0	0	0	(0)	0	(0)
16	Healthcare Services Provided by Other NHS Bodies	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
17		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
18		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Non Healthcare Services Provided by Other NHS Bodies	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
20		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
21		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
22	Other Private & Voluntary Sector	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
23		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
24		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
25	Joint Financing & Other	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
26		Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
27		Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
28	Total	Budget/Plan		268	936	915	2,699	843	890	2,745	930	886	2,807	946	2,816	1,204	17,678
29		Actual/F'cast		267	2,103	1,800	1,492	1,495	1,614	1,662	1,603	1,567	1,661	1,667	1,714	2,370	18,647
30		Variance		(1)	1,167	885	(1,206)	653	724	(1,083)	674	682	(1,146)	722	(1,101)	1,166	969

Cwm Taf Morgannwg ULHB

May 23

This Table is currently showing 1 errors

Table C4 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	268	936	915	2,699	843	890	2,745	930	886	2,807	946	2,816	1,204	17,678	341	17,337	931	18,268
	Month 1 - Actual/Forecast	267	1,808	1,609	1,293	1,285	1,394	1,431	1,351	1,352	1,440	1,450	1,497	2,075	16,176	90	16,086	1,254	17,340
	Variance	(1)	872	694	(1,406)	442	504	(1,313)	422	466	(1,367)	504	(1,319)	871	(1,502)	(251)	(1,251)	323	(928)
	In Year - Plan	0	296	191	199	210	220	230	251	215	220	217	217	296	2,466	574	1,892	451	2,343
	In Year - Actual/Forecast	0	295	191	199	210	220	230	252	216	221	218	218	295	2,471	574	1,896	487	2,384
	Variance	0	(1)	0	0	0	0	0	1	1	1	1	1	(1)	5	0	4	36	40
	Total Plan	268	1,232	1,106	2,898	1,053	1,110	2,975	1,181	1,101	3,027	1,163	3,033	1,500	20,144	915	19,229	1,382	20,611
	Total Actual/Forecast	267	2,103	1,800	1,492	1,495	1,614	1,662	1,603	1,567	1,661	1,667	1,714	2,370	18,647	664	17,982	1,741	19,724
	Total Variance	(1)	871	694	(1,405)	443	504	(1,313)	423	467	(1,366)	505	(1,318)	870	(1,497)	(251)	(1,247)	359	(888)
Net Income Generation	Month 1 - Plan	0	37	18	351	101	102	101	101	102	101	101	102	37	1,217	217	1,000	0	1,000
	Month 1 - Actual/Forecast	0	0	55	351	101	102	101	101	102	101	101	102	0	1,220	220	1,000	0	1,000
	Variance	0	(37)	37	0	0	0	0	0	0	0	0	0	(37)	3	3	0	0	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	0	37	18	351	101	102	101	101	102	101	101	102	37	1,217	217	1,000	0	1,000
	Total Actual/Forecast	0	0	55	351	101	102	101	101	102	101	101	102	0	1,220	220	1,000	0	1,000
	Total Variance	0	(37)	37	0	0	0	0	0	0	0	0	0	(37)	3	3	0	0	0
Accountancy Gains	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	Month 1 - Plan	268	973	933	3,050	944	992	2,846	1,031	988	2,908	1,047	2,918	1,241	18,895	558	18,337	931	19,268
	Month 1 - Actual/Forecast	267	1,808	1,664	1,644	1,386	1,496	1,533	1,453	1,454	1,541	1,551	1,599	2,075	17,396	310	17,086	1,254	18,340
	Variance	(1)	835	731	(1,405)	443	504	(1,313)	422	466	(1,367)	505	(1,319)	834	(1,499)	(248)	(1,251)	323	(928)
	In Year - Plan	0	296	191	199	210	220	230	251	215	220	217	217	296	2,466	574	1,892	451	2,343
	In Year - Actual/Forecast	0	295	191	199	210	220	230	252	216	221	218	218	295	2,471	574	1,896	487	2,384
	Variance	0	(1)	0	0	0	0	0	1	1	1	1	1	(1)	5	0	4	36	40
	Total Plan	268	1,269	1,124	3,249	1,154	1,212	3,076	1,282	1,203	3,128	1,264	3,135	1,537	21,361	1,132	20,229	1,382	21,611
	Total Actual/Forecast	267	2,103	1,855	1,844	1,597	1,716	1,763	1,705	1,670	1,762	1,769	1,817	2,370	19,867	884	18,982	1,741	20,724
	Total Variance	(1)	834	731	(1,405)	443	505	(1,313)	423	467	(1,366)	505	(1,318)	833	(1,494)	(248)	(1,247)	359	(888)

ACTION LOG: PLANNING, PERFORMANCE & FINANCE COMMITTEE					
Minute Reference	**Date of Meeting Action Originated**	**Issue**	**Lead Officer**	**Timescale for Action to be completed**	**Status of Action** (as at 12.06.23)
2.2.2	May 2023	**Action Log** To be fully reviewed and old completed actions removed.	Assistant Director of Governance & Risk	June 2023	**Completed** Action Log reviewed and updated.
4.1.0	May 2023	**Organisational Risk Register** To query whether the Laundry Risk 4772 had been completed	Chief Operating Officer	June 2023	**In progress** Facilities colleagues are waiting for Broadbent engineers to visit the laundry to complete some remedial work prior to Micross Electronics being able to upgrade the system. The delay is as a consequence of engineer availability across the UK and limited staff resource. The matter is being actively followed up and it is hoped that an appointment will be available imminently. Once this is complete, the system upgrade will be achieved and it is anticipated this will be completed by the end of August 2023.
4.1.0	May 2023	**Organisational Risk Register**	Chief Operating Officer	June 2023	Colleagues from Planned Care have met to discuss with colleagues from Corporate

		Risks being undertaken as part of TI process to be updated for next meeting.			Services. It has been agreed that the risk will now be called, 'Risk of potential harm due to patients waiting longer than Welsh Government targets for RTT and Elective Surgery'. Further discussion and additions will be made imminently.
4.1.0	May 2023	**Organisational Risk Register** Risk 4491 to be updated by the next meeting.	Chief Operating Officer	June 2023	**In Progress** As above.
4.1.0	May 2023	**Organisational Risk Register** To query the introduction of an 'issues log'.	Assistant Director of Governance & Risk	June 2023	**Propose to close:** AD Governance & Risk and Chief Operating Officer have discussed this request and suggested the following approach. "Issues" which are activity that is happening are captured in the performance reports and updates received from the COO and Care Group functions. In terms of risks that are stagnant due to reasons beyond the control of the Health Board, these will be further strengthened to consider their Risk

					Treatment options i.e. Treat, Tolerate, Transfer etc. The AD Governance & Risk will work through this next step in its maturity journey with colleagues with a view to presenting the Organisational Risk Register in this way before the end of the calendar year. It is built into the Work Programme.
5.1.0	May 2023	**Planned Care Recovery** To query the issue with funding for ODPs	Chief Operating Officer	June 2023	**Completed** ODPs have now been recruited into posts from the streamlining process this year. The Planned Care Group will continue to recruit into any ODP vacancies if needed as is normal practice outside of the streamlining process if required.
5.1.0	May 2023	**Planned Care Recovery** To discuss To discuss the WISE Pain Service outside of the meeting.	Chief Operating Officer	June 2023	**In progress** This meeting has not yet taken place. Meeting will be scheduled into diaries as soon as possible.
5.3.0	May 2023	**Spotlight: Mental Health Activity & Performance** To query whether harm reviews are undertaken for patients waiting over six	Assistant Director of Primary, Community & mental Health	June 2023	**Completed** The MH&LD have reviewed their process for supporting people waiting over 26 weeks for a Psychological

		months for psychological therapies. To query the amount of patients that do not attend for the CAMHS Service.			Intervention. They contact people at set intervals on the waiting list to also then check if they want remain on the list and revisiting the priority need at that time. Any reported harm at that stage is then managed both clinically and where appropriate through Datix in order that service undertakes a comprehensive review of circumstances and processes to inform learning. The Care group considered what added value harm reviews would bring and feel the current process allow for identification and learning from harm but critically also the opportunity to address the harm early as typically harm reviews are done retrospectively once a person had received their clinical appointment so the potential to address the harm was lost. They tend to sit outside the usual governance arrangements and incident reporting via datix is more robust and can be analysed and tracked. In terms of psychological therapy the

					'waiting well' project will provide that additional support more proactively.
5.4.0	February 2023	**Sepsis Compliance Report** To provide a report on Digitisation to a future meeting	Director of Digital	June 2023	**In progress** On Agenda for October 2023 meeting.
5.3.0	October 2022	**Integrated Performance Dashboard** To receive a deep-dive into Mental Health	Chief Operating Officer	May 2023	**Complete** Received at May 2023 meeting.
PREVIOUSLY COMPLETED ACTIONS					
4.1.0	February 2023	**Organisational Risk Register** Share the update on Risk 4071 outside of the meeting.	Assistant Director of Governance & Risk	April 2023	**Complete** Update sent via Email 2.3.23
5.1.0	February 2023	**Planned Care Recovery and Cancer Delivery programme** To that an overarching cover report is received for future iterations of this item.	Deputy Chief Operating Officer	April 2023	**Complete** An overarching report will be included going forward
5.1.0	February 2023	**Targeted Intervention** Review the reporting for Executive Leadership Group on page 6 of the slides in terms of the	Deputy Chief Operating Officer	April 2023	**Complete** The Chief Operating Officer has clarified that the structure captured on slide 6 of the presentation slides received at the February

		governance reporting framework.			2023 meeting was reflecting information flow rather than a hierarchy of decision/reporting. Therefore, no changes have been made.
6.1.0	February 2023	**Month 10 Finance Report** To schedule quarterly Estates Update Reports for the Committee on the Cycle of Business and Forward Plan.	Governance Team	April 2023	**Complete** Items added to Forward Plan and Annual Cycle of Business. Report scheduled for June 2023 meeting.

AGENDA ITEM
4.1

PLANNING, PERFORMANCE & FINANCE COMMITTEE

ORGANISATIONAL RISK REGISTER

Date of meeting	27th June 2023
FOI Status	Public
If closed please indicate reason	Not Applicable – Public Meeting
Prepared by	Cally Hamblyn, Assistant Director of Governance & Risk
Presented by	Cally Hamblyn, Assistant Director of Governance & Risk
Approving Executive Sponsor	Paul Mears, Chief Executive
Report purpose	FOR REVIEW & APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
Service, Function and Executive Formal Review	April / May 2023	RISKS REVIEWED
Operational Management Board – Phase 1 Risks Scoring 20 and above	19th April 2023	RISKS REVIEWED
Executive Leadership Group	15th May 2023	REVIEWED AND MANAGEMENT SIGN OFF RECEIVED
Audit & Risk Committee	21st June 2023	RISKS REVIEWED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The purpose of this report is for the Committee to review and discuss the organisational risk register and consider whether the assigned risks have been appropriately assessed.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 At the Operational Management Board meeting on the 19th April 2023, a targeted review of risks scoring 20 and above (escalated to the Organisational Risk Register) was undertaken and Care Group Director Teams were tasked with specific review actions. Improvement in terms of mitigation, moderated scoring and timeframes will hopefully be evident over the next few reporting periods.

2.2 The Care Group Highlight Reports received a the Operational Management Board will now include a specific risk update in terms of 'new, closed, de-escalated' risks for the Organisational Risk Register.

2.3 Monthly Risk Management Awareness Sessions (Virtually via Teams). The monthly sessions are set in the calendar until the end of 2023. **403** members of staff trained to date.

2.6 Risks on the organisational risk register have been updated as indicated in red.

3 KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 **Principal / Strategic Risks (Board Assurance Framework)**
The organisational risks captured in Appendix 1 are aligned to the Principal/Strategic Risks reported to the Board via the Board Assurance Framework Report. These risks as assigned to the Planning, Performance & Finance Committee

- Risk No. 1 – Sufficient capacity to meet emergency and elective demand. Risk score of 20.
- Risk No. 3 - Finance Revenue Resources. Risk score of 20.

3.2 **NEW RISKS**

Financial Stability Risks

- Datix ID 5425 – Failure to achieve financial balance in 2023-2024. Risk score of 20. This risk replaces Datix Risk ID 5153.
- Datix ID 5427 - Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023-2024. Risk score of 20. This risk replaces Datix Risk ID 5154.

3.3 **CHANGES TO RISKs**

a) Risks where the risk rating INCREASED during the period
Nil as assigned to this Committee.

b) Risks where the risk rating DECREASED during the period
Nil as assigned to this Committee.

3.4 **CLOSED RISKS FROM THE ORGANISATIONAL RISK REGISTER**
Nil as assigned to this Committee.

3.5 **POINTS TO NOTE**

An update on Datix Risk ID 4458 - Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.) has been received since the Organisational Risk Register was published. This update has been included below:

- Update 18th May 2023 from the Unscheduled Care (USC) Group - Programme of work lead by the USC senior team, acute site general managers and heads of nursing to support improvement against the metrics identified. Whilst there has been improvement against these targets the improvement work needs to be embedded as business as usual.

3.6 **Organisational Risk Register - Visual Heat Map by Datix Risk ID (Risks rated 15 and above):**

Consequence						
	5			4772		
	4				4458	4491 4071 5427 5425
	3					5207
	2					
	1					
CxL		1	2	3	4	5
		Likelihood				

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	No (Include further detail below) If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not applicable for the Risk Register item.

Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Committee are asked to:

- **Review** the risks escalated to the Organisational Risk Register at Appendix 1.
- **Consider** whether the Committee can seek assurance from the report that all that can be done is being done to mitigate the risks.

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5425 (Replacing 5153)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to achieve financial balance in 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2023/24. Resulting in: Potential deficit in 2023/24 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 23/24 Context: The context is that the draft financial plan for 22/23, . This planned deficit is also dependent on the delivery of efficiency savings of £27.3m which is a significant step up in savings compared to recent	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive leadership Group, the Planning, Performance & Finance Committee and the Board.	May 2023: The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper needs to be submitted to WG by 31 May.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	New risk escalated to the Org Risk Register May 2023 - replacing Risk ID 5153	28.04.2023	28.04.2023	31.05.2023
5427 (Replacing 5154)	Executive Director of Finance & Procurement	Central Support Function - Finance	Deputy Director of Finance	Sustaining Our Future	Financial Stability Risk	Failure to reduce the planned recurrent deficit of £79.6m at the end of 2023/24.	IF: The Health Board is not able to plan and deliver changes which enable current run rates of expenditure to align with the available funding for 2023/24. Then: The Health Board will not be able to deliver a break-even financial position for 2024/25. Resulting in: Potential deficit in 2024/25 leading to potential short term unsustainable cost reductions with associated risks, qualification of the accounts and potential Welsh Government regulatory action. Failure to meet statutory financial duty WG not supporting the Health Board's plan Potential cash shortfalls in the latter months of 24/25	Developing the Health Board's understanding and use of Value Based Healthcare principles to drive service planning and improvement going forward. Developing a more project and programmatic approach to planning and delivery of efficiency savings schemes, with focus on pipeline schemes as well as schemes in delivery. Including the development and implementation of the CTM Improvement Plans. Developing the Value & Efficiency Programme with a focus on 'Enabling schemes' to support savings identification and delivery. Routine monitoring arrangements in place. Regular reporting to the Executive Leadership Group, the Planning, Performance & Finance Committee and the Board.	May 2023: The WG response dated 21 April states that the level of financial deficit in the plan is not an acceptable or supportable position. The requirement is to deliver improvement to delivery of ministerial priorities and the financial plans submitted. A supplementary paper needs to be submitted to WG by 31 May.	Planning, Performance & Finance Committee	20	C4xL5	12 C4 x L3	New risk escalated to the Org Risk Register May 2023 - replacing Risk ID 5154	28.04.2023	28.04.2023	31.05.2023
4491	Chief Operating Officer	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety - Physical and/or Psychological harm	Failure to meet the demand for patient care at all points of the patient journey	**IF:** The Health Board is unable to meet the demand upon its services at all stages of the patient journey. **Then:** the Health Board's ability to provide high quality care will be reduced. **Resulting in:** Potential avoidable harm to patients	Controls are in place and include: • Technical list management processes as follows: - Speciality specific plans are in place to ensure patients requiring clinical review are assessed. - All patients identified will be clinically reviewed which will include an assessment of avoidable harm which will be reported and acted upon accordingly. - A process has been implemented to ensure no new sub specialty codes can be added to an unreported list, this will be refined over the coming months. - All unreported lists that appear to require reporting have been added to the RTT reported lists - All unreported lists that are to remain unreported (as they do not form part of the RTT criteria) are being reviewed and will be visible and monitored going forward. • Patients prioritised on clinical need using nationally defined categories • Demand and Capacity Planning being refined in the UHB to assist with longer term planning. • Outsourcing is a fundamental part of the Health Board's plan going forward. • The Health Board will continue to work towards improved capacity for Day Surgery and 23:59 case load. • A Harm Review process is being piloted within Ophthalmology – it will be rolled out to other areas. • The Health Board has taken advice from outside agencies especially the DU when the potential for improvement is found. • Appropriate monitoring at ILG and Health Board levels via scheduled and formal performance meetings with additional audits undertaken when areas of concern are identified Planned Care board established. - The Health Board is exploring working with neighbouring HBs in order to utilise their estate for operating.	The Health Board has established a Planned Care Board, with a full programme of work to address FUNB, demand and capacity and a recovery programme which will include cancer patients; The plans have timescales – which are being monitored, however it is likely that it will take time to reduce waiting times to acceptable levels in the post-covid-19 environment. The PCH Improvement Programme has significantly accelerated a number of mitigating actions designed to improve flow, reduce risk and improve the quality of care in the unscheduled care pathway. Updates on this are provided through the Quality & Safety Committee including specific actions and measures. There is also a PCH Improvement Board that meets monthly with the COO as the SRO. The Health Board is centralising the operational management and decision making around all elective services with the clear aim of increasing and protecting elective activity as we deal with the pressures of the Covid-19 pandemic and winter. This process commenced in late October 2021 and greater clarity will be provided in the next review. The IMTP process will drive the development and prioritisation of these plans ahead of implementation in 2022-2023.Additionally as part of the IMTP Process we will be able to complete robust capacity and demand planning for all surgical specialities for the first time, this will allow us to fully understand our likely trajectory for recovery during 2022-2023 and beyond. Update July 2022 - Risk scoring unchanged. Revised Improvement trajectories for each specialty now in place updated via the Planned Care Recovery Programme Board. The Health Board is working with Cardiff and Vale University Health Board and Swansea Bay University Health Board to support recovery actions in high risk specialities. Update request escalated to Interim Planned Care Director. The Care Group Director of Nursing has confirmed their intention on launching a series of risk and compliance huddles over the course of April, May and June to ensure rigour, validity and accuracy behind existing risks.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4xL5	12 C4 x L3	↔	11.01.2021	28.10.2022	30.11.2022
4071	Chief Operating Officer All Integrated Locality Groups Linked to RTE 5039 / 4513	Planned Care Group	Interim Planned Care Service Group Director	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to sustain services as currently configured to meet cancer targets.	**IF:** The Health Board fails to sustain services as currently configured to meet cancer targets. **Then:** The Health Boards ability to provide safe high quality care will be reduced. **Resulting in**: Compromised safety of patients, potential avoidable harm due to waiting time delays for treatment.	Tight management processes to manage individual cases on the cancer Pathway. Regular reviews of patients who are paused on the pathway as a result of diagnostics or treatment not being available. To ensure patients receive care as soon as it becomes available. Regular Quality impact assessments with the MDTs, to understand areas of challenge and risk Harm review process to identify patients with waits of over 104 days and potential pathway improvements. Initiatives to protect surgical capacity at the Vale hospital for ASA 1+2 level patients until alternatives become available. All three sites are working to maximising access to ASA level 3+4 surgery on the acute sites. HB working to ensure haematological SACT delivery capacity is maintained. Ongoing comprehensive demand and capacity analysis with directorates to maximise efficiencies. Considerable work around recommencing endoscopy and other diagnostic services whilst also finding suitable alternatives for impacted diagnostics. Alternative arrangements for MDT and clinics, utilising Virtual options Cancer performance is monitored through the more rigours monthly performance review process. Each Care Group now reports actions against an agreed improvement trajectory.	Update April 2023 - New Service Level Agreement signed with Tenovus Cancer Care, for a telephone call back system to provide additional support to patients. It is a service to support the patients who are waiting/improve the patient experience. There is no additional mitigation that has been added this month. Next review 31.5.2023.	Quality & Safety Committee Planning, Performance & Finance Committee.	20	C4 x L5	12 (C4 x L3)	↔	01/04/2014	28.04.2023	31.05.2023
4458	Chief Operating Officer	Unscheduled Care Group	Care Group Service Director - Unscheduled Care.	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm	Failure to Deliver Emergency Department Metrics (including 15 minute Handover and 4 and 12 hour breaches.)	**If:** the Health Board fails to deliver against the Emergency Department Metrics **Then:** The Health Boards ability to provide safe high quality care will be reduced. Patients will be waiting in the ambulance rather than being transferred to the Emergency Department. **Resulting In:** A poor environment and experience to care for the patient. Delaying the release of an emergency ambulance to attend further emergency calls. Compromised safety of patients, potential avoidable harm due to waiting time delays. Potential of harm to patients in delays waiting for treatment.	Senior Decision makers available in the Emergency Department. Regular assessments including fundamentals of care in line with National Policy. Additional Capacity opened when safe staffing to do so. Senior presence at Health Board Capacity Meeting to identify risk sharing. Winter Protections Schemes Implemented within ILG's. Operational Performance is now monitored through the monthly performance review. Performance review process has been restructured to bring more rigour with a focus on specific operational improvements. Programme improvement is monitored through the monthly Unscheduled Care Improvement Board, which reports into Management Board.	The Unscheduled Care Improvement Board will monitor progress on the programme on a monthly basis. Given the decrease in compliance for 12 and 4 hour waits, it is impossible to outline progress at this point. It is anticipated that the work of the Urgent Care Improvement Group will be able to report some improvement in the coming months. Update September 2022 Update – UEC Six Goals Improvement Programme now commenced – workstream 2 (integrated front door) – rapid mobilisation of other elements of the front door (SDEC, Acute frailty assessment, Hot/rapid access clinics) to facilitate ED de-crowding and timely ambulance offload. Update 3.11.2022 - now being addressed via UEC 6 goals programme, workstreams 2, 3 and 4. Aim to improve whole hospital/system flow, implementing D2RA model and pathways Dec 22, implementing enabling processes to improve flow and discharge - including e-whiteboards/e-discharge referrals, discharge hub, additional components of integrated front door (including acute frailty ax, hot clinics, SDEC), discharge lounges on each site.	Quality & Safety Committee Planning, Performance & Finance Committee	16	C4 x L4	12 (C4 x L3)	↔	04/12/2020	3.11.2022	31.12.2022
4772	Chief Operating Officer	Central Support Function - Facilities	Governance and compliance manager, Facilities	Improving Care	Operational: • Core Business • Business Objectives • Environmental / Estates Impact • Projects Including systems and processes, Service /business interruption	Replacement of press software on the 13 & 10 stage CBW presses	**If:** The 10 & 13 stage Lavatec presses have old software control systems, and are both vulnerable to failure. Following a fault developing and a recent maintenance call out it was identified that the 10 stage press is working intermittently caused by a software problem. **Then**: If the 10 Stage press control system fails the consequence of not purchasing the software replacement would result in the laundry service being unable to produce to full capacity and reduced to around 55%. If the Stage 10 press control system software fails then it could also impact on the Stage 13 press. The consequence of both presses failing and not purchasing the software replacement would result in the laundry service being unable to process any laundry which will result in all CTMUHB laundry being outsourced to commercial laundries. The costs will be significantly higher than those incurred in-house. **Resulting In:** •Potential of service failure due to existing system. •Potential of CTM sites being without bedding and linen at existing volumes and turnaround times. •Potential increased costs resulting from having to outsource laundry processing to commercial laundries in the event of equipment failure.	The All - Wales Laundry review continues, and at the current time, it is likely that services will be provided from CTM laundry until at least 2024. After this time, the equipment could be moved and rehoused elsewhere to continue to support CTM and the All-Wales Laundry agenda. Previous IMTP submissions have included as a priority £375K for a replacement automated sorting and roll cage washer/dryer system at the laundry. The software that controls system for the CBW forms an integral part of the current press. Benefits of equipment being replaced: •Reduced risk of service failure and therefore improved confidence in continued production. •Easier to diagnose and put right any mechanical defects. The Laundry is being monitored remotely by the system supplying company. This ensures that we are able to run the system and any problems quickly rectified on the 13 stage CBW. The 10 stage new software has now been installed and updated and all snagging completed. We were in the process of arranging a date for the 13 stage CBW software to be updated when the bolts on the 10 stage sheared, this will be repaired Monday 4th July 2022 we will then arrange for the new software to be updated on the 13 stage. There is a robust contingency plan in place we are able to continue with a normal service until these issues are resolved. We also have the ability to call upon the other L4 region production units. The contingency plan provides for a 5 day full service with ability to call on the other L4 within the All Wales Laundry agreement to produce our linen if needed.	Update April 2023: SON to be submitted and if successful replacement software purchased and installed. Timescale: 31/05/2023. SON approved and funding provided, awaiting installation. Update from Deputy Linen Services Manager that order has been raised to replace. 10 stage press received completed software upgrade. We are now ready for the installation of the software upgrade to the 13-stage press. All items needed for the upgrade have been received by the supplier. The in-house electrical work has been completed. The supplier has provided an installation date for the end of March 2023- beginning of April 2023. This will allow the installation of the new chemical system to be installed prior to the upgrade. The upgrade comes as part of a new chemical contract between NWSSP and Ecolab who will be providing the equipment as part of the contract. Based on this update the risk remains as a high risk and will be reviewed in 3 months time or once the software has been installed. Review Date: 31/05/2023	Quality & Safety Committee Planning, Performance & Finance Committee	15	15 (C5xL3)	5 (C5xL1)	↔	27.07.2021	13.04.2023	31.05.2023

Datix ID	Strategic Risk owner	Care Group / Service Function	Identified Risk Owner/Manager	Strategic Goal	Risk Domain	Risk Title	Risk Description	Controls in place	Action Plan	Assuring Committees	Rating (current)	Heat Map Link (Consequence X Likelihood)	Rating (Target)	Trend	Opened	Last Reviewed	Next Review Date
5207	Executive Director of Strategy & Transformation	Primary & Community Care Group or Central Function?	Deputy Director of Strategy and Partnerships	Improving Care	Patient / Staff /Public Safety Impact on the safety – Physical and/or Psychological harm & Statutory Duty / Legislation	Care Home Capacity	**If:** the rising costs of delivering care in private facilities drives a number of providers to cease trading. **Then:** there will be a loss of capacity within the system. **Resulting in:** exacerbated delays in hospital flow, an impact on wait times and increased admission to hospital for displaced patients. Patient experience will be impacted due to increased hospital stays. There will also be a longer term impact on residential care opportunities.	Multi Agency Operational Group established that effectively risk assesses the homes and manages any emergent contractual/ provider/ safeguarding issues, we wonder if this is forward looking enough in the current context. Local Authorities have regular contact with Care Homes to assess any challenges that they are facing and will intervene as appropriate based on risk and circumstances.	Via the Regional Partnership Board and other partnership meetings questions will continued to be escalated to seek assurance. Reports on specific incidents will be taken to Planning, Performance & Finance Committee. Care Providers will continue to engage with Welsh Government to escalate their concerns around the current position. CTMUHB is working with Care Inspectorate Wales (CIW)and the local authorities to understand the implications of the HB providing care services either as a provider in its own right or in partnership with a local authority Update April 2023 - No changes made bar next review date as cost of living crisis still relevant.	Quality & Safety Committee Planning, Performance & Finance Committee	15	C5xL3	10 C5xL2	↔	19.8.2022	13.04.2023	30.06.2023

AGENDA ITEM
5.1

PLANNING, PERFORMANCE & FINANCE COMMITTEE

6 Goals for Urgent and Emergency Care Programme

Date of meeting	27/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	ANNA PEPPER, PROGRAMME MANAGER
Presented by	Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor	Chief Operating Officer (COO, DPCMH)
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
	D2RA - Discharge to Recover than Assess BCBC - Bridgend County Borough Council MTCBC - Merthyr Tydfil County Borough Council RCTCBC - Rhondda Cynon Taf County Borough Council RPB - Regional Partnership Board SDEC – Same Day Emergency Care UEC – Urgent & Emergency Care eToC – Electronic Transfer of Care DHCW – Digital Health Care Wales PCH – Prince Charles Hospital RGH – Royal Glamorgan Hospital PoW – Princess of Wales Hospital

	SMOC – Senior Manager on Call NIV – Non Invasive Ventilation PROMS – Patient Recorded Outcome Measures PREMS – Patient Recorded Experience Measures

1. SITUATION/BACKGROUND

1.1 In July 2022 Welsh Government launched the '6 Goals for Urgent and Emergency Care' national programme, which set out expectations for health and social care, independent and third sector partners for the delivery of the right care, in the right place, first time for physical and mental health.

The Six Goals Programme scope, plan and its delivery were produced and agreed in partnership between health and social care organisations across Cwm Taf Morgannwg University Health Board (CTMUHB) and the first phase of the programme was delivered between July 2022 and February 2023 through 24 task and finish groups with defined scope and objectives and reported/escalated issues and risks using agreed programme governance structure.
The Programme is a major contributor to the 2021-2024 Integrated Medium-Term Plan (IMTP) and CTM 2030 Strategy supporting delivery of strategic objectives under 'Improving Care' pillar.

In March 2023, gateway review of the programme was conducted and its findings including current delivery status, review of risks and barriers to delivery and future plans and recommendations for the delivery of second phase (April to September 2023) was presented at the Programme Board meeting on 10th March 2023.

It was agreed that the following task and finish groups (projects) had completed the delivery of agreed objectives and transitioned into business-as-usual operational delivery:

1) Minor Injury Unit T&F Group
2) Emergency Department T&F Group
3) Non-Invasive Pathway T&F Group

(Project Closure Reports will be completed and submitted to Programme Board for review and final sign-off)

In May 2023, the Programme Board agreed distribution of 6 Goals national funding, the proposal was submitted to Executive Leadership Group for approval and subsequently the allocation of funding was signed off by the Executive Team on 5th June 2023 (**Appendix 1**).

It was agreed that the following task and finish groups (projects) had completed the delivery of agreed objectives and transitioned into business-as-usual operational delivery:

1) Stroke Pathway Resilience Task & Finish Group:
a) Developed a rapid improvement for stroke pathway from RGH to PCH;
b) Agreed and formalised operational processes:
Stroke bed capacity part of SMOC protocol – ring-fencing beds
Stroke release protocol from Emergency Department (ED)
Include stroke in 10am call template
Availability of immediate transport between sites and appropriate mitigations

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Programme Board agreed a focused approach and delivery plan for phase two of the programme with redefined structure and accelerated roadmaps to develop and/or mobilise priority plans. Phase two will be governed and monitored through four strategic workstreams:

Workstream 1: Attendance Avoidance

Senior Delivery Lead: Service Director for Primary Care and Community
Senior Responsible Officer: Deputy Chief Operating Officer Primary Care, Community and Mental Health

1) Navigation Hub Project Board including Urgent Primary Care, Acute Response, Virtual Ward, 111 and 111#2 (Mental Health)
Delivery of Navigation Hub is in progress with increasing activity, with a number of established access pathways including:

a) District Nurse Call Taking – operating 24/7 365 days across Merthyr Tydfil and Rhondda Cynon Taf
b) ROLE – verification of deaths that are natural and unexpected with no suspicious circumstances
c) Nursing Homes Pathway – offering advice to nursing home prior to calling 999 for conveyance
d) GP Out of Hours – operating daily between hours 18:30 – 08:00 365 days a year
e) Emergency Dental Service – triage and appointment service for patients experiencing dental pain operating 24/7 365 days a year
f) Professional Line – offering service to Nursing Homes, paramedics, district nursing, Macmillan nurses for professional advice or to direct patient referral to GP Out of Hours operating between 18:30 – 08:00 365 days a year

g) 111#2 – telephone advice and support line that will provide guidance for people of all ages who are experiencing mental health need. The pathway will be phased into 24/7 service by April 2023
h) Physician Telephone & Streaming Service (PTaS) offering advice to paramedics on scene regarding patient conveyance and streaming operating between hours 18:30 – 08:00 365 days a year

The Project Board will prioritise development of rapid palliative discharge services pathway and emergency department redirection pathways (including access to SDEC pathway) in phase two.

2) High Intensity Frequent Attenders Task and Finish Group – further development of scope and objectives of the project is in progress and will be reported on via programme governance structures

Workstream 2: Integrated Front Door

Senior Delivery Lead(s): Unscheduled Care Group Service Director, Medical Director Unscheduled Care
Senior Responsible Officer: Deputy Chief Operating Officer Unscheduled Care

1) Same Day Emergency Care (SDEC) Task & Finish Group will focus on development of medical SDEC in Prince Charles Hospital in Merthyr Tydfil (following approval of capital funding request to redevelop former vaccination centre into designated SDEC area) and Princess of Wales Hospital in Bridgend with a focus on admission avoidance and returning people to the community when acute inpatient admission is not required.

   Detailed data analysis of demand and capacity on three acute sites was conducted in March 2023 with subsequent submission of SDEC requirements plans to Delivery Unit including optimal workforce model to meet current and future demand on the service based on data analysis and projections.

2) Acute Medicine Task & Finish Group agreed principles and model for acute medicine unit. The group focus will be to finalise operational policy (including outcomes of ongoing national review) and formalise forward plan for operational implementation.

3) Frailty Pathway Task & Finish Group will finalise the acute frailty model approach for CTM UHB supporting the implementation of the new front door models, working closely with community frailty provision, falls services, to ensure a linked up frailty pathway across CTM.

4) eWhiteboards Phase 2 & 3 Task & Finish Group will focus on development of dashboard specification for Emergency Departments and Same Day Emergency Care service.

Workstream 3: Acute Hospital Flow and Discharge

Senior Delivery Lead(s): Nurse Director for Unscheduled care; Medical Director Unscheduled Care
Senior Responsible Officer: Deputy Chief Operating Officer Unscheduled Care

Bed Management & Flow Task & Finish Group will:

a) Develop standardised Safe to Start template and meetings scripts;
b) Finalise CTM-wide escalation cards and service operational policy,
c) Finalise pre-emptive boarding service operational policy
d) Finalise CTM cross-site call service operational policy to include:

- Stroke specific status in RGH
- NIV beds status
- Fracture neck of femur bed status

Workstream 4: Integrated Discharge Delivery Board

Senior Delivery Lead(s): Clinical Service Group Manager Community, Head of Adult Social Care, Bridgend County Borough Council

D2RA Implementation and Embedding Delivery Group and D2RA Hub and Supported Discharge Delivery Group will:

1) Produce revised governance and delivery structure with a clear operational reporting into Unplanned Care Operational Board, Primary and Community Operational Board and associated Local Authority Boards.
2) Co-design and re-develop of an integrated delivery plan through the D2RA implementation group, with key milestones and outcomes identified.
3) Revise Service Operational Policy of the D2RA hub with a rapid 90-day improvement plan developed through the Hub and Supported Discharge group.
4) Produce benefits realisation plan with data collected through the hub and reporting to the Integrated Discharge Board.

5) Develop PROMS and PREMS with revised focus on patient / family/ friends/care network experience. Revision of patient information, communication and engagement with support of regional engagement team.
6) Re-design and develop digital solutions with revised eToC, Supported Discharge Notification and Discharge Dashboard.
7) Produce clear guidance, pathways and accessible support for front line staff with handbooks, revised intranet/online resources and mentoring.
8) Produce staff training and engagement delivery plan in line with national resources and support.
9) Develop of an integrated intermediate care strategy in line with the approved integrated model with provision mapped to D2RA pathways, with a rapid 90-day improvement plan related to bed based pathways 2 and 3.

2.2 Digital Enablers and Innovation:

1) Complete on-boarding of electronic Transfer of Care (eToC) onto Welsh Care Records Service (WCRS) and integration of eToC with Clinical Service (DHCW)
2) Complete eWhiteboards access provision for local authority social care staff

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 No risks have been identified specifically at this point, work is underway to focus on delivery and completion of agreed actions.

Any programme related risks are managed and mitigated through regular risk review and escalation through programme governance structure.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Effective Care
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below. EIA process under review – awaiting further guidance to complete for the programme purposes
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Contained with the report
Link to Strategic Goals	Improving Health

5. RECOMMENDATION

5.1 The Committee is asked to **NOTE** the content of this report and described progress of work.

Appendix 1

Scheme Type	Care Group	Scheme	Recurrent/One-Off	Recurrent Cost	Cost already incurred Yes/No
D2RA	Primary Care & Communities	D2RA Practitioner	Recurrent	£51,000	No
SDEC	Planned Care	RGH SAU	Recurrent	£130,000	Yes
SDEC	Therapies	POW Front Door Therapy	Recurrent	£199,000	No
SDEC	Therapies	PCH Front Door Therapy	Recurrent	£88,000	Yes
SDEC	Unscheduled Care	RGH AECU	Recurrent	£180,00	Yes
SDEC	Unscheduled Care	POW AESU	Recurrent	£334,000	Yes
SDEC	Unscheduled Care	POW Frailty	Recurrent	£431,000	Yes
SDEC	Unscheduled Care	PCH Admin Support	Recurrent	£58,000	No
SDEC	Unscheduled Care	PCH Frailty	Recurrent	£134,000	Yes
SDEC	Unscheduled Care	PCH Frailty	Recurrent	£134,000	Yes
SDEC	Unscheduled Care	PCH Frailty	Recurrent	£70,000	No
UPCC	Primary Care & Communities	Navigation Hub	Recurrent	£598,000	Yes
UPCC	Primary Care & Communities	Navigation Hub	Recurrent	£90,000	No
DIGITAL	Unscheduled Care	eWhiteboards Development	One-Off	£121,000	No
Triumvirate	Unscheduled Care	6 Goals team	Recurrent	£228,000	Yes
TOTAL:				**£2,846,000**	

ALLOCATED FUNDING TOTAL	**£2,960,000**	**Contingency - £114,000**

AGENDA ITEM
5.2

PLANNING, PERFORMANCE & FINANCE COMMITTEE

INTEGRATED PERFORMANCE DASHBOARD

Date of meeting	(27/06/2023)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Jose Roper, Senior Performance Monitoring Officer
Presented by	Gethin Hughes, Chief Operating Officer
Approving Executive Sponsor	Gethin Hughes, Chief Operating Officer
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
Gethin Hughes	14/06/2023	Choose an item.

ACRONYMS	
AMU	Acute Medical Unit
C.difficle	Clostridium difficle
CAMHS	Child and Adolescent Mental Health Services
COO	Chief Operating Officer
CTM	Cwm Taf Morgannwg
CTP	Care and Treatment Plan
CYP	Children and Young People

D2RA	Discharge to Recover then Assess model
DHCW	Digital Health and Care Wales
DNA	Did Not Attend
DToC	Delayed Transfers of Care
E.coli	Escherichia coli bacteraemia
ED	Emergency Department
ESD	Early Supported Discharge
FUNB	Follow-up Outpatients Not Booked
HIW	Health Inspectorate Wales
IMTP	Integrated Medium Term Plan
IPC	Infection Prevention and Control
Klebsiella sp.	Klebsiella sp. Bacteraemia
LD	Learning Disabilities
LRI's	Locally Reportable Incidents
LPMHSS	Local Primary Mental Health Support Service
MDT	Multidisciplinary Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NOUS	Non Obstetric Ultra-Sound
ONS	Office for National Statistics
OoH	Out of Hours
P.aeruginosa	Pseudomonas aeruginosa bacteraemia
PADR/PDR	Personal Appraisal and Development Review
p-CAMHS	Primary Child and Adolescent Mental Health Services
PCH	Prince Charles Hospital
PIFU	Patient Initiated Follow Up
POW	Princess of Wales
PSPP	Public Sector Payment Performance
PTR	Putting Things Right
PUs	Pressure Ulcers
QIA	Quality Impact Assessment
QIM	Quality Improvement Measures
RCS	Royal College of Surgeons
RCT	Rhondda Cynon Taff
RGH	Royal Glamorgan Hospital
RTT	Referral to Treatment Times
S.aureus	Staphylococcus aureus bacteraemia
SALT	Speech and Language Therapy
s-CAMHS	Specialist Child and Adolescent Mental Health Services
SCP	Single Cancer Pathway
SIs	Serious Incidents
SOS	See on Symptom
SSNAP	Sentinel Stroke National Audit Programme
WAST	Welsh Ambulance Service NHS Trust
WCP	Welsh Clinical Portal
WG	Welsh Government
WHSSC	Welsh Health Specialised Services Committee
WPAS	Welsh Patient Administration System
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda

1. SITUATION/BACKGROUND

1.1 This report sets out the UHB's performance against the Welsh Government's (WG) Performance Framework and other priority areas for the UHB.

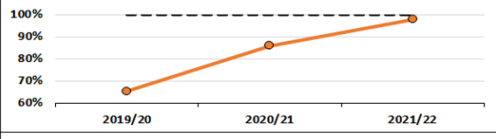
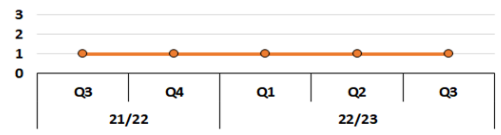
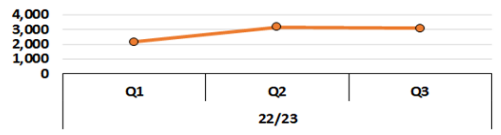
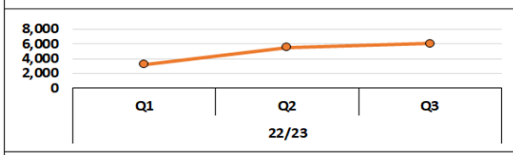
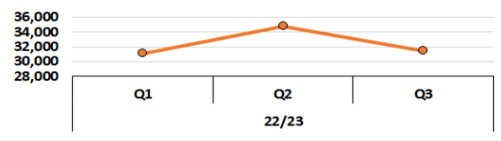
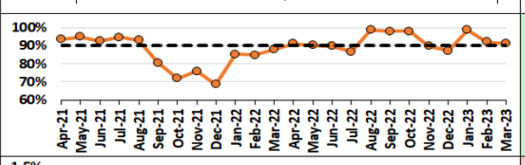
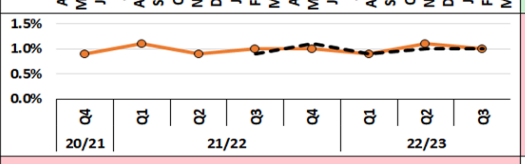
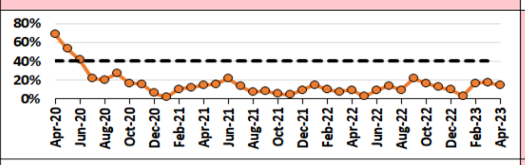
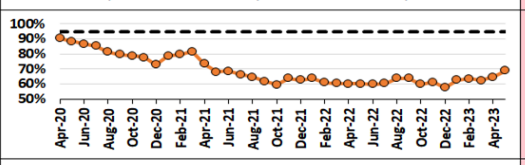
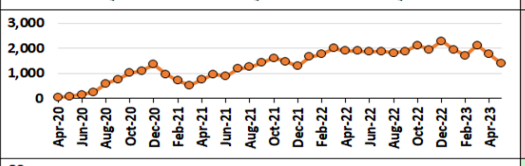
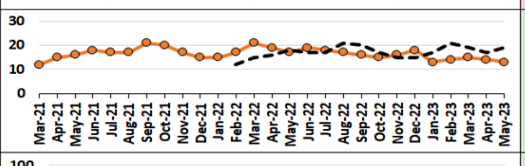
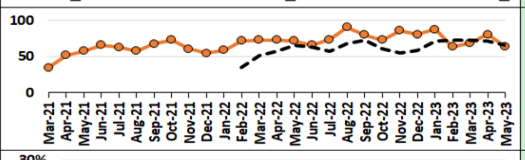
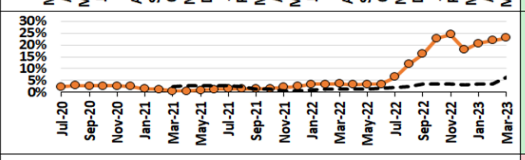
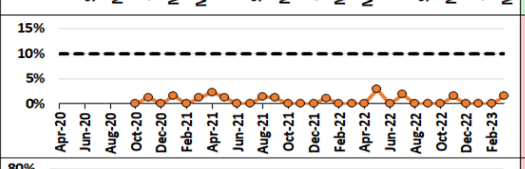
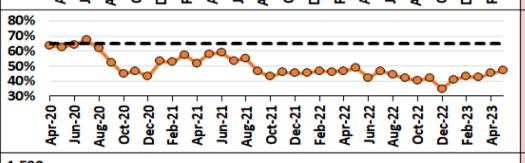
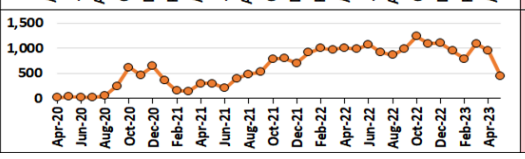
The report is intended to provide an ongoing assessment of the UHB's progress in delivering the Ministerial and Health Board's priorities as described in our Integrated Medium Term Plan, concentrating on areas of greatest priority and those areas where a significant change in performance has been observed, rather than a full discrete evaluation of all measures.

As the performance framework for this year is yet to be finalised by Welsh Government, we will continue to report against the 2022/23 measures, the majority of which we anticipate will remain in the future framework: https://gov.wales/nhs-wales-performance-framework-2022-2023

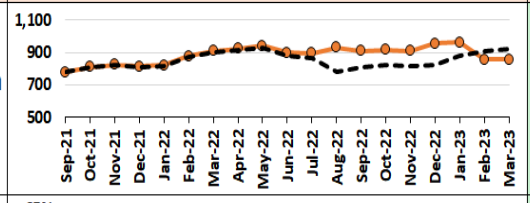
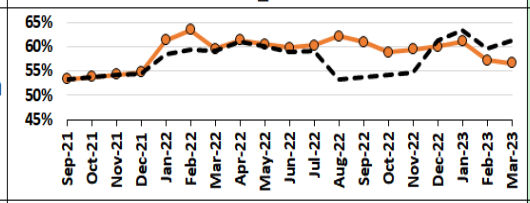
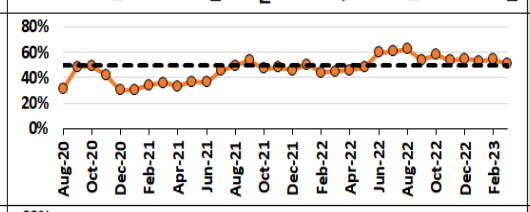
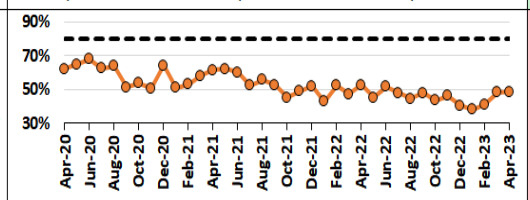
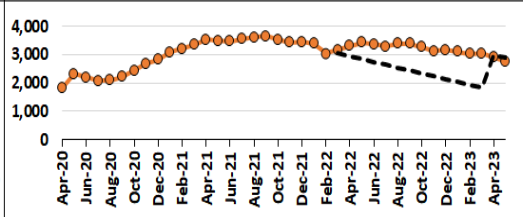
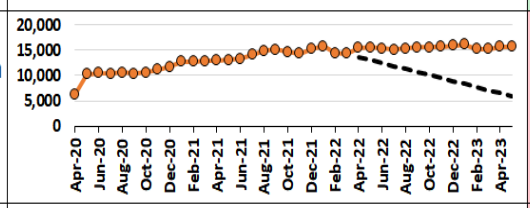
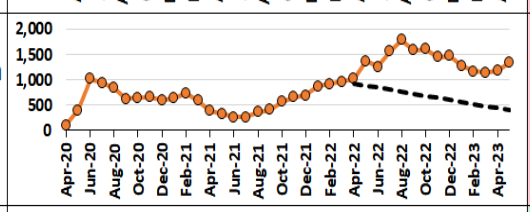
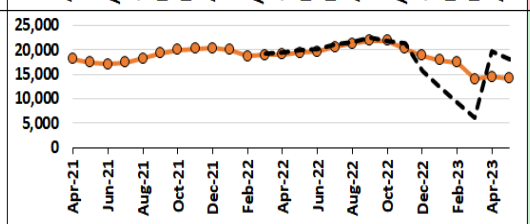
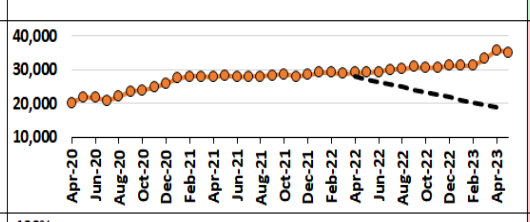
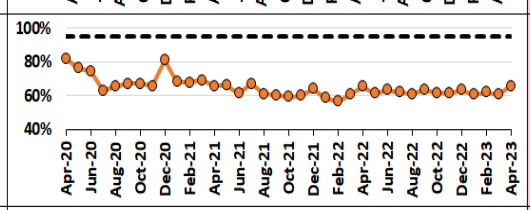
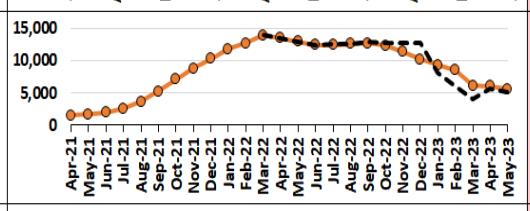
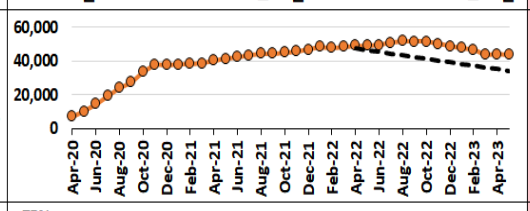
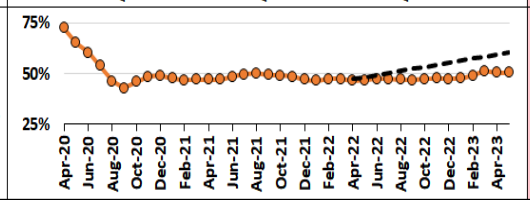
2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

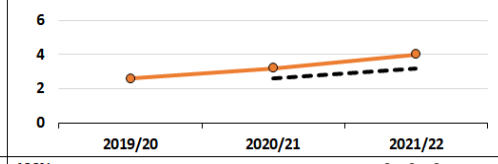
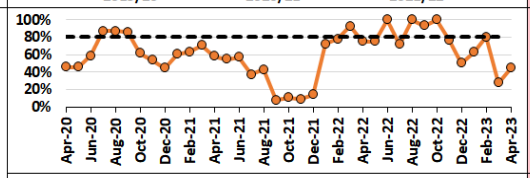
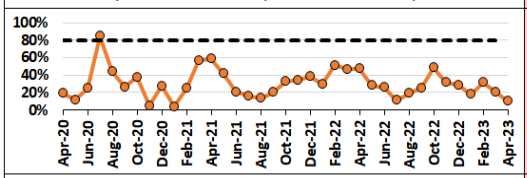
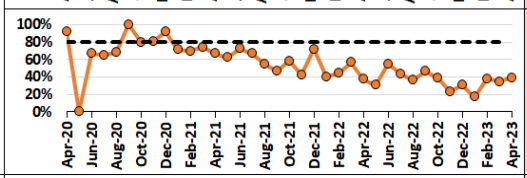
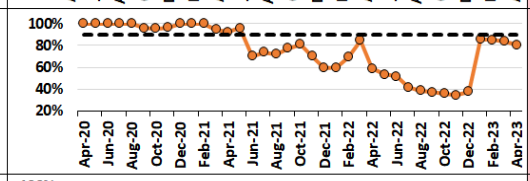
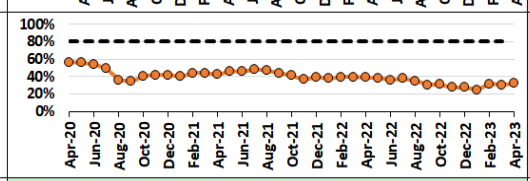
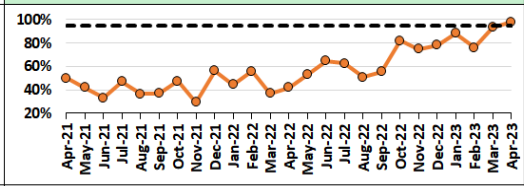
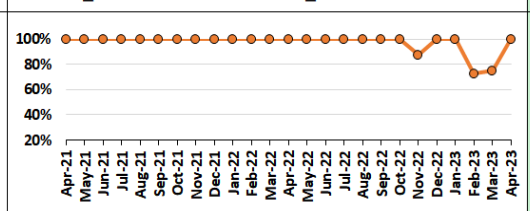
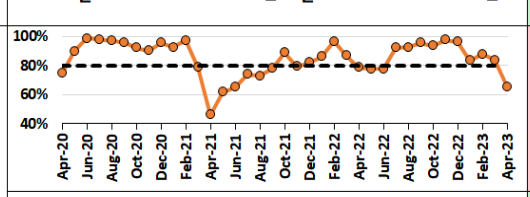
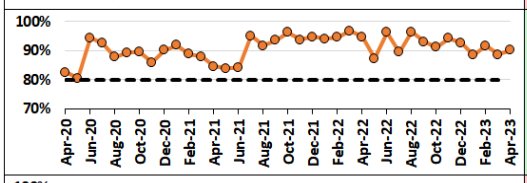
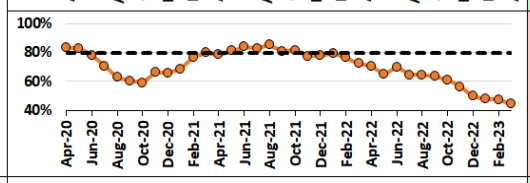
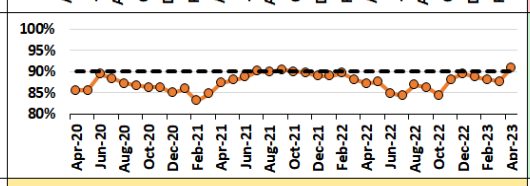
2.1 The UHB's strategic assessment of progress towards delivery of the NHS Wales Quadruple Aim are shown below:

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

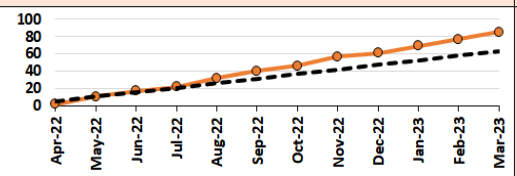
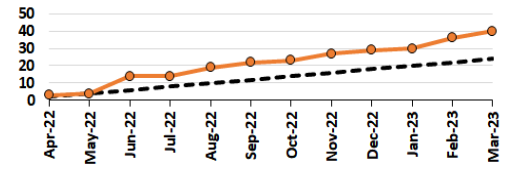
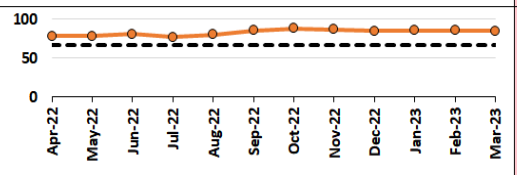
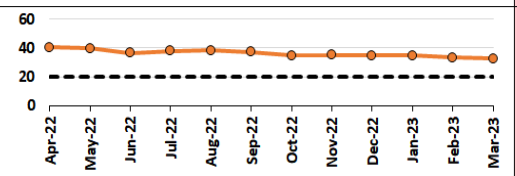
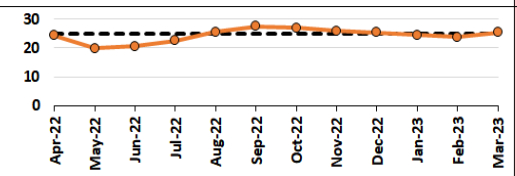
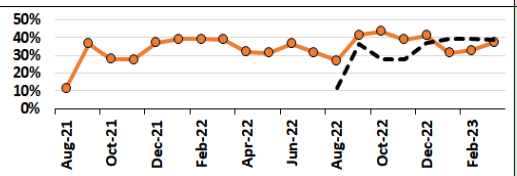
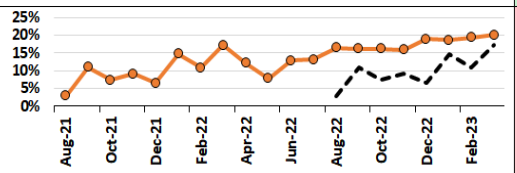
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved / Target Failed — Latest Position	
Primary & Community Care	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	100%		98%	2021/22
	Number of Urgent Primary Care Centres (UPCC) established in each Health Board footprint (i.e. both UPPC models)	As outlined in the Health Board's Six Goals Programme Plan		1	Q3 2022/23
	Number of new patients (children aged under 18 years) accessing NHS dental services	4 Quarter Improvement Trend		3,090	
	Number of new patients (adults aged 18 years and over) accessing NHS dental services			6,085	
	Number of existing patients accessing NHS dental services			31,441	
Urgent & Emergency Care	% of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being completed	90%		91.1%	Mar-23
	Percentage of total conveyances taken to a service other than a Type One Emergency Department	4 Quarter Improvement Trend		1.0%	Q3 2022/23
	Qualitative report detailing progress against the Health Boards' plans to deliver a Same Day Emergency Care Service (12 hours a day, 7 days a week) across all acute sites	7 days a week, 12 hours a day Same Day Emergency Care across 100% of acute sites by April 2025	Majority not on track & improvement needs to be made	N/A	Q2 2022/23
	% of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time	39.5% (SSNAP Quarterly Average)		14.7%	Apr-23
	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	95%		68.9%	May-23
	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge	Zero		1,384	
	Median time from arrival at an emergency department to triage by a clinician	12 month reduction trend		13	
	Median time from arrival at an emergency department to assessment by a senior clinical decision maker	12 month reduction trend		64	
	% of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours	12 month improvement trend		23.0%	Mar-23
	% of stroke patients who receive mechanical thrombectomy	10%		1.5%	Mar-23
	% of emergency responses to red calls arriving within (up to and including) 8 minutes	65%		47.2%	May-23
	Number of ambulance patient handovers over 1 hour	Zero		445	

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

	Performance Measure	Target	*Key:* Trend / Target/Trajectory	Key: Target Achieved / Target Failed — Latest Position	
Patient Flow & Discharge	Number of people admitted as an emergency who remain in an acute or community hospital over 21 days since admission	12 month reduction trend		858	Mar-23
	% of total emergency bed days accrued by people with a length of stay over 21 days	12 month reduction trend		56.6%	
	% of stroke patients that receive at least 45 minutes of speech and language therapy input in 5 out of 7 days	50%		50.7%	
Elective Planned Care	% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of 80% by 2026		48.6%	Apr-23
	Number of patients waiting over 8 weeks for a diagnostic endoscopy	Improvement trajectory towards a national target of zero by March 2026		2,774	May-23
	Number of patients waiting more than 8 weeks for a specified diagnostic	12 month reduction trend towards zero by spring 2024		15,726	
	Number of patients waiting more than 14 weeks for a specified therapy	12 month reduction trend towards zero by spring 2024		1,349	
	Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards eliminating over 52 week waits by June 2023		14,183	
	Number of patients waiting for a follow-up outpatient appointment who are delayed over 100%	National Target of Reduction by March 2024		35,125	
	% of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	95%		65.7%	Apr-23
	Number of patients waiting more than 104 weeks for referral to treatment	Improvement trajectory towards a national target of zero by June 2023		5,567	May-23
	Number of patients waiting more than 36 weeks for treatment	Improvement trajectory towards a national target of zero by 2026		43,685	
	% of patients waiting less than 26 weeks for treatment	Improvement trajectory towards a national target of 95% by 2026		50.5%	

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement					
	Performance Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved / Target Failed — Latest Position	
Mental Health	Rate of hospital admissions with any mention of intentional self-harm for children and young people (age 10-24 years) per 1,000 population	Annual Reduction		4.02	2021/22
	% of patients waiting less than 28 days for a first outpatient appointment for Specialist Child and Adolescent Mental Health Services (sCAMHS)	80%		44.4%	Apr-23
	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age under 18 years)			10.3%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)			39.0%	
	% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for those age under 18 years	90%		80.6%	
	% of children and young people waiting less than 26 weeks to start an ADHD or ASD a neurodevelopment assessment	80%		31.9%	
	Qualitative report detailing progress to develop a whole school approach to CAMHS in reach services	Evidence of Improvement	On track	N/A	Sep 22 - Mar 23
	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital between 09:00 and 21:00 hours that have received a gate-keeping assessment by the CRHT service prior to admission	95%		98.1%	Apr-23
	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital who have not received a gate keeping assessment by the CRHTS that have received a follow up assessment by the CRHTS within 24 hours of admission	100%		100.0%	
	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age 18 years and over)	80%		65.5%	Apr-23
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)			90.2%	
	% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health			44.5%	
	% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for those age 18 years and over	90%		90.9%	
	Qualitative report detailing progress to improve dementia care (providing evidence of learning and development in line with the Good Work – Dementia Learning and Development Framework) and increasing access to timely diagnosis	Evidence of Improvement	Majority on track, but scope to improve	N/A	Sep 22 - Mar 23
Learning Disabilities	Qualitative report detailing progress against the priority areas to improve the lives of people with learning disabilities	Evidence of Improvement	Majority on track, but scope to improve		

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

	Measure	Target	Key: Trend / Target/Trajectory	Key: Target Achieved / Target Failed — Latest Position	
Hospital Infection Control	Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp	58		85	Cumulative Numbers Apr to Mar 2023
	Cumulative number of laboratory confirmed bacteraemia cases: p. aeruginosa	22		40	
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: E.coli	67.00 per 100,000 population		84.92	Cumulative Rate Apr to Mar 2023
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: S.aureus bacteraemia	20.00 per 100,000 population		32.68	
	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: C.difficile	25.00 per 100,000 population		25.34	
	% of confirmed COVID cases within hospital which had a definite hospital onset of COVID	Reduction against the same month in 2021-22		31.1%	Mar-23
	% of confirmed COVID cases within hospital which had a probable hospital onset of COVID	Reduction against the same month in 2021-22		20.1%	

2.2 Access

Detailed analysis is provided in the following section of this report, with headlines from the Access Scorecard provided below:

2.2.1 Urgent Care:

During May, around 69% of patients were treated within 4 hours in our Emergency and Minor Injury Departments, with around 45% of ambulances ready to respond to the next '999' call within 15 minutes of arrival at an ED, which is a notable improvement form the previous month (24.9%).

Additionally, the proportion of patients whose care was "handed over" from the Welsh Ambulance Service within 60 minutes also improved to 82% during May, this equates to the number of patient breaches more than halving from the previous month, bringing the total to 445 this period.

There were 17,532 attendances over the course of the month, 14% more attendances than in the equivalent period last year and a similar increase in the number of attendances observed last month.

2.2.2 Stroke Care:

Overall, compliance against the desired performance standards in stroke care continues to remain at low levels. During April:

- in total there were 68 patients presenting with stroke, which is a 30% reduction on the numbers of patients in the previous month, (noting April's admissions levels were the highest level recorded since July 2018 (97))
- 10 of the 68 stroke patients, 14.7%, were admitted to the stroke units within 4 hours
- 46.4% of patients received a CT scan within an hour of presenting in ED and likewise, 46.4% of stroke patients who required admission were assessed by a stroke specialist within 24 hours.

2.2.3 Planned Care & Cancer Care:

The position at the end of May is shown in the scorecard, noting:

- 14,183 patients have been waiting over a year for a first outpatient attendance (April - 14,317)
- 5,567 patients have been waiting over 2 years for treatment (April - 5,855)
- 15,726 patients have been waiting over 8 weeks for a diagnostic procedure, an almost static position from the previous month (April – 15,727)
- 1,349 patients have been waiting over 14 weeks for therapy (April – 1,173)

- 742 patients have been waiting in excess of 62 days on an urgent suspected cancer pathway (April - 640)

Please note that the following scorecard is in development and trajectory data will be revised in future iterations of this report:

2023/24 National Performance Trajectory

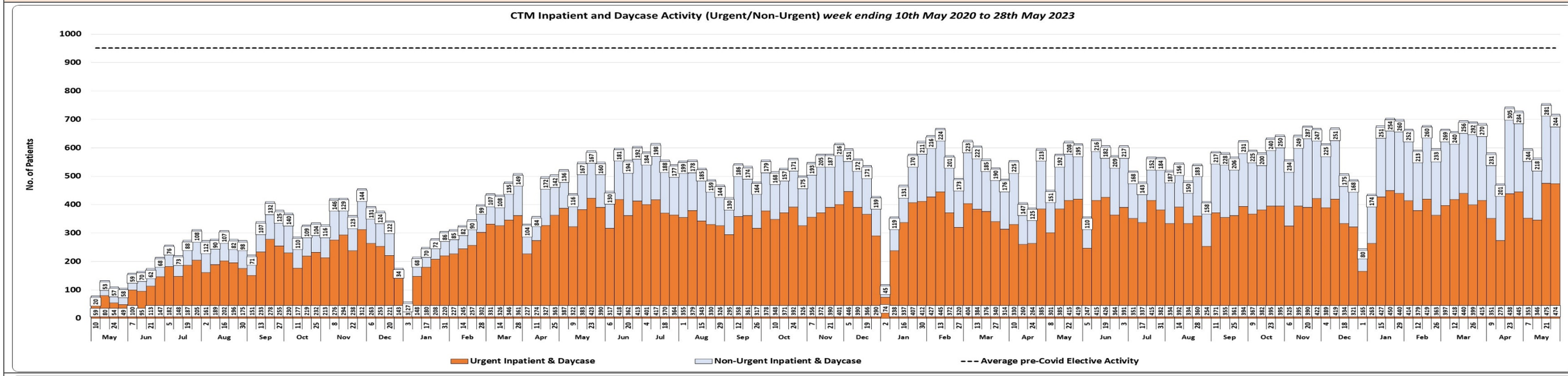
ACCESS TO TIMELY PLANNED CARE

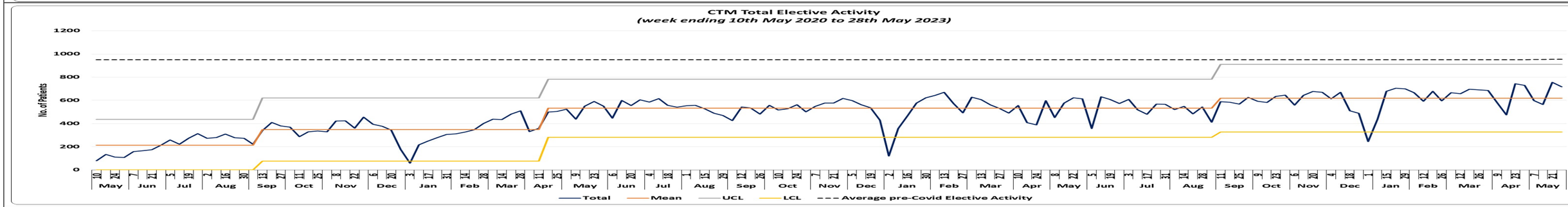
Key: National Target Met | National Target Failed | Trajectory | Actual

Measure	Performance Against Target	Current Period	Trajectory / Actual (Mar 23 – Mar 24)
Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Improvement trajectory towards a national target of reduction by March 2024	1,369	Traj: 1,234 / 1,303 / 1,303 / 1,303 / 1,303 / 1,303 / 1,303 / 1,303 / 1,303 / 1,303 / 1,303 / 1,303 / 1,303 Act: 1,456 / 1,401 / 1,384
Number of patients waiting over 52 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by June 2023	14,467	Traj: 14,017 / 19,704 / 18,010 / 16,317 / 14,475 / 12,628 / 11,271 / 9,974 / 8,699 / 7,424 / 6,247 / 5,199 / 4,187 Act: 14,017 / 14,317 / 14,183
Number of patients waiting more than 36 weeks for a new outpatient appointment	Improvement trajectory towards a national target of zero by March 2024	29,187	Traj: 23,569 / 28,693 / 27,055 / 25,376 / 24,522 / 23,606 / 22,691 / 21,766 / 20,856 / 19,879 / 18,903 / 18,029 / 17,156 Act: 23,569 / 23,741 / 23,318
Number of patients waiting more than 104 weeks for treatment	Improvement trajectory towards a national target of zero by June 2023	6,020	Traj: 6,151 / 6,020 / 5,357 / 5,902 / 5,071 / 4,068 / 3,080 / 2,119 / 1,210 / 413 / 231 / 107 / - Act: 6,151 / 5,855 / 5,567
Number of patients waiting more than 52 weeks for treatment	Improvement trajectory towards a national target of zero by 2025	29,187	Traj: 23,569 / 29,187 / 27,520 / 25,841 / 24,659 / 22,933 / 21,642 / 20,340 / 19,072 / 17,380 / 15,954 / 14,647 / 13,366 Act: 23,569 / 23,741 / 23,318
Number of patients waiting over 8 weeks for a specified diagnostic	Improvement trajectory towards a national target of zero by March 2024	15,724	Act: 15,299 / 15,727 / 15,726
Number of patients waiting over 14 weeks for a specified therapy	Improvement trajectory towards a national target of zero by March 2024	1,185	Traj: 1,145 Act: 1,145 / 1,173 / 1,349
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Improvement trajectory towards a national target of reduction by March 2024	35,795	Traj: 33,208 / 35,795 / 35,625 / 35,455 / 35,285 / 35,115 / 34,945 / 34,775 / 34,605 / 34,435 / 34,265 / 34,095 / 33,925 Act: 33,208 / 35,260 / 35,121
Number of patients waiting more than 62 days for their first definitive cancer treatment from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of reduction by March 2024	640	Traj: 640 / 538 / 529 / 516 / 512 / 511 / 490 / 455 / 450 / 424 / 404 / 396 / 392 Act: 640 / 742
Percentage of patient starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Improvement trajectory towards a national target of reduction by March 2024	49.0%	Traj: 48.4% / 58.3% / 59.0% / 60.3% / 60.9% / 61.3% / 62.8% / 64.8% / 65.4% / 67.2% / 69.1% / 69.6% / 69.8% Act: 48.4% / 48.6%
Number of ambulance patient handovers over 1 hour	Improvement trajectory towards a national target of zero by March 2024	952	Traj: 1,094 / 952 / 397 / - / 255 / 357 / 329 / 407 / 419 / 465 / 390 / 351 / 316 Act: 1,094 / 952 / 445
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	Improvement trajectory towards a national target of zero by March 2024	1,738	Traj: 2,092 / 1,716 / 1,754 / 1,754 / 1,313 / 1,313 / 1,313 / 724 / 724 / 724 / 724 / 724 / 724 Act: 2,092 / 1,676 / 1,384

Cwm Taf Morgannwg – Inpatient / Day Case Activity – to week ending 28th May 2023

Activity Undertaken within Internal Hospital Capacity – Inpatient and Day Case





Greatest Volume Specialties compared to pre & intra Covid

Monthly Elective Treatment Activity compared to pre & intra Covid period						
Specialty	**May-19**	**May-20**	**May-21**	**May-22**	**May-23**	**2023 as % 2019 (pre-Covid)**
Gastroenterology	1064	173	818	889	856	80%
Orthopaedics	464	6	182	266	334	72%
Urology	403	135	299	289	329	82%
Ophthalmology	386		174	232	250	65%
General Surgery	383	13	162	196	238	62%
Gynaecology	255	47	116	150	218	85%
Ear Nose and Throat Service	246	19	108	128	159	65%
Cardiology	116	11	65	79	92	79%
Oral Surgery	78	1	40	52	72	92%
Breast Surgery	45	18	44	54	68	151%
General Medicine	6	3	3	5	45	750%
Anaesthetics	22		2	12	38	173%
Paediatrics	38		18	41		0%
Total	**3506**	**426**	**2031**	**2393**	**2699**	**77%**

How are we doing?

As per the charts above, the number of weekly elective treatments has been gradually increasing, with the average number of elective admissions for May at 659 per week, a 4% increase in the number of cases electively admitted during April.

Since the start of April 2021 to date, CTM have sent 2,810 patients to be treated at Spire and Nuffield Hospitals. Of these patients, 2,080 (on average 80 patients per month) have been treated, as detailed below:

The table above compares the greatest volume specialties of elective activity compared to the average pre & intra Covid levels. Whilst continual improvement in volumes is apparent as a UHB we are delivering only 77% of the volumes that were achieved pre covid. Numerous initiatives to increase both productivity and overall volumes have started to be initiated, and are described overleaf, although some of the larger schemes, such as the interim dervice model for trauma, are not antiicipated to commence until the end of Summer.

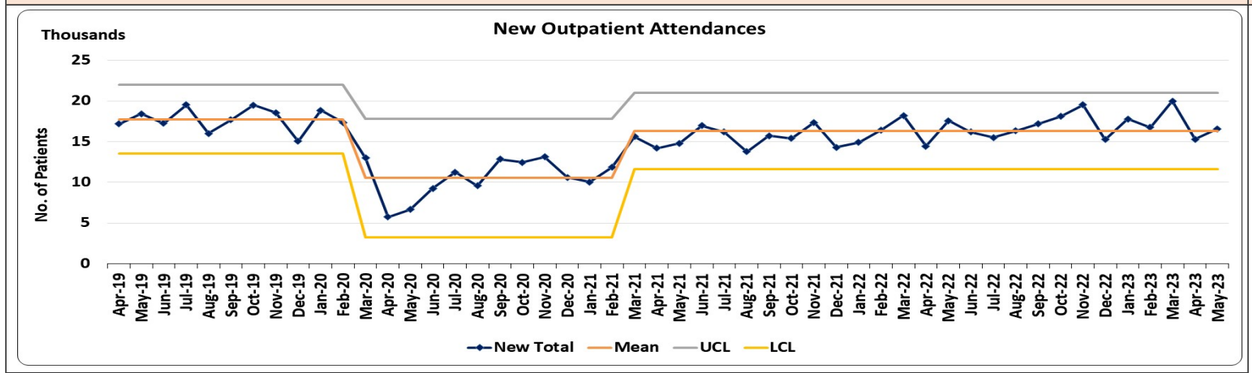
Outsourced Activity as at end of May 2023						
Specialty	Sent to Date	Returned	Treated to Date	Dated	Outpatient Booked	Outstanding
SPIRE - Orthopaedics	1131	157	891	70	13	0
SPIRE - Shoulders	25	10	15	0	0	0

Elective Activity continued on the next page…

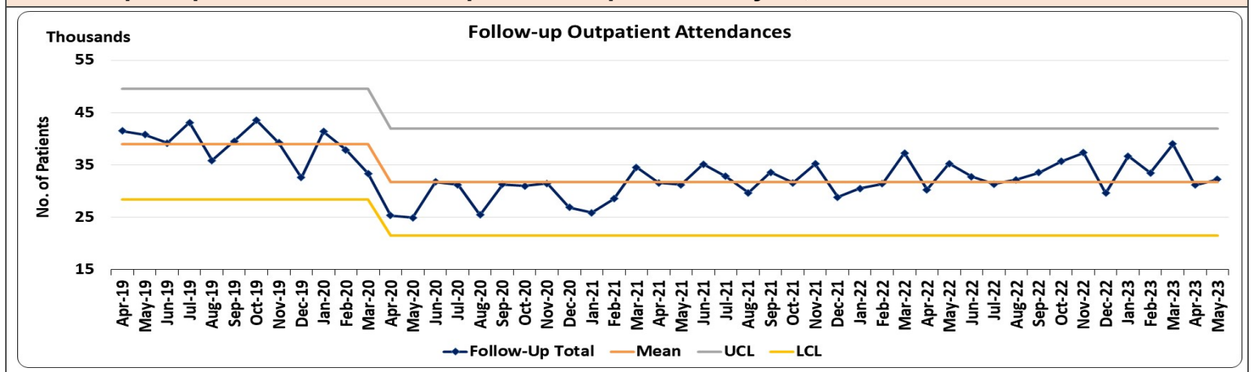
Elective Activity: What actions are we taking & when is improvement anticipated?	What are the main areas of risk?
Ophthalmology: CTM continue to work in partnership with C&VUHB Vanguard Programme to reduce waiting times for patients waiting for a cataract operation. Initial agreement was to send Stage 4 patients only, though since 1st April 2023 the agreement is to send New outpatient appointments referred for cataract surgical opinion. Capacity has been divided between C&V, CTM and AB Health Boards. Although the regional recruitment and funding developments are still being worked through it has been agreed to continue with the regional treatment capacity in UHW Vanguard theatres for Q2. CTM have been allocated a further 498 slots and are required to send a minimum of 83 referrals per week – this is 49% of the available capacity (36% for AB), which is aligned to the regional calculations. **Orthopaedics:** Principle efforts have focused on improving theatre productivity. These efforts have seen theatre activity at PCH increase by 52% over the last 4 months and improved levels of efficiency and a wider case mix of procedures being undertaken at Neath Port Talbot Hospital, including elective overnight arthroplasty surgery. Temporary changes to the trauma model which will greatly increase elective capacity are now being planned. To sustain the improvements, many of which have resulted from staff working overtime, changes to the workforce model are under consideration and a bed plan is being developed to increase elective inpatient bed capacity which should greatly increase productivity and enable backfill opportunities to be realised. Day case availability in PCH is being explored with regular backfill lists focusing on long waiting patients. The SBU disaggregation is likely to favorably impact the long waits with approx. 30% of the waiting list transferring to SBU on 1st July. Protected arthroplasty beds are being considered and the HB is exploring the opportunity for weekend operating once capacity is secured. The interview date for the new Shoulder Surgeon has been planned for August 2023. **Theatre Productivity and Improvement Schemes to Maximise Utilisation: "**6-4-2" scheduling continues with great success and benefit realisation. PCH service leads have introduced this scheduling, allowing the services to understand if any missed opportunities can be improved and learned from. The process continues to improve theatre and in session utilisation. Looking to utilise Text Reminder service for theatres to reduce on the day and late cancellations. At RGH the number of General Surgery, ENT, Urology and colorectal operating sessions being delivered is at or exceeds pre-Covid theatre capacity. **"6-4-2 model - in this process theatre lists start being built at 6 weeks from the day of surgery, lists are signed off at 4 weeks from the day of surgery and at 2 weeks all lists are 'locked down' (subject to only exceptional changes).* The DSU at PCH is now fully operational with the additional support from insourcing theatre team. **General Surgery:** Continuing to utilise all available inpatient and day surgery theatre capacity at POW and Neath Port Talbot hospital and further theatre capacity has been provided by the insourcing team, ID Medical, which provides theatre teams. A 6 month locum consultant has recently been appointed to undertake additional operating sessions. Of the two current consultant vacancies within the Upper GI Service, one has been appointed to on a permanent basis following interviews during June, with the other being covered by a locum appointment. An additional locum surgeon has been appointed to work as an emergency surgeon and this will increase activity lost due to the consultant on-call and will enable further improvement in backlog reduction.. **ENT:** Funding of the ENT service plan which will deliver the ministerial priorities for 2023/24 has recently been agreed and is in the process of being actioned. **OMFS (Oral Maxillofacial Surgery):** Interviews for the Consultant Endodontic Specialist post are scheduled for the 16th June. A paper to support a 2nd Restorative consultant has been submitted to board. **Inpatient Bed capacity: A** weekly task and finish group has been initiated to re-open Ward 16 in Princess of Wales Hospital as a 16 bedded surgical unit.	The organisational change process has the potential to disrupt delivery as the service is heavily dependent upon the goodwill of numerous staff to ensure opportunities to increase activity can be taken. There is insufficient bed capacity for elective work in order to run services efficiently and at levels comparative with national guidance. Currently POW only has 9 beds identified for elective care., There are no ring-fenced inpatient beds at this time due to the challenges with flow across the system and the level of clinical risk this is causing within our ED's and Assessment Units. The lack of ring-fenced capacity continues to impact on productivity and efficiencies through DSU. In partial mitigation, all inpatient cases start off within DSU footprint and are then transferred to available inpatient bed post-operatively; a pathway that this has reduced, but not eliminated cancellations. The ongoing requirement to work with 2 different PAS systems within CTM is inefficient and poses the potential for patients to be removed from one system and not added to another. **Risks relating to Day case and Theatres:** Limited recovery space at POW to support low risk, high volume day case activity, though this may be mitigated with the opening of ward 16. Limited options to relocate diagnostic pathways from PCH DSU due to restricted treatment/recovery space. Previous funding has been frozen due to slow recruitment into vacant positions. A high number of vacancies remain across Theatre Practitioner groups, limiting ability to increase current scheduled activity. The UHB continues to use high levels of overtime to cover existing planned activity. The service is unable to recruit ODP's outside of annual streamlining recruitment every September, which presents timing constraints on programme budgeting decisions. New workforce model still awaiting approval and funding to enable theatres to be fully staffed at PCH, overarching CTM Business Case being updated to include POW and RGH. Insourcing team still in situ. **Ophthalmology:** Many of the current and long term issues stem from across site working and historical ways of working. Working with 2 different PAS systems within CTM continues to cause issues. Room space continues to be a problem across all 4 sites within CTM UHB. There remains a consultant vacancy with interviews planned for June. This will be a full time post working across the Health Board, specialising in cornea. Due to patients waiting longer than they did pre-pandemic, cataracts are more complex so in some cases restricting numbers on lists. 90% of cataract lists across the Health Board are teaching lists and this is reflected in numbers on the list. Ongoing vacancies, including a glaucoma practitioner. The optometry lead is leaving in June, this will impact on the glaucoma clinics. **General Surgery:** -Limited theatre capacity for upper GI surgery. - Limited laparoscopic equipment for certain procedures in NPTH resulting in patients being treated out of turn. -Limited consultant capacity for specialist upper limb surgery. -Disproportionate number of higher ASA grade patients on the waiting lists to acute capacity. - Significant issues with pre-operative assessment (POA) capacity that has delayed surgery for a number of long waiting patients. - Limited capacity for elective theatre lists - Pre-assessment capacity in RGH is an ongoing; barrier to moving patients through to surgery

Cwm Taf Morgannwg – Outpatient Attendances and Waiting Times – May 2023

New Outpatient Attendances May 2023 – provisionally 16,564 attendances



Follow-up Outpatient Attendances April 2023 – provisionally 32,227 attendances



Number of patients who have waited over 104 weeks for New Outpatient Appointment at end of May 2023 – 1,240

Specialty	31/03/2023	30/04/2023	Provisional Status at 31/05/2023	Improvement from the previous month
Ophthalmology	218	224	279	55
Urology	533	373	261	-112
Dermatology	176	202	164	-38
General Medicine	64	70	86	16
Breast Surgery	53	54	64	10
Rheumatology	27	26	30	4
Ear, Nose & Throat Service	270	132	23	-109
Gastroenterology	25	32	17	-15
Restorative Dentistry		1	9	8
Trauma & Orthopaedics	5	16	5	-11
Oral Surgery	1	2	4	2
Colorectal		2	3	1
General Surgery	68	22	3	-19
Cardiology	4	3	2	-1
Total	**1444**	**1159**	**950**	**-209**

How are we doing?

As at the end of May 2023, there were 69,950 patients awaiting a new outpatient appointment, of which, 17,434 (25%) patients were categorised as urgent and 10,795 (15%) were ophthalmic patients who are prioritised to alternative clinical triage criteria. The total waiting list volume represents an increase of around 1% (559) on the 69,391 patients waiting at the end of the equivalent period last year.

WG had set a target of having no patients waiting over 104 weeks for a first outpatient appointment at the end of March 2023. As it currently stands, at the end of May there were 950 patients (14.5% less than in March) who have waited in excess of two years for a new outpatient appointment, as detailed in the table top right.

What actions are we taking & when is improvement anticipated?

The following actions are being taken to eliminate waits of >104 weeks:

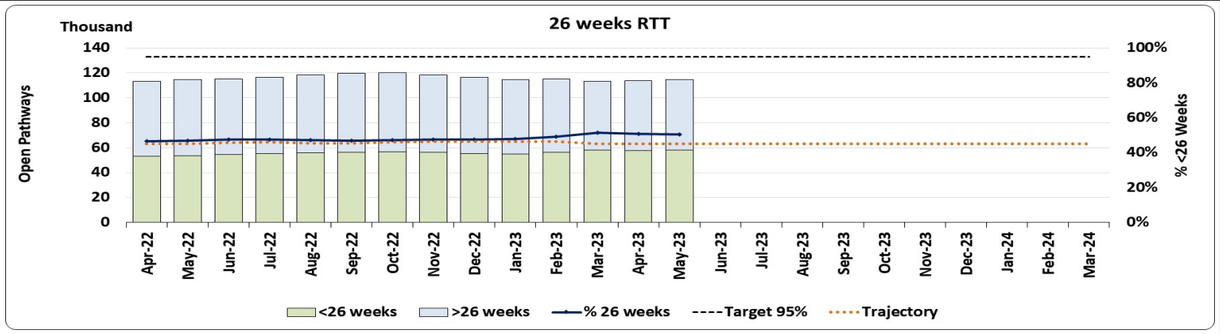
- **Outpatient utilisation and improvement programme**: initiated, focusing on clinic utilisation booking processes, standardisation & reduction of DNA's. Partial booking of all new appointments continue at PCH.
- **Prioritisation exercise**: underway to review the realised benefits of recovery schemes to inform the allocation of PCR funds for the next financial year.
- **Use of WISE for Pain Management patients**: CTM's Wellness Improvement Service (WISE) is now established as the initial intervention for Pain Management, Stage 1 referrals and for any patient coming back to us requiring treatment (Stage 4), we have set up additional backfill pain lists. Of the first cohort of 366 offered assessment, 39% (142) chose to be off-listed and the remainder (224) underwent assessment and enrolment to Wise. Next cohort of patients waiting 52 weeks and over sent. Further bid being developed to support Stage 4 and potential conversion from Stage 1.
- **Super Saturday Clinics**: reviewed across all Specialties and already undertaken in Oral Maxillofacial Surgery and Cardiology; continue to run with maximum planned activity. Conversion rates continue to be monitored.
- **Health Board wide Waiting Lists**: weekly performance meetings on a specialty, rather than locality level, allowing for whole HB focus on waiting list performance. Addressing inequity across sites e.g. General Surgery patients being transferred from RGH to PCH who have a higher rate of virtual appointments.
- **LGI:** Clerical and Clinical validation as a live weekly process. CTM wide FIT process to agree go live date.
- **Text Reminder:** Text Reminder and Broadcast Messenger gone live for Endoscopy; showing great success – the service will monitor DNA rates over the next few months. Looking to roll out same service for Pre-Assessment and Theatres to reduce on the day and late cancellations due to patient choice or unwell.
- **Urology:** Continuing to offer WLI's to reduce the patients waiting >104 for a urology appointment, though there appears to be very little uptake from a nursing perspective to support the additional activity during the week or weekend.
- **General Surgery**: The appointment of a locum consultant has allowed the service to significantly reduce the stage 1 wait over the previous 2 months, with the anticipation to be clear of 52 weeks by September 23. Currently working with the consultant body to train registrars to see new patients in clinic alongside the consultant for routine hernia cases to reduce the backlog.
- **Orthopaedics**: Ongoing validating with the appointment of a waiting list validator. Anticipated reduction in stage 1 by 30% with the SBU disaggregation.
- **ENT** continues to make sustained progress to reduce the backlog of patients waiting for a 1st OPA appointment and patients waiting over 104+ weeks will be clear by the end of June
- **Oral Surgery** Awaiting confirmation on WLI clinics offered out to the teams. The OMFS consultants have increased clinic capacity by 4 new patients. 12 restorative patients @ 104 weeks will be booked before the end of August. One clinic will be moved from UHW to PCH to support Oncology patients.

What are the main areas of risk?

- Those specialties with a high Urgent Suspected Cancer referral rate have highlighted that the capacity for referrals prioritised as routine will continue to experience long waits whilst the backlog is addressed
- **Ophthalmology -** Non-continuation of high volume outsourcing in the interim of the regional Programme. Recurrent demand outweighs capacity.
- **Urology -** Cancer demand is greater than core clinical capacity.
- **Breast -** Progress continues to be affected by capacity being prioritised for cancer provision. However, a plan has been submitted with approval pending to reduce the RTT cohort with up to 80 additional slots to support clearance of 104+ by end of June 23
- **Colorectal and General Surgery -** Limited outpatient capacity for the locum consultant.
- **Orthopaedics** – Upper limb deficit in D&C due to only having one surgeon in POW. Interviews for a consultant orthopaedic surgeon with an interest in Shoulders are taking place in June.

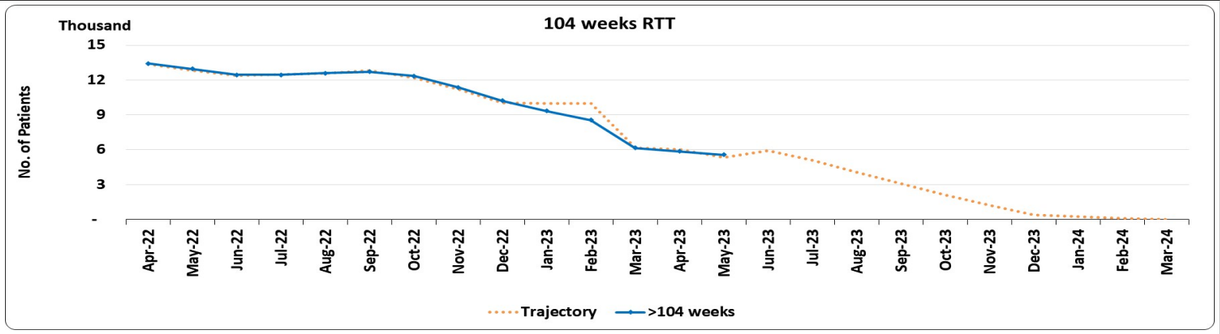
Referral to Treatment Times (RTT) – May 2023 (Provisional Position) – Total Open Pathways 114,768

% of patients waiting less than **26 weeks RTT (50.5%)** – Target is Improvement Trajectory towards a national target of 95% by 2026



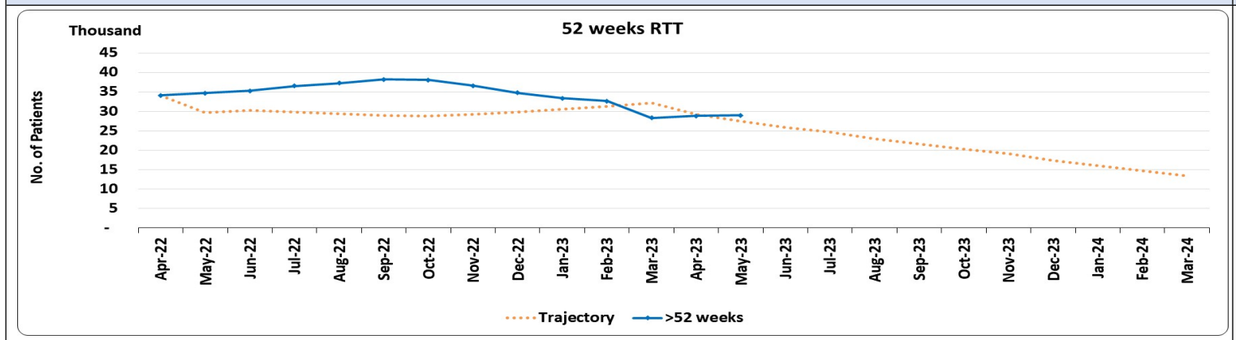
The 26 week position performance for May across Cwm Taf Morgannwg is 50.5%. Given the long waiting times, this statistic should be considered more as an indicator of our ability to treat in turn and our urgency rates, as opposed to a definitive indicator of progress in improving access.

Number of patients waiting **>104 weeks (5,567)** - Target is Improvement Trajectory towards a national target of Zero by June 2023



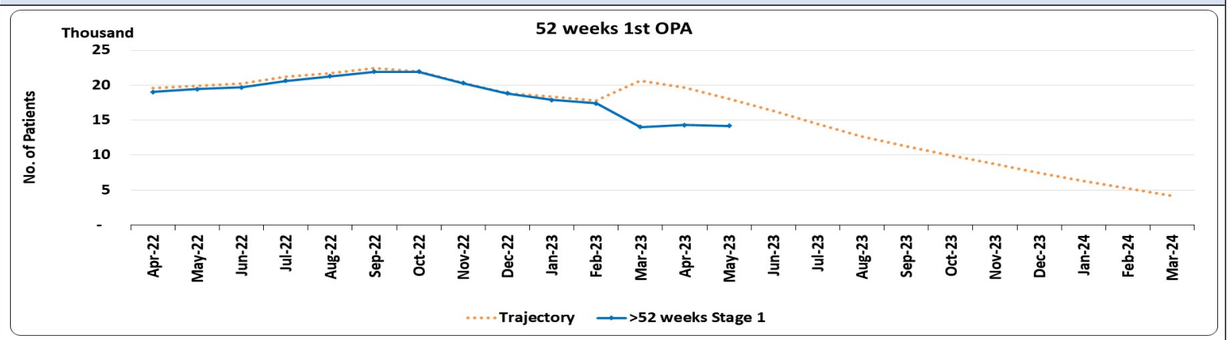
The provisional position across Cwm Taf Morgannwg for patients waiting over 104 weeks for referral to treatment at the end of May is 5,567, a reduction of 4.9% (288) from the reported April position.

Number of patients waiting **>52 weeks RTT** (**29,006)** – Target is Improvement Trajectory towards a national target of Zero by March 2025



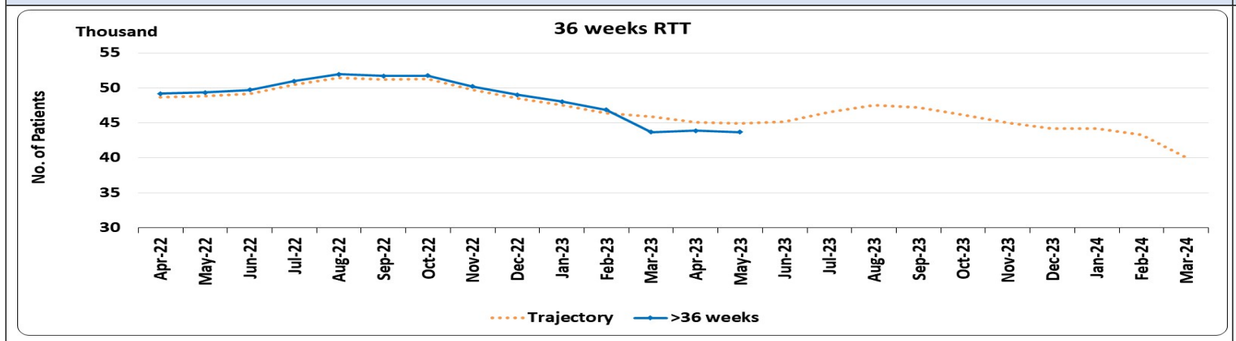
The provisional position across the Health Board for patients waiting over 52 weeks for referral to treatment at the end of May is 29,006, an increase of 0.5% (154) from the April reported position

Number of patients waiting **over 52 weeks** for a **new outpatient appointment (14,183)** - Target is Improvement Trajectory towards eliminating over 52 week waits by June 2023



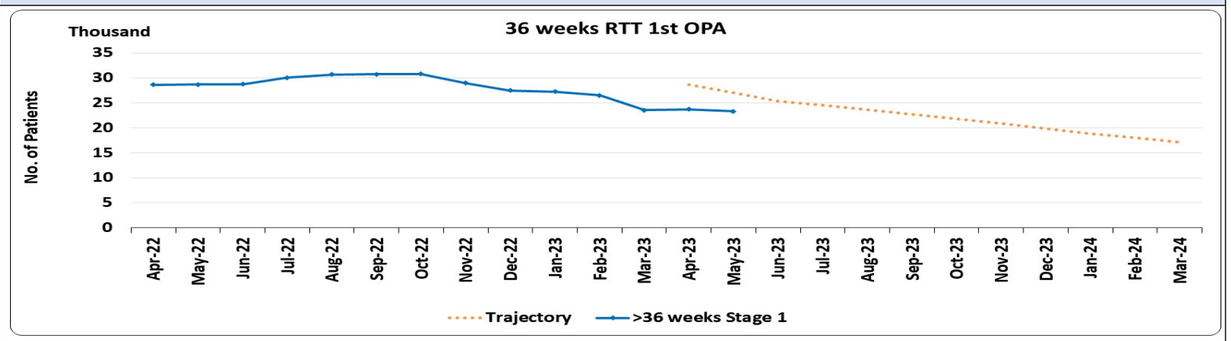
The provisional position across the Health Board for patients waiting over 52 weeks at Stage 1 (1st Outpatient Appointment) at the end of May is 14,183, a reduction of 0.9% (134) from the April reported position. The variance from the trajectory is explained by the large number of urgent patients still waiting more than 4 weeks for an appointment.

Number of patients waiting **>36 weeks RTT (43,685)** Target – Improvement Trajectory towards a national target of Zero by March 2026



The number of patients waiting over 36 weeks at the end of May, across Cwm Taf Morgannwg, is a provisional position of 43,685 patients, which is a reduction of 0.5% (199) from April (N.B. includes the 29,006 patients waiting over 52 weeks).

Number of patients waiting **over 36 weeks** for a **new outpatient appointment (23,318)** - Target is Improvement Trajectory towards eliminating over 36 week waits by March 2024



The provisional position across the Health Board for patients waiting over 36 weeks at Stage 1 (1st Outpatient Appointment) at the end of May is 23,318, which as it currently stands is a reduction of 1.8% (423) from the April reported position. (N.B. includes the 14,183 Stage 1 patients waiting over 52 weeks).

RTT continued on the next page…

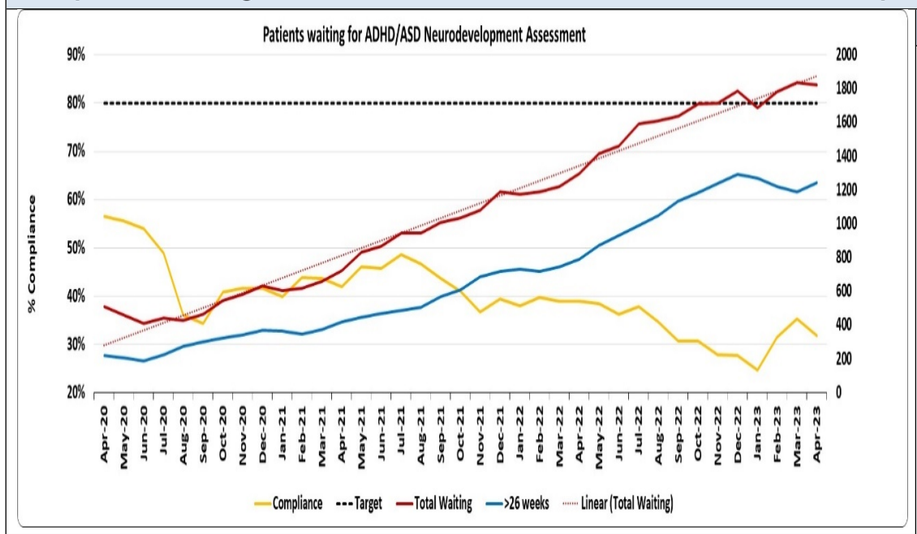
Cont'd…Referral to Treatment Times (RTT) – May 2023 (provisional position)

Total number of open pathways per specialty - May 2023 (provisional)

Specialty	Number of Urgent Patients Waiting >12 Weeks	26 Weeks Compliance	>26 to 36 Weeks	>36 to 52 Weeks	>52 Weeks to 104 Weeks	>104 Weeks to 156 Weeks	>156 Weeks	Total Open Pathways
Anaesthetics	172	39.4%	142	224	232	54	19	1108
Cardiology	808	67.1%	756	643	235	23	9	5064
Care of the Elderly	1	100.0%	0	0	0	0	0	47
Dermatology	1486	52.2%	833	1183	1429	119	54	7568
Endocrinology	5	66.9%	67	53	0	0	0	362
Gastroenterology	1048	57.7%	455	522	607	60	15	3921
General Medicine	443	63.0%	339	351	261	84	3	2803
Nephrology	20	91.0%	15	0	0	0	0	166
Respiratory Medicine	88	70.7%	200	208	177	22	0	2074
Rheumatology	315	60.3%	200	185	193	78	21	1704
Sport and Exercise Medicine		100.0%	0	0	0	0	0	8
Thoracic Medicine	20	80.1%	72	46	16	0	0	674
Geriatric Medicine	1	100.0%	0	0	0	0	0	36
Diagnostics		52.5%	1003	932	1991	545	8	9439
Therapies		76.4%	253	283	57	3	0	2524
Ophthalmology	415	42.8%	1492	1951	4206	437	37	14211
Oral Surgery	658	58.0%	575	413	311	53	9	3243
Orthodontics	64	78.0%	38	25	2	0	0	296
Restorative Dentistry	26	34.2%	23	12	60	9	0	158
Ear, Nose & Throat Service	759	44.4%	1214	1471	3502	370	332	12397
Gynaecology	958	55.1%	1060	1040	1106	265	268	8320
Paediatrics	157	79.7%	357	179	18	0	0	2730
Haematology (Clinical)	12	91.1%	21	0	0	0	0	237
General Surgery	691	43.4%	1006	1160	2393	384	163	9019
Orthopaedics	1922	38.8%	1592	2267	3693	703	272	13939
Urology	942	44.9%	740	789	1814	606	273	7660
Breast Surgery	380	45.9%	163	178	330	88	4	1411
Colorectal	649	45.1%	457	564	806	142	35	3649
Total	**12040**	**50.5%**	**13073**	**14679**	**23439**	**4045**	**1522**	**114768**

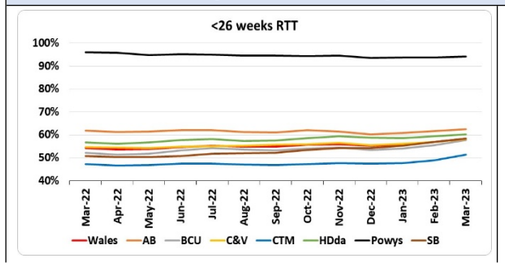
How are we doing?	What actions are we taking & when is improvement anticipated?	What are the main areas of risk?
General Surgery: 37 patients awaiting over 156 weeks, 108 patients waiting over 104 weeks and 494 waiting over 52 weeks. Maximising all planned theatre lists to clear stage 4, >156 and >104 weeks. Increased backfill plus weekend working to target inpatient cases. **Orthopaedics:** 180 patients currently waiting over 156 weeks, 187 waiting over 104 weeks and 965 patients waiting over 52 weeks.	**General Surgery:** Validation of the waiting list is ongoing. The appointment of a locum consultant has increased operating and outpatient capacity. Working with colleagues in diagnostics to support the stage 2 waiting list to get a definitive plan for patients. **Orthopaedics:** Ongoing waiting list validating with the appointment of a waiting list validator resulting in significant improvements at stages 2 and 3. Increasing inpatient activity by utilising other HB sites. Securing a ring fenced elective arthroplasty ward to allow the increase in arthroplasty surgery in POW and potentially weekend operating. Anticipated for July/August.	There are sizeable backlogs of urgent patients which will impact on how quickly efforts to reduce the routine backlog. The trajectories assumes that these will be cleared prior to the routines, and as such comparison with the trajectories may be misleading. Ophthalmology, Breast and Orthopaedics remain areas of risk from a pure volume perspective. **General Surgery:** Limited operating capacity. Limited capacity in POW. Significant delays to diagnostics with some areas not seeing routine patients. **Orthopaedics:** Limited inpatient capacity. Limited on theatre capacity. High number of ASA 3 and 4 patients on the T&O waiting list needing admission to an acute site with increased LoS.

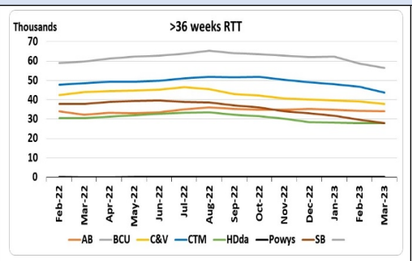
% of patients waiting less than 26 weeks to start an ADHD/ASD Neurodevelopment Assessment (31.9%) -Target 80%

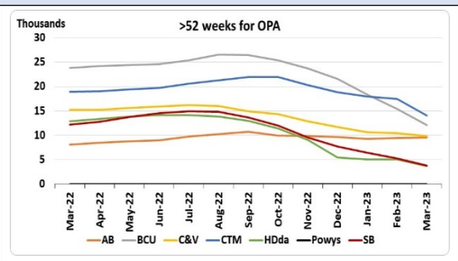


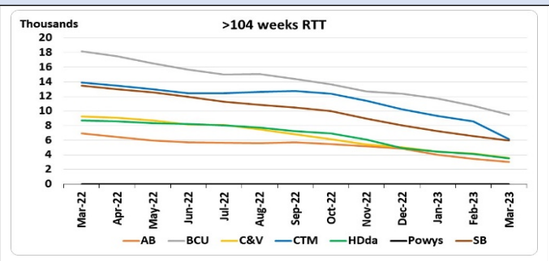
How are we doing?	What actions are we taking & when is improvement anticipated?	What are the risks?
Although a minor improvement in performance from February 2023 is observed, the chart to the left highlights that there has been a significant deterioration in the compliance over the last three years against the 26 week target for Neurodevelopment services, with compliance at 31.9% for April and continuing to remain well below the target threshold of 80%. Short term funding has meant that we have been able to deliver WLIs so that no children will be waiting >104 weeks for an assessment. Currently there are 688 patients to be seen before end of March 2024 before reaching 104 weeks. Core capacity will provide 320 and the remainder will need to be seen via WLI to prevent 104 week breach by end of March.	Children & Families are looking to utilise the £100k ND IP resource for waiting list reduction. The ND improvement programme is looking at service redesign, spanning early intervention, assessment, education and transition. Recognising the complexities in order to reach across the different partners and communities across the health board. In addition, scoping work is being progressed to assess the demand, capacity and design of ND services.	Demand outstrips capacity. A better understanding is needed of what is currently offered by the third sector and wider community services and what gaps exist. Resource constraints on multidisciplinary provision that lead to assessment outcomes. Identifying constraints that are impacting on the ability to deliver timely services. Reliance on short term funding does not provide a longer term solution, hence services are being reviewed with partners

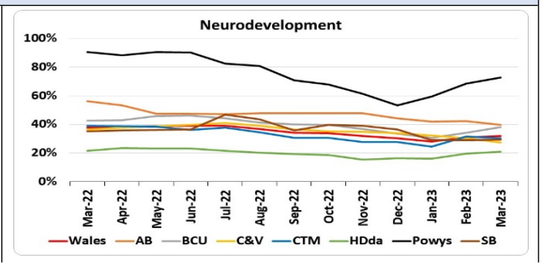
How do we compare with our peers?











Status as at March 2023		
Health Board	Compliance	Rank
Powys	94.3%	1st
AB	62.5%	2nd
HDda	60.2%	3rd
SB	58.4%	4th
C&V	58.2%	5th
BCU	57.9%	6th
CTM	**51.3%**	**7th**

Status as at March 2023		
Health Board	Compliance	Rank
Powys	110	1st
HDda	27,973	2nd
SB	27,977	3rd
AB	33,997	4th
C&V	37,897	5th
CTM	**43,674**	**6th**
BCU	56,339	7th

Status as at March 2023		
Health Board	Compliance	Rank
Powys	1	1st
HDda	3,715	2nd
SB	3,751	3rd
AB	9,552	4th
C&V	9,799	5th
BCU	12,090	6th
CTM	**14,017**	**7th**

Status as at March 2023		
Health Board	Compliance	Rank
Powys	0	1st
AB	3,030	2nd
HDda	3,495	3rd
C&V	3,601	4th
SB	5,934	5th
CTM	**6,151**	**6th**
BCU	9,515	7th

Status as at March 2023		
Health Board	Compliance	Rank
Powys	72.7%	1st
AB	39.7%	2nd
BCU	38.2%	3rd
CTM	**30.4%**	**4th**
SB	29.5%	5th
C&V	27.3%	6th
HDda	20.9%	7th

Diagnostics & Therapies – May 2023 (Provisional Position)

Number of patients waiting >8 weeks for Diagnostics

Target - 12 month reduction trend towards Zero by spring 2024

Total >8 weeks 15,726

CTMUHB - Number of Patients waiting more than 8 Weeks for a Diagnostic Test		
Cardiology	Echo Cardiogram	640
Cardiology Services	Cardiac CT	2
	Cardiac MRI	7
	Diagnostic Angiography	83
	Stress Test	41
	DSE	49
	TOE	4
	Heart Rhythm Recording	124
	B.P. Monitoring	1
Bronchoscopy		5
Colonoscopy		615
Gastroscopy		734
Cystoscopy		645
Flexi Sig		775
Radiology	Non-Cardiac CT	671
	Non Cardiac MRI	1631
	NOUS	8908
	Non-Cardiac Nuclear	60
Imaging	Fluoroscopy	83
Physiological Measurement	Urodynamics	117
Neurophysiology	EMG	240
	NCS	291
Total		15726

Diagnostics	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	15,437	15,579	15,363	15,080	15,315	15,570	15,547	15,651	15,886	16,114	15,294	15,299
2023/24	15,727	15,726										

Number of patients waiting >14 weeks for Therapies

Target - 12 month reduction trend towards Zero by spring 2024

Total >14 weeks 1,349

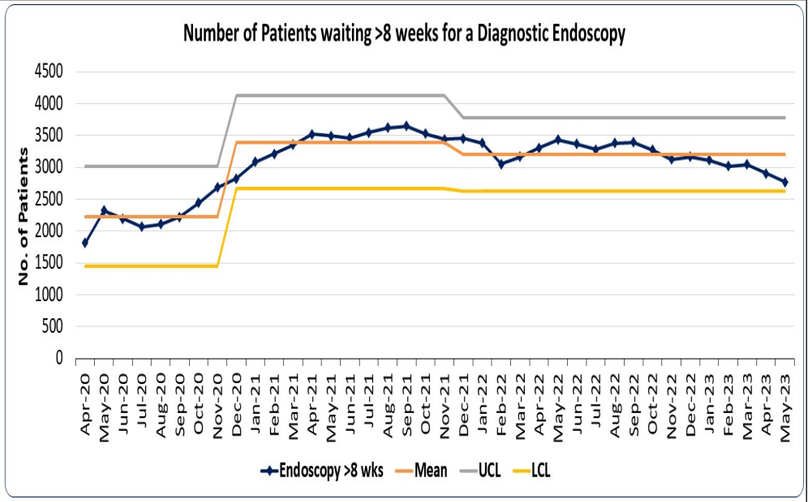
CTMUHB - Number of Patients waiting more than 14 Weeks for a Therapy	
Arts Therapy	1
Audiology	5
Dietetics	1130
Occupational Therapy	37
Physiotherapy	1
Podiatry	0
Speech & Language	175
Total	1349

Therapies	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	1,019	1,370	1,265	1,570	1,795	1,589	1,615	1,452	1,474	1,284	1,175	1,145
2023/24	1,173	1,349										

Number of patients waiting >8 weeks for Diagnostic Endoscopy

Target - Improvement Trajectory towards target of Zero by March

Total >8 weeks 2,774



How are we doing?

Diagnostics: At the end of May, 15,726 patients had been waiting in excess of 8 weeks for a diagnostic procedure, which as it currently stands is an almost static position on the number of patients waiting over 8 weeks that was reported at the end of April.

Endoscopy observed a further improvement of 4.4% in the number patients waiting in excess of eight weeks (128 patients) although the number of patients currently breaching the target now stands at 2,774.

The NOUS service continues to have the highest volume of breaching patients with 8,908 currently waiting over 8 weeks for a scan, which is an increase of 2.4% (207) patients on the reported position for April.

Therapies: There are provisionally 1,349 patients breaching the 14 week target for therapies in May, an increase of 15% (176 patients) on the reported position for April.

The Dietetic service accounts for almost 84% of the total patients waiting beyond the 14 week target for therapies.

What actions are we taking & when is improvement anticipated?

Endoscopy: Transformation Programme commenced across CTM looking at new ways of working around scheduling, productivity and efficiencies.

Electronic partial booking and text reminder service gone live with good success. The “6-4-2” model agreed and we await a “go live” date.

Weekly Task and Finish Group rolled out with key stakeholders to set priorities, actions and monitor delivery. Standardised templates commenced at PCH to be rolled out across CTM.

Bowel Screening Wales recovery plan drafted with recovery schemes, planned activity, timeframes and financial risks.

Radiology: Planned care recovery actions in place.

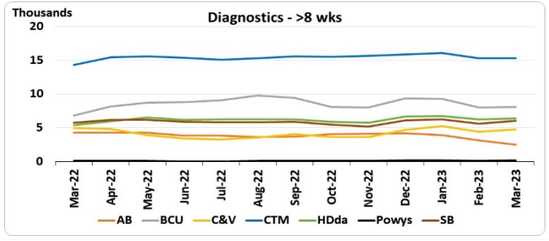
Booking through end of may and into June to additional weekends and evening for Ultrasound scanning. Trajectory discussed and agreed with team and will start seeing a steady reduction in the patients waiting over 8 weeks going forward.

Trajectories for CT and MR also reviewed and will be looking to set in place plans to potentially use more capacity on weekends after summer period.

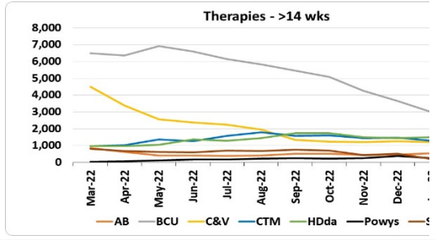
What are the main areas of risk?

- Demand and Capacity imbalance shown in most diagnostic and therapy services as demand has risen. Also CT likely to rise further with new BSW protocols for earlier screening for younger patients.
- Current sickness and vacancies within the administration teams and amongst Ultrasonographers, is reducing throughput volumes, exacerbated by a lack of Band 2 and Band 3, HCA support staff.
- Diagnostic services continue to hold a number of Consultant vacancies and remain unable to recruit.
- Endoscopy Competing Priorities – faces challenges with competing priorities with the service trying to deliver and maintain the cancer pathway, accommodate longest waiters for delivery of the RTT targets 156 & 104 weeks, hit the 8 week diagnostic target whilst reducing the backlog of overdue surveillance patients.
- Neurophysiology Services – following a recent reduction in the availability of Neurology services in CTM, capacity for Nerve Conduction Studies has been significantly reduced. This will have a direct impact on delivery for the Orthopaedic targets going forward.
- Cardio Pulmonary Service – Backlogs in CPU will continue to directly impact on the delivery of Cardiology targets.

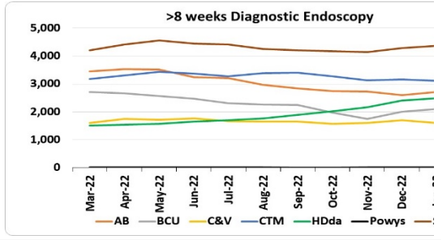
How do we compare with our peers?



Status as at March 2023		
Health Board	Compliance	Rank
Powys	132	1st
AB	3,146	2nd
C&V	4,421	3rd
SB	5,645	4th
HDda	6,226	5th
BCU	8,057	6th
CTM	**15,294**	**7th**



Status as at March 2023		
Health Board	Compliance	Rank
Powys	190	1st
SB	193	2nd
AB	521	3rd
C&V	953	4th
CTM	**1,145**	**5th**
HDda	1,895	6th
BCU	2,192	7th



Status as at March 2023		
Health Board	Compliance	Rank
Powys	11	1st
C&V	1,563	2nd
AB	2,061	3rd
BCU	2,098	4th
HDda	2,302	5th
CTM	**3,048**	**6th**
SB	4,554	7th

Follow-up Outpatients Not Booked (FUNB) – Provisional Position May 2023

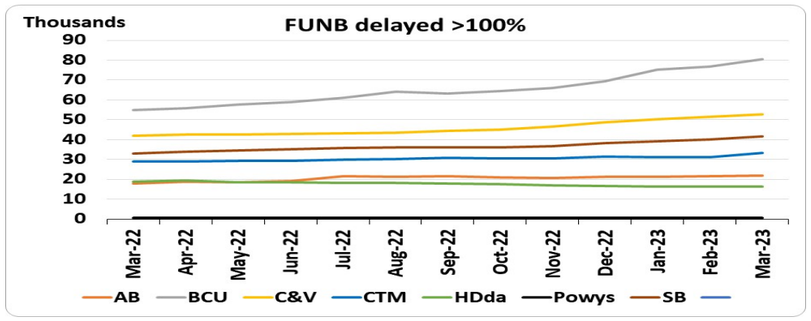
Number of patients waiting for a Follow-up with documented target date

No. of patients waiting for follow-up appointment			
No documented target date	Not Booked	Booked	Total
0	80,504	52,541	133,045

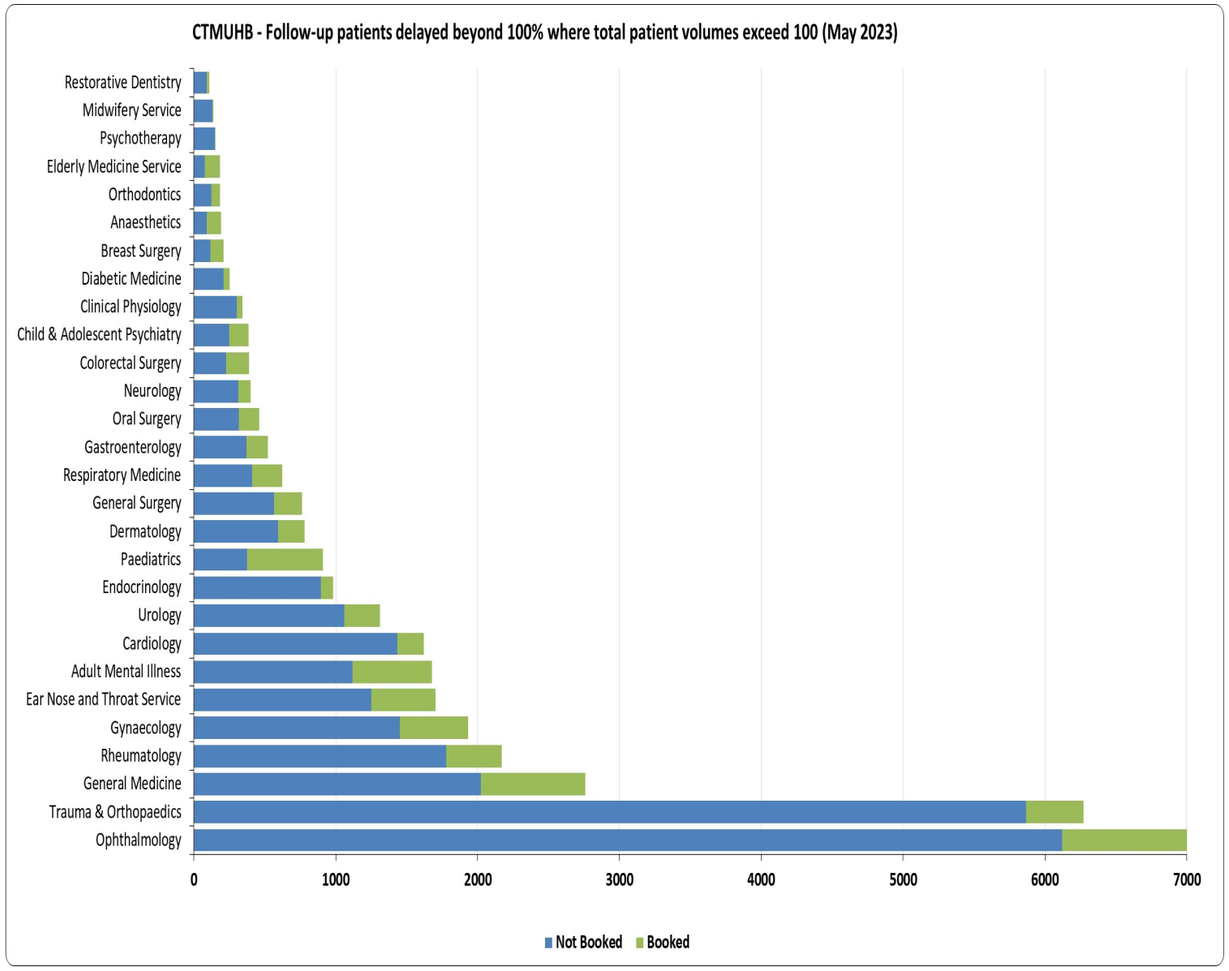
Number of patients waiting for a Follow-up delayed over 100% - Target: Improvement trajectory towards a national target of reduction by March 2024

No. of patients delayed over 100% past their target date			
Not Booked	Booked	Total	% of all follow-up appoints delayed by 100%
27,963	7,162	35,125	26.4%

How do we compare with our peers?



Status as at March 20	
Health Board	Compliance
Powys	602
HDda	16,207
AB	21,871
CTM	**33,208**
SB	41,710
C&V	52,742
BCU	80,322



How are we doing?

The number of patients waiting for a follow-up appointment in Cwm Taf Morgannwg UHB, at the end of May 2023, provisionally stands at 133,045, which is an increase of 23% on the patients waiting during the equivalent period of 2022. There are currently no patients without a documented target date

Of the patients waiting, 35,125 (around 26%) have been waiting more than 100% longer than their clinician advised, representing an increase of 20% on the equivalent period last year.

Combined outpatient activity levels during May 2023 continue to be below pre-Covid levels (around 17% fewer) and 8% lower than equivalent period of 2022 (the three bank holidays during May will have an impact on activity levels), with the provisional May figures below for new and follow-up patients compared to prior the pandemic:

- Total New Patients seen: 16,564; which is a reduction of around 9% on the Pre-Covid average (19/20) of 18,186.
- Total Follow-up Patients seen: 32,227; around a 20% reduction on the Pre-Covid average (19/20) of 40,500.

What actions are we taking & when is improvement anticipated?

General Surgery: Ongoing validating of the FUNB list with regular consultant input. Return to normal capacity for follow up appointments.

Orthopaedics: Ongoing consultant validating of their FUNB list as significant numbers are not anticipated to require a follow up appointment. Booking of all follow ups into clinics to reduce the FUNB holding list, utilising any spare capacity. Utilise any surplus capacity from the SBU disaggregation to reduce FUNB in the interim.

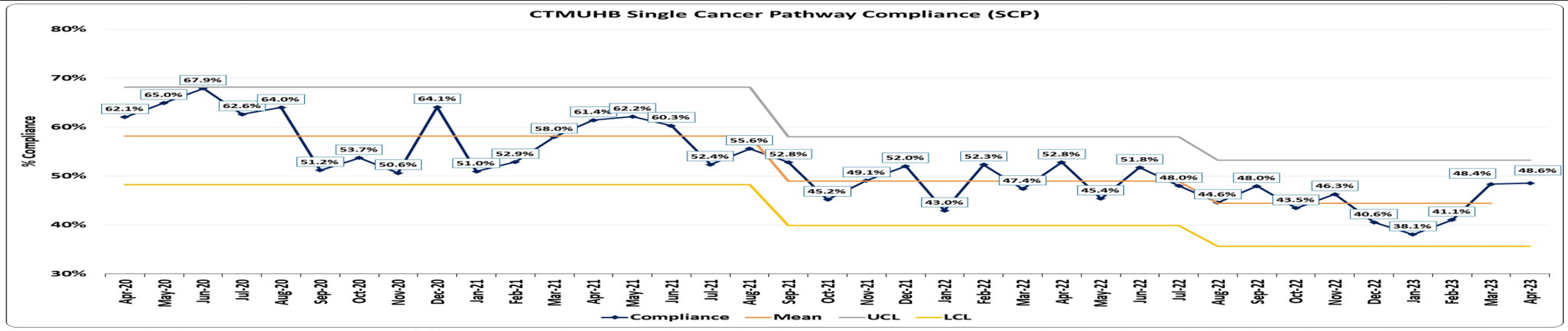
What are the main areas of risk?

General Surgery: Capacity deficiency in clinics to manage new and follow up patients appropriately.

Orthopaedics: Administrative support to remove patients from the FUNB after validating.

Single Cancer Pathway (SCP) – April 2023

% of patients starting first definitive cancer treatment within 62 days from point of suspicion - Target - Improvement Trajectory towards a national target of 80% by 2026 – **Compliance April 2023 – 48.6%**

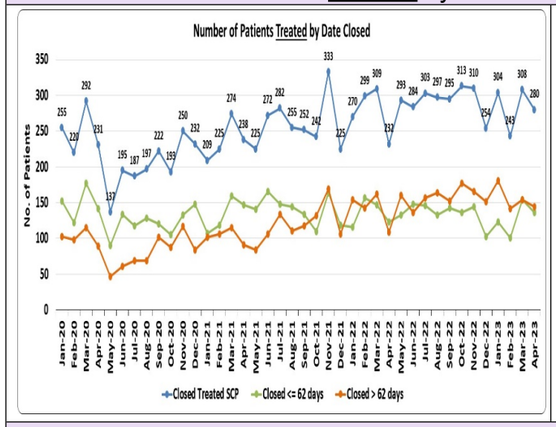


CTMUHB - SCP % Treated Without Suspensions - April 2023				
Tumour site	Treated in Target Without Suspensions	Patient Breaches	Total Treated	% Treated in Target Without Suspensions
Head and neck	2	4	6	33.3%
Upper GI	10	12	22	45.5%
Lower GI	10	21	31	32.3%
Lung	16	15	31	51.6%
Sarcoma	1	0	1	100.0%
Skin (exc BCC)	54	13	67	80.6%
Brain/CNS	1	0	1	100.0%
Breast	15	24	39	38.5%
Gynaecological	5	7	12	41.7%
Urological	16	44	60	26.7%
Haematological	4	4	8	50.0%
Other	2	0	2	100.0%
Total	136	144	280	48.6%

Performance for April remained almost static at 48.6%, with four of the tumour sites reaching the target threshold, as seen in the table above. Predicted compliance for May currently stands at 50.3%.

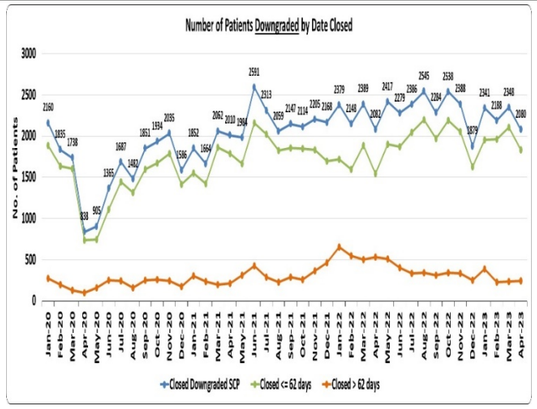
Delays at first outpatient (44%) and diagnostic stage (40%) continue to be the biggest concern and significant factor for not achieving target, with 1st outpatient volumes deteriorating over the last month. Diagnostic delays remain in radiology for CTC's, endoscopy and pathology.

Patients Treated by Closed Date



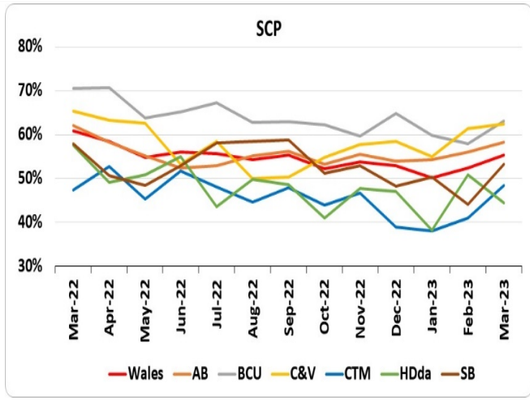
Overall cancer treatment volumes have increased marginally during the past 12 months to around 290 per month, compared to 266 in the equivalent period of the previous year. This represents an average monthly increase of 9%.

Patients Downgraded by Closed Date



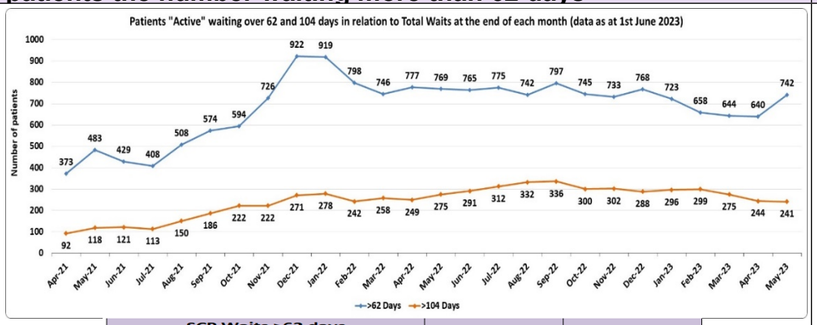
The number of patients on the SCP pathway who have been downgraded (told they do not have cancer) after having been seen at 1st Outpatient appointment or following a diagnostic test, has followed a monthly upward trend with the average for the past 12 months being 4% higher than the equivalent time span of the previous year.

How do we compare with our peers?



Status as at March 2023		
Health Board	Compliance	Rank
BCU	63.1%	1st
C&V	62.5%	2nd
AB	58.2%	3rd
SB	53.2%	4th
CTM	**48.4%**	**5th**
HDda	44.5%	6th

Patients currently waiting on a Cancer Pathway and of those patients the number waiting more than 62 days



SCP Waits >62 days (data as at 1st June 2023)	>62 to 124 days	125+ days
Sarcoma	1	
Breast	20	
Brain/CNS	1	
Gynaecological	157	11
Haematological (exc acute leukaemia)	5	2
Head and neck	18	3
Lower GI	180	70
Lung	27	5
Skin (exc BCC)	28	4
Upper GI	53	15
Urological	101	33
Other	8	
Total	**599**	**143**

What actions are we taking & when is improvement anticipated?

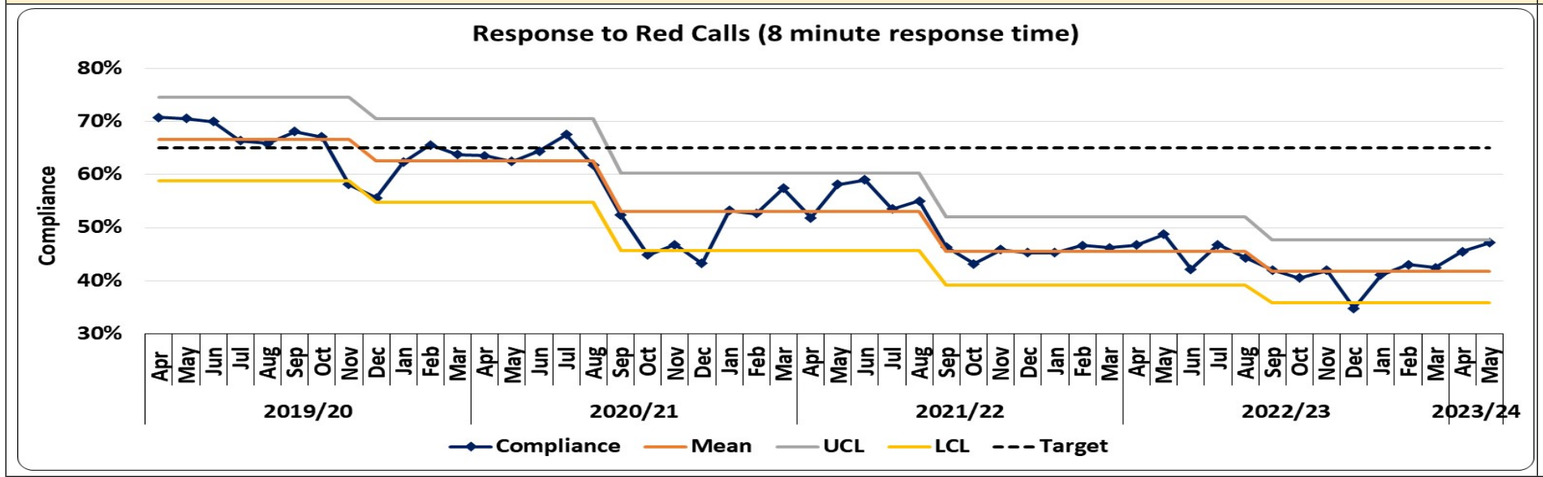
- New Breast surgeon commencing 26th June
- Improved processes and theatre utilisation of symptomatic endoscopy lists
- Merging of Urology MDT's scheduled 11th July
- FIT pathway launched 15th May
- Live Canisc replacement live in Breast & scheduled to go live in Urology from 6th June
- Urology service review completed & action plan being developed to work through recommendations
- Streamlining and standardisation of MDT and clinical lead JD's
- Shifting of trans nasal endoscopies out of endoscopy theatre once equipment received
- WLI's / super Saturdays to increase activity
- Implementation of Short, medium and long-term plan for reducing gynaecology backlog and provide sustainability of service
- Centralisation of Breast services from all three DGH sites into the Snowdrop Centre, Llantrisant Health Park planned before September
- Change to PAC process – short term plan to reduce waiting time & backlog

What are the main areas of risk?

- Performance challenges evident in all tumour sites whilst backlog clearance remains focus.
- 84% of all patients on the active SCP are at 1st outpatient or diagnostic stage
- Resources required to effectively plan and implement the Wrapper / Canisc replacement Programme.
- Delays in pathology, endoscopy continue with deterioration in SB path for POW patients
- Delays in tertiary investigations & treatments at SB, Velindre Cancer Centre and C&V.
- Bowel Screening Wales diagnostic colonoscopy
- Urology tumour site – nursing establishment
- Gynaecology tumour site
- Implementation of genomic testing for new targeted therapies
- PAC

Emergency Ambulance Services – Response to Red Calls & Red Release Requests – May 2023

Response to Red Calls - % of emergency responses to Red Calls arriving within 8 minutes (Target 65%) May 2023 – 47.2%



Immediate Vehicle Release Requests

Period	PCH			RGH			POW		
	Requests	Accepted	Compliance	Requests	Accepted	Compliance	Requests	Accepted	Compliance
Apr-22	10	7	70.0%	9	4	44.4%	8	3	37.5%
May-22	15	13	86.7%	6	5	83.3%	11	5	45.5%
Jun-22	12	11	91.7%	13	10	76.9%	23	8	34.8%
Jul-22	13	13	100.0%	10	9	90.0%	15	7	46.7%
Aug-22	9	7	77.8%	17	15	88.2%	15	4	26.7%
Sep-22	15	13	86.7%	17	14	82.4%	16	2	12.5%
Oct-22	26	26	100.0%	16	12	75.0%	15	4	26.7%
Nov-22	25	24	96.0%	19	15	78.9%	17	9	52.9%
Dec-22	30	25	83.3%	32	26	81.3%	25	1	4.0%
Jan-23	20	19	95.0%	19	13	68.4%	7	2	28.6%
Feb-23	8	8	100.0%	10	9	90.0%	3	3	100.0%
Mar-23	14	14	100.0%	11	10	90.9%	12	11	91.7%
Apr-23	15	15	100.0%	7	3	42.9%	3	3	100.0%
May-23	2	2	100.0%	2	2	100.0%	1	1	100.0%

How are we doing?

Response to Red Calls: Response times to life-threatening calls further improved to 47.2% in May as did the National compliance, improving to 54.4%. The minimum expected standard is for 65% of Red Calls to be responded to within 8 minutes.

The volume of Red Calls during May totalled 606 for the CTM area, a similar volume to the 12 month average of 602 per month, but is over 16% higher than the equivalent period of 2022.

Immediate Release Requests *(shown above right):* received when a WAST crew, which is currently with a patient at hospital, needs to be released to respond to an urgent call, amounted to 5 during May*. The ED services were able to support affirmatively all of those requests. The Ministerial requirement is for all red release requests to be supported.

**Please note that data for May 2023 is provisional and may be subject to change in future iterations of this report.*

What actions are we taking & when is improvement anticipated?

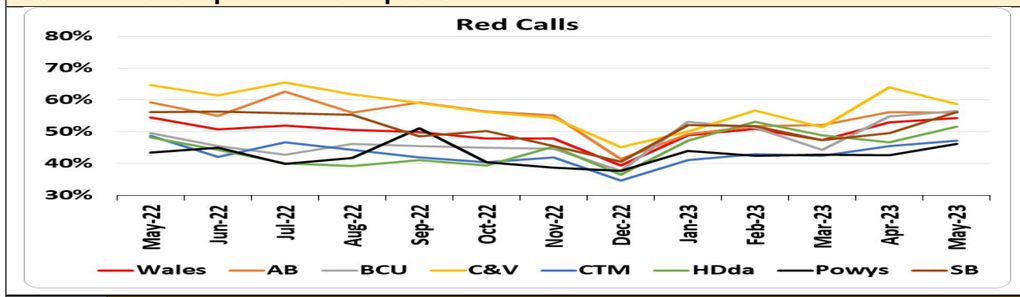
- Trajectories agreed
- Weekly data v improvement "deep dive" against trajectories
- Weekly performance/assurance meetings in place
- Navigation Hub increased utilisation
- Pan CTM - Immediate response and Pre-emptive transfer procedures reviewed
- Pan CTM Emergency Pressure Escalation Procedure review complete – plan launch
- Robust out of hours and weekend planning process in place
- Update Safe to Start process pan CTM
- Unscheduled Care Senior leadership team proactively engaged and leading programme for improvement
- Fortnightly Silver operational meetings between CTM and WAST established

What are the main areas of risk?

A number of Winter schemes (funded and unfunded) that were due to cease on the 31 March 2023, have been extended. This includes an additional D2RA Ward at the Princess of Wales Hospital Site and the GP assessment area at Prince Charles Hospital.

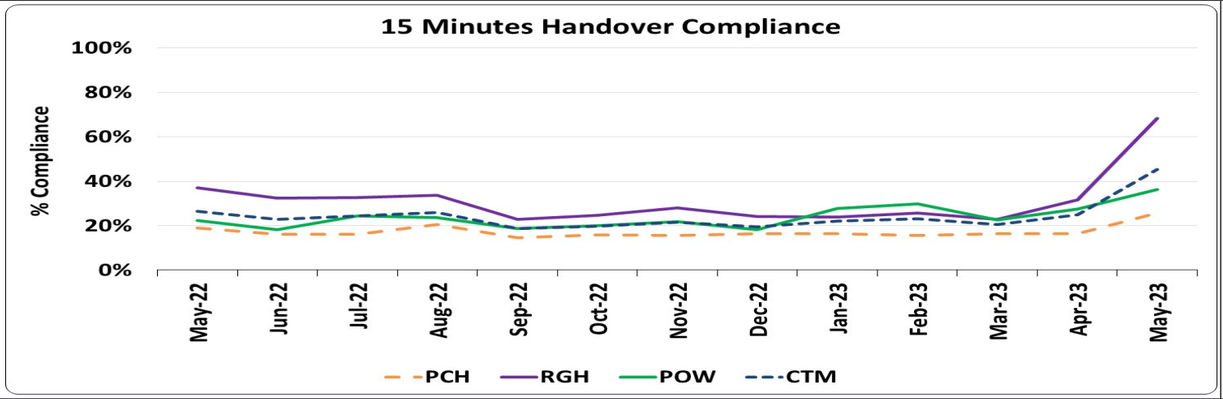
These schemes are currenty supporting our ability to manage risk. This risk sits across a number of Care Groups.

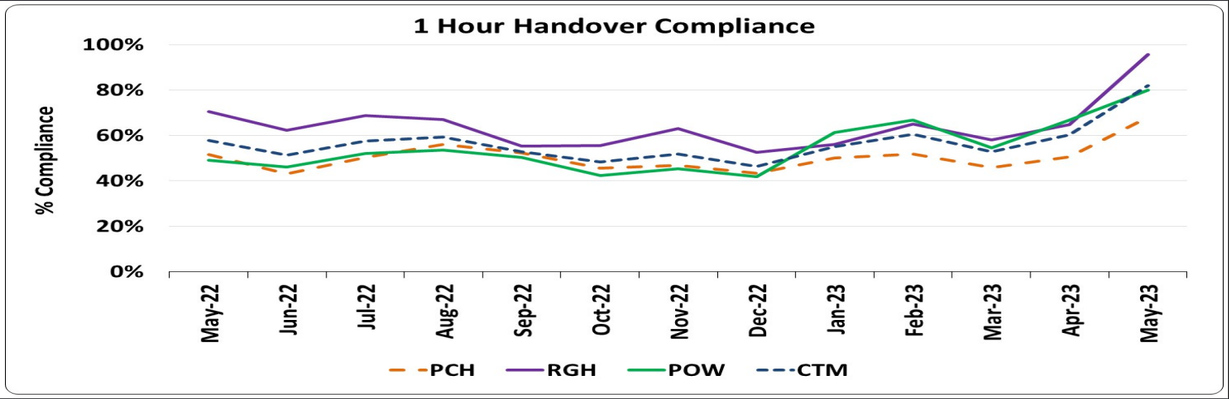
How do we compare with our peers?



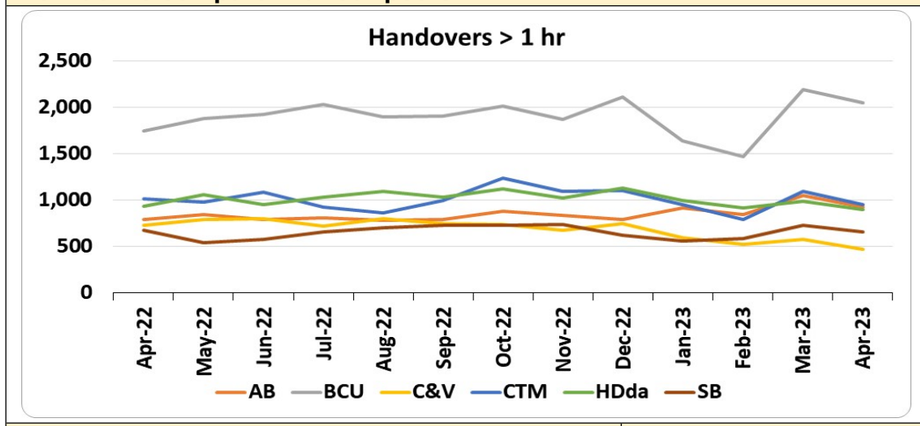
Status as at May 2023		
Health Board	Compliance	Rank
C&V	58.8%	1st
BCU	56.5%	2nd
SB	56.3%	3rd
AB	56.1%	4th
HDda	51.7%	5th
CTM	**47.2%**	**6th**
Powys	46.2%	7th

Number of ambulance handovers within 15 minutes – Target Improvement	Number of ambulance handovers over 1 hour – Target Zero
Total handovers 2,471 of which 1,117 handovers were within 15 minutes (45.2%)	**445 handovers were over 1 hour (82.0% of handovers were within 1 hour)**



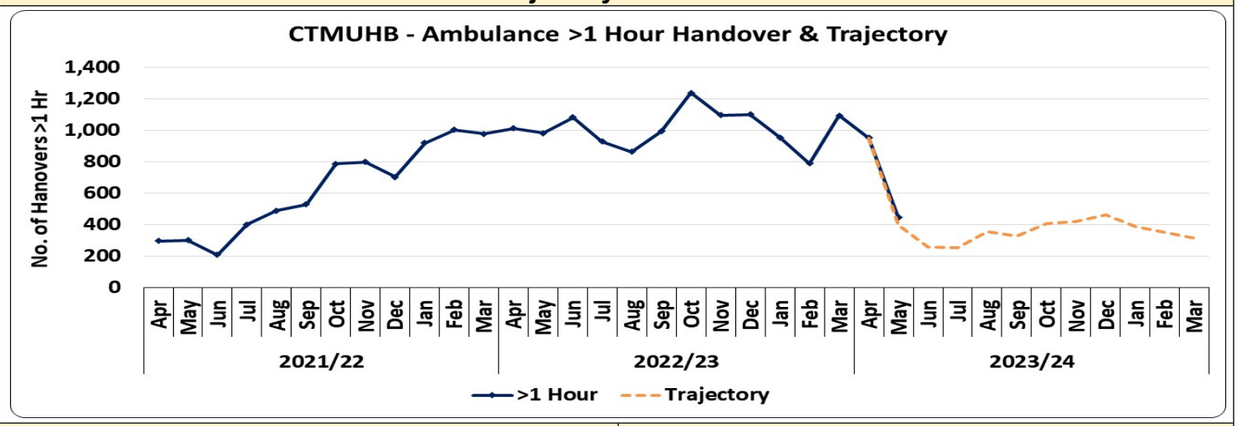


How do we compare with our peers?



Status as at April 2023		
Health Board	Compliance	Rank
C&V	469	1st
SB	659	2nd
HDda	901	3rd
AB	925	4th
CTM	**952**	**5th**
BCU	2,048	6th

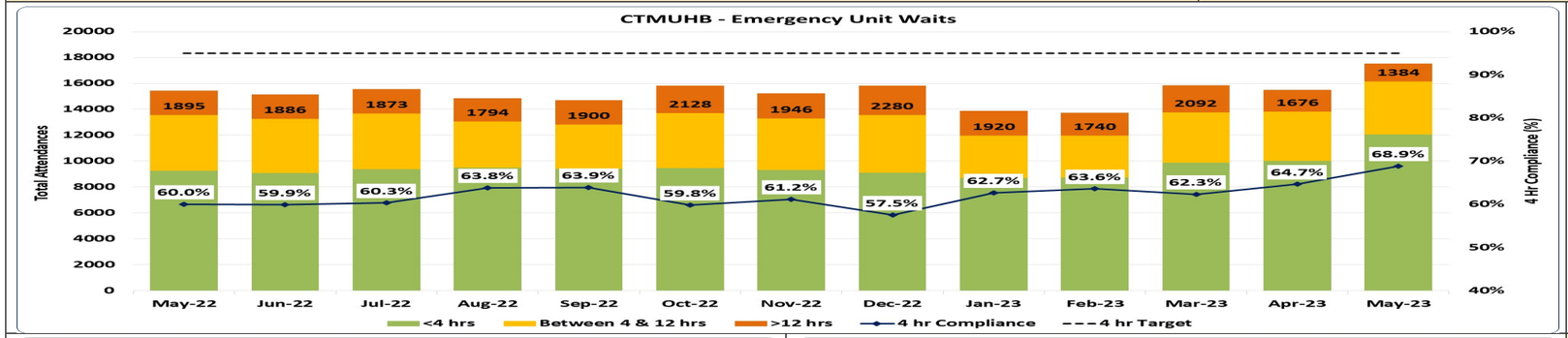
Reduce >1 Hour Ambulance Handover Trajectory

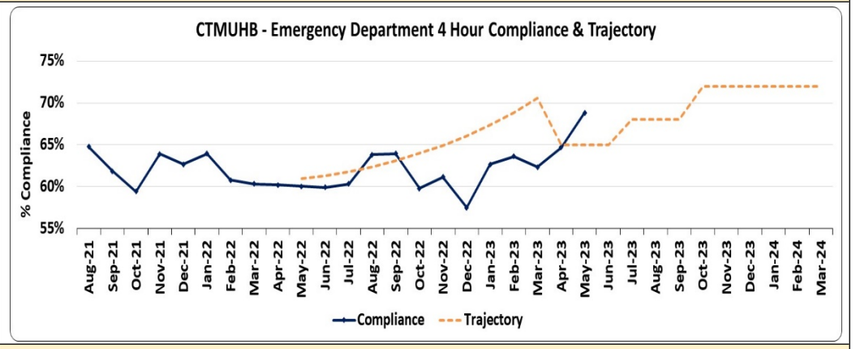


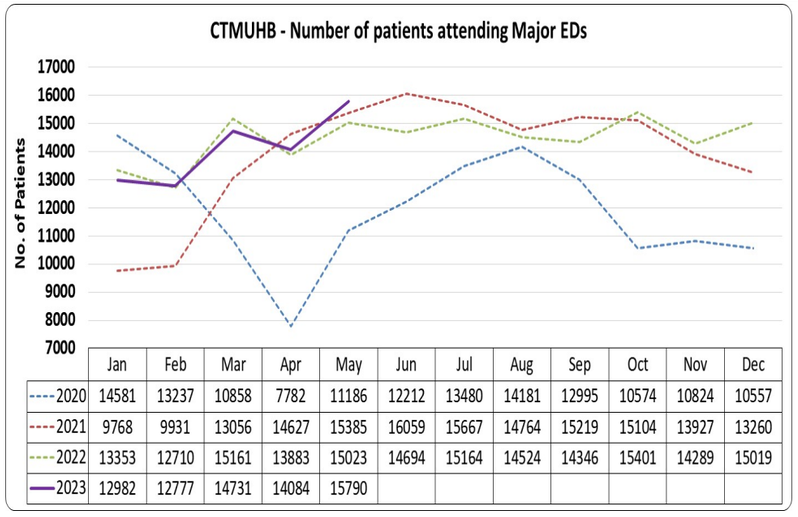
How are we doing?	What actions are we taking & when is improvement anticipated?	What are the main areas of risk?
During May 2023, compliance for both the 15 minute and one hour handover times saw a marked improvement with performance at 45.2% and 82.0% respectively, although, there remained 445 patients who breached the one hour zero tolerance set by WG. Compared to April, the volume of handovers were around 3.6% higher (on average 2 patients more per day), bringing the total number of ambulance conveyances to our major emergency departments to 2,471, which is 11% higher than the 12 month average of 2,222 per month. The current volume is also 3.6% higher than the volume seen in the comparable period of 2022.	As per the actions on the previous page with: • Focused improvement programme to reduce Ambulance Handover delays "go live" at Royal Glamorgan hospital – 28 April 2023 with roll out to Princess of Wales Hospital and Prince Charles Hospital • Ambulance Handover Escalation Card in place	System flow remains highly impacted by capacity within social care.

Emergency Unit Waits – May 2023 (Provisional Position) - Total Attendances 17,532

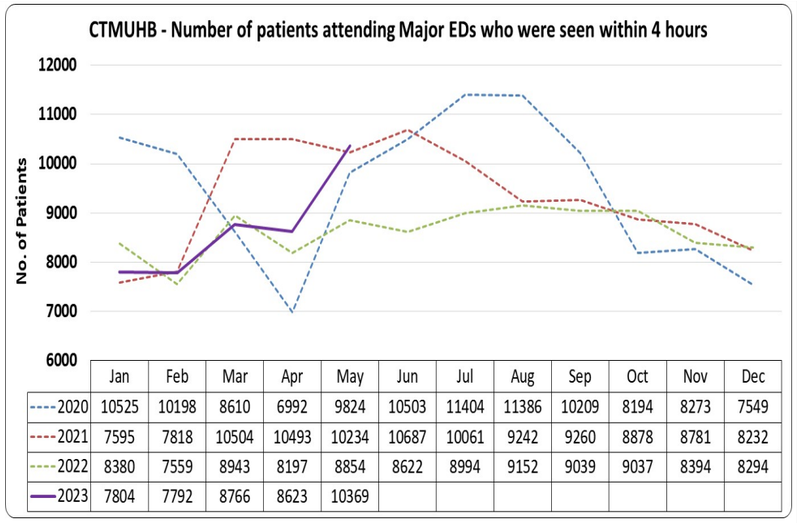
% of patients who spend <4 hours in all major and minor emergency care facilities from arrival to admission, transfer or discharge - Target 95%	Number of patients who spend 12 hours or more in emergency care facilities from arrival to admission, transfer or discharge - Target Zero
68.9% were seen within 4 hours (Waiting >4 hrs 5,461)	**7.9% of patients were waiting over 12 hours (1,384)**





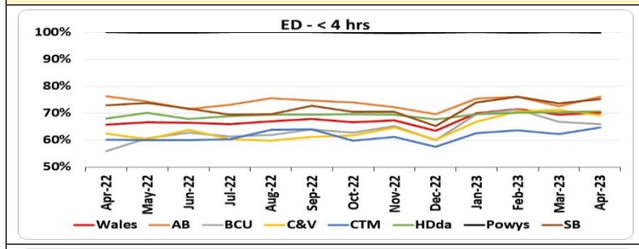


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	14581	13237	10858	7782	11186	12212	13480	14181	12995	10574	10824	10557
2021	9768	9931	13056	14627	15385	16059	15667	14764	15219	15104	13927	13260
2022	13353	12710	15161	13883	15023	14694	15164	14524	14346	15401	14289	15019
2023	12982	12777	14731	14084	15790							

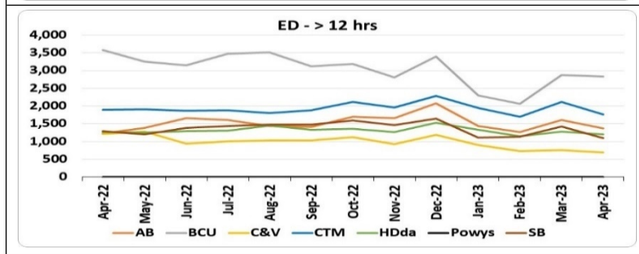


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	10525	10198	8610	6992	9824	10503	11404	11386	10209	8194	8273	7549
2021	7595	7818	10504	10493	10234	10687	10061	9242	9260	8878	8781	8232
2022	8380	7559	8943	8197	8854	8622	8994	9152	9039	9037	8394	8294
2023	7804	7792	8766	8623	10369							

How do we compare with our peers?



Status as at April 2023		
Health Board	Compliance	Rank
Powys	99.8%	1st
AB	76.2%	2nd
SB	75.2%	3rd
HDda	70.7%	4th
C&V	69.3%	5th
BCU	65.9%	6th
CTM	**64.7%**	**7th**



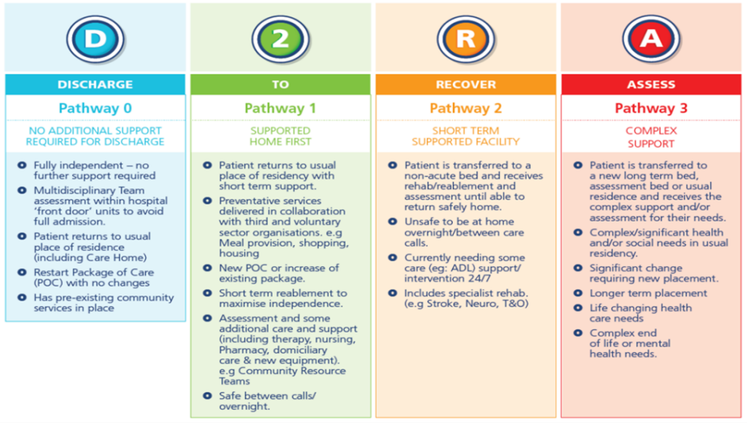
Status as at April 2023		
Health Board	Compliance	Rank
Powys	0	1st
C&V	696	2nd
SB	1,095	3rd
HDda	1,199	4th
AB	1,373	5th
CTM	**1,759**	**6th**
BCU	2,827	7th

How are we doing?	What actions are we taking & when is improvement anticipated?	What are the main areas of risk?
Demand for ED has been 7.7% higher during the past three months (Mar – May) than the equivalent time span of 2022, with a similar increase on 2021 (7.6%), and attendances during May being 13.5% higher than the same period of 2022. The proportion of patients being admitted, discharged or transferred within 4 hours of their arrival at our emergency care facilities further improved to 68.9% in May, but remains below the compliance target of 95%. 4 hour compliance improved at all major sites; most notably RGH & POW (70.7% & 65% respectively) whilst PCH observed a slight improvement to 61.3%. The number of patients who were waiting in excess of 12 hours reduced by around 17% to 1,384, with a marked improvement at RGH, where the number of patients breaching 12 hours reduced by 42% on the previous month. The number of patients waiting over 12 hours by unit was as follows:	• <4 Hour Trajectories agreed / >12 Hours to be agreed • Weekly data v improvement "deep dive" against trajectories • Weekly performance/assurance meetings in place • Progress development of medical SDEC within PCH and POW incorporating frailty • Review footprint / activity / workforce • Stop clock guidance review underway • Ambulance Lost Hours improvement driving flow from ED • Change to reporting of GP expected patients at PCH – 22 May 2023 subject to adherence to information standards • Capital requirements for the SDEC implementation at PCH has been approved.	• Aspiration of care group to deliver December 2023 to support seasonal pressures. Risk around delivery of Capital Programme in timescale required. • Funding confirmation required for medical workforce to provide SDEC at PCH

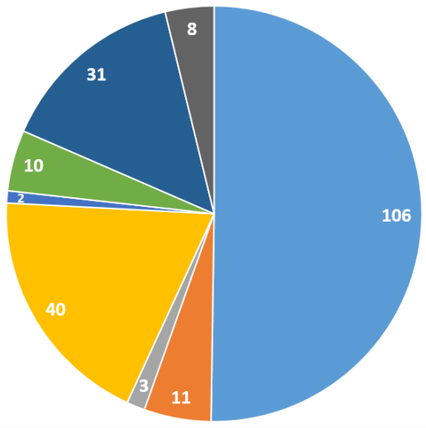
Unit	Apr-23	May-23	% improvement on the previous period
PCH	714	622	12.9%
RGH	477	276	42.1%
POW	485	486	-0.2%

Monitoring Patient Pathways of Care Delays - *please note that this page is in development as weekly reporting ceased 28th March 2023. Formal embedding of the Pathways of Care Reporting Framework is taking place & in the interim data from April 2023 has been locally sourced & reflects the data captured for the discharge monitoring of our patients.*

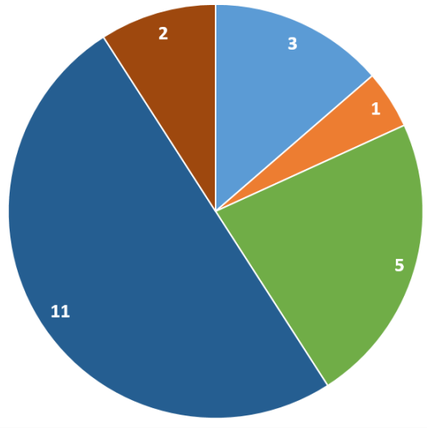
The Discharge to Recover then Assess Model (Wales) – D2RA



Non-Mental Health Patient Pathway of Care Delay Reasons May 2023



Mental Health Patient Pathway of Care Delay Reasons May 2023



How are we doing?	What actions are we taking & when is improvement anticipated?	What are the main areas of risk

Please note that the new reporting arrangements came into effect 1st April 2023 and whilst we continue to embed the model of D2RA throughout CTMUHB, data quality issues remain.

The total number of patients who have been clinically optimised for discharge and are currently awaiting their next stage of care (May 2023 census point), equates to 233 patients i.e. 211 non-Mental Health patients and 22 Mental Health patients, as is shown in the pie charts above.

The number of delays per Local Authority are as follows:

Healthcare Facility	Blaenau Gwent	Bridgend	Caerphilly	Merthyr Tydfil	Rhondda Cynon Taff	Vale of Glamorgan	Total
Pinewood House					2		2
Prince Charles Hospital	1		11	12	7		31
Princess of Wales Hospital		48				4	52
The Royal Glamorgan Hospital	1				29		30
Ysbyty Cwm Cynon				34	32		66
Ysbyty Cwm Rhondda					52		52
Grand Total	**2**	**48**	**11**	**46**	**122**	**4**	**233**

- From the end of May, Pathway of Care Delays are overseen through the governance of the Integrated Discharge Delivery Board; a newly established board that is accountable for the design, delivery and discharge performance in CTM, identifying areas for improvement and making appropriate challenge where performance is stalled. Ultimately ensuring that patients get the right care at the right time in the right place; irrespective of hospital and system pressures.

- Two operational work streams have been established to improve performance. One focusing on the central D2RA hub and supported discharge team and the other looking at the capacity and delivery of discharge pathways. A rapid improvement plan is being drafted in line with the 6 Goals of Urgent and Emergency Care Improvement Plan.

- A plan to accelerate improvement under a key area of delay in CTM is the Trusted Assessor Model. We are currently in the fist phase of delivery which involves implementing a trusted assessment document (Electronic Transfer of Care eToC) into all hospital sites.

- There is delay associated with complex assessment (including MCA assessment) a community provision with identified capacity issues for domiciliary care overall, as well as specific issues for EMI nursing beds. The board is working with the integrated commissioning group to inform an effective commissioning strategy that links to additional funding available through the Further, Faster, Together Programme.

  This is down to a number of reasons, but the main one is lack of capacity and availability of packages of care in the community.

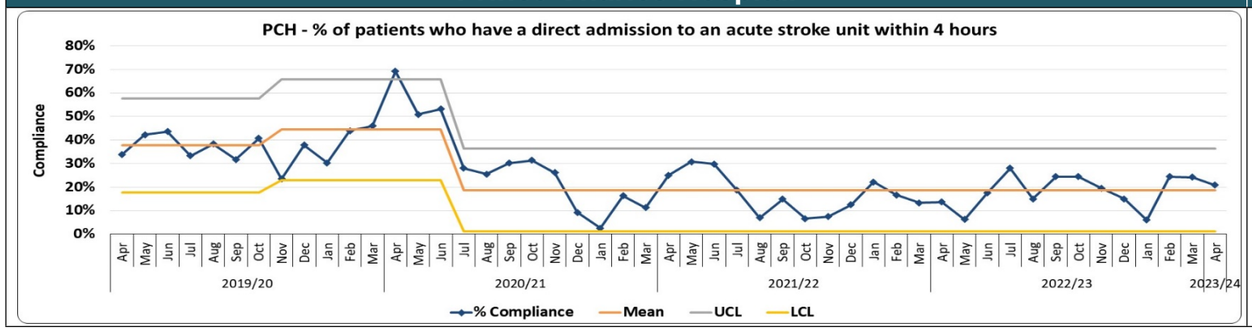
  The D2RA/ETOC has been reviewed and lessons learnt has been captured and an improvement plan has been drafted to improve flow.

- Re-design of paperwork and processes to ensure that trusted assessment works seamlessly
- Community capacity for D2RA pathways
- Gaps/vacancies in the supported discharge team
- Short-term funding only
- RIF resources to meet the needs of the new discharge process
- Long term staffing solution for the D2RA hub

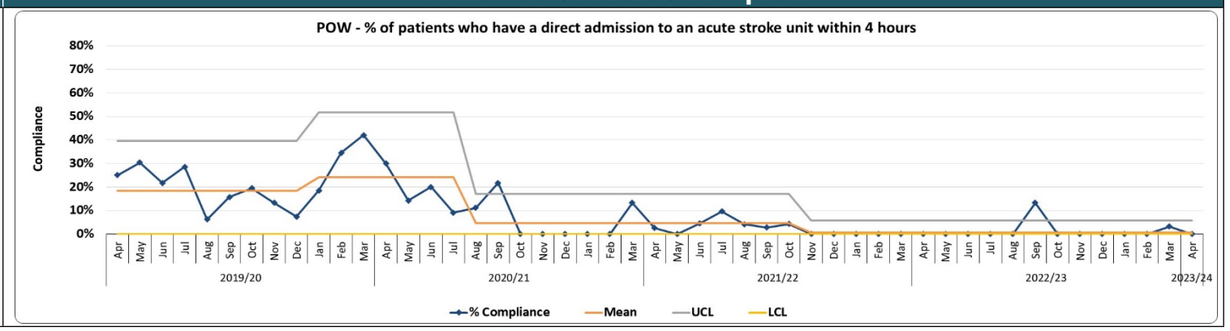
Stroke Quality Improvement Measures (QIMs) – April 2023

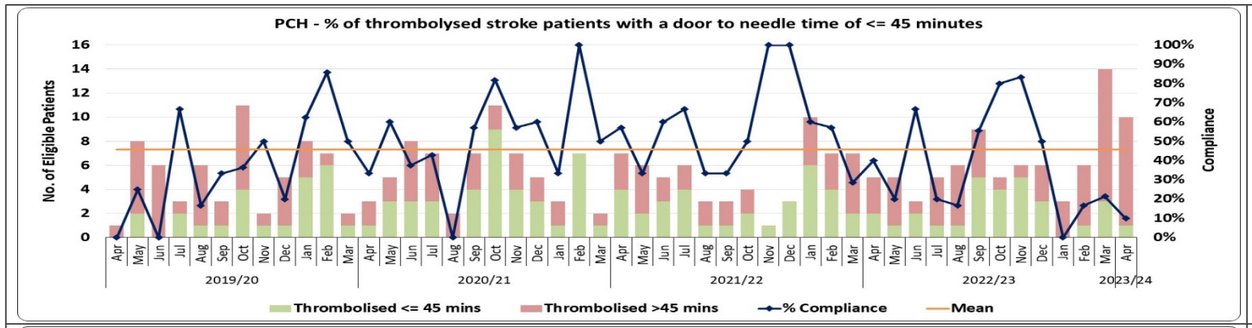
% compliance with direct admission to an acute stroke unit within 4 hours			% compliance of thrombolysed stroke patients with a door to needle time within 45 minutes			% compliance of patients diagnosed with stroke received a CT scan within 1 hour			% compliance assessed by a stroke consultant within 24 hours		
PCH	**POW**	**CTM**	**PCH**	**POW**	**CTM**	**PCH**	**POW**	**CTM**	**PCH**	**POW**	**CTM**
20.8%	**0.0%**	**14.7%**	**10.0%**	**50.0%**	**16.7%**	**46.9%**	**45.0%**	**46.4%**	**49.0%**	**40.0%**	**46.4%**

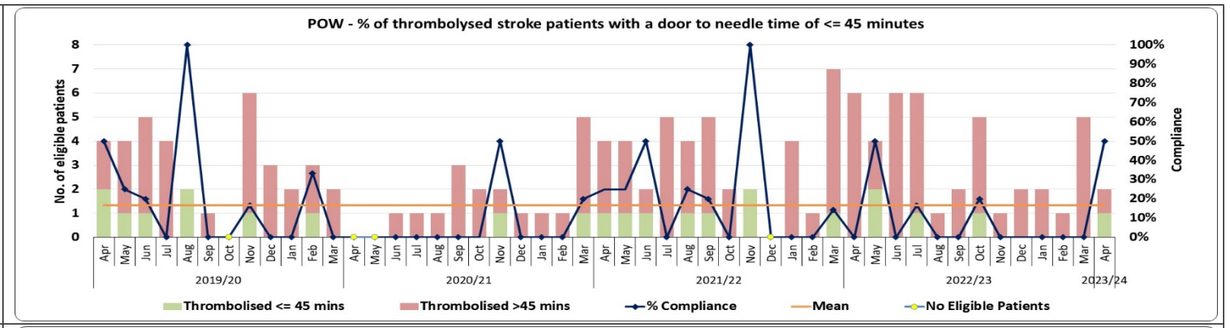
Prince Charles Hospital

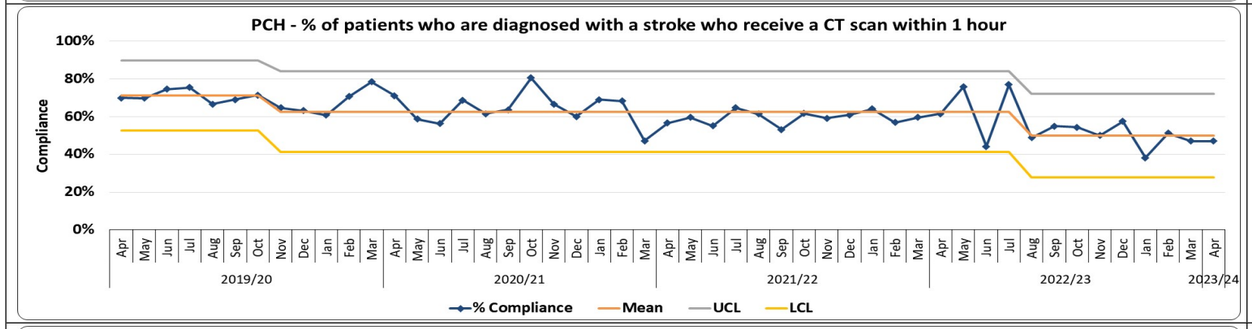


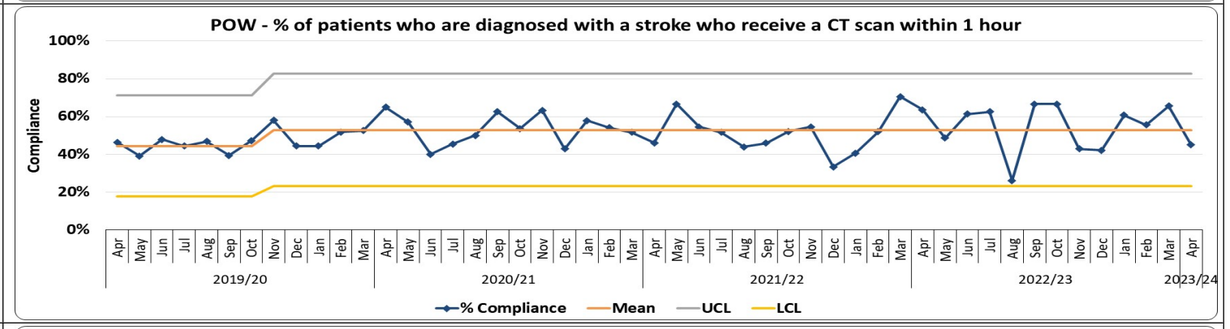
Princess of Wales Hospital

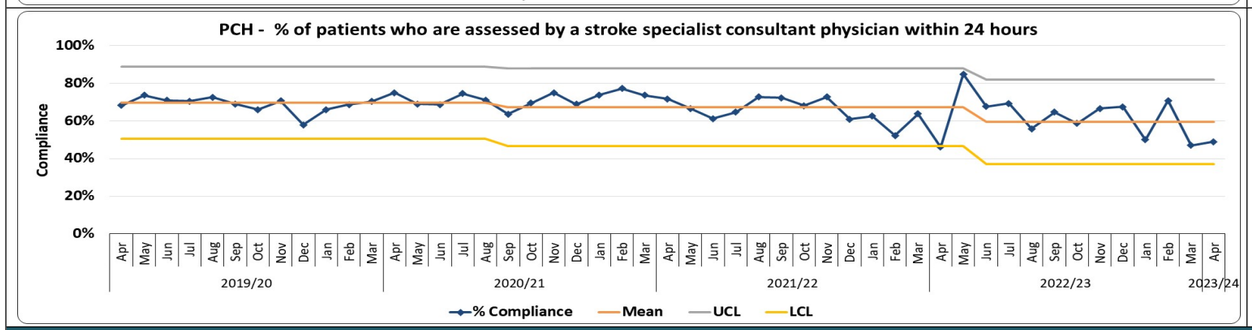


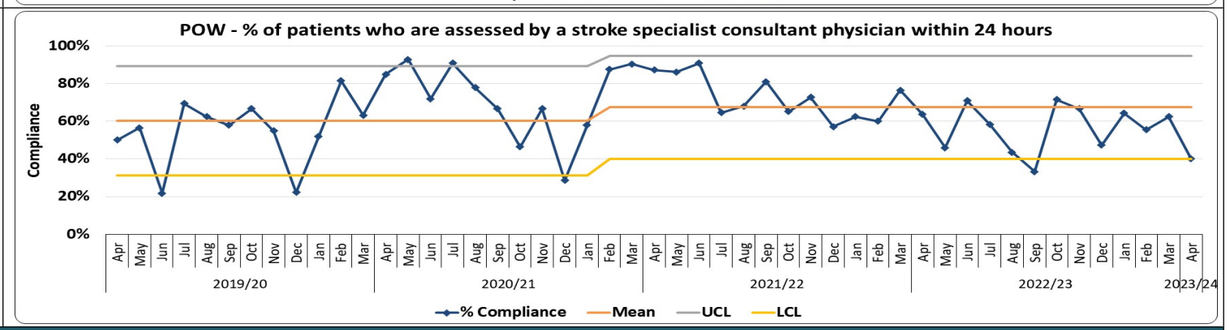












Stroke QIMS continued on the next page…

Cont'd…Stroke Quality Improvement Measures (QIMs) – April 2023

How are we doing?

Stroke QIMs - April 2023		PCH	POW	CTM
% of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit within 4 hours	Total admissions	48	20	68
	No. of patients within 4 hours	10	0	10
	% Compliance	**20.8%**	**0.0%**	**14.7%**
% of thrombolysed stroke patients with a door to needle time of <= 45 mins	Total thrombolysed	10	2	12
	No of patients within 45 mins	1	1	2
	% Compliance	**10.0%**	**50.0%**	**16.7%**
% of patients who are diagnosed with a stroke who receive a CT scan within 1 hour	Number diagnosed	49	20	69
	No. of patients within 1 hour	23	9	32
	% Compliance	**46.9%**	**45.0%**	**46.4%**
% of patients who are assessed by a stroke specialist consultant physician within 24 hours	Total admissions	49	20	69
	No. of patients within 24	24	8	32
	% Compliance	**49.0%**	**40.0%**	**46.4%**

During April, 14.7% (10 out of 68 admissions) of stroke patients were admitted directly to an acute stroke unit within 4 hours. Two of the twelve eligible patients were thrombolysed within 45 minutes (16.7%) and 46.4% of patients (32 out of 69 diagnosed patients) had a CT scan within an hour. There were also 32 out of the 69 stroke patients (46.4%) seen by a specialist stroke physician within 24 hours of arrival at the hospital.

The following key factors continue to impact on performance against stroke care standards:

- 5-day/week service model for medical and therapy provision.
- Lack of access to an Early Supported Discharge team and adequate bedded rehabilitation unit impact on length of stay and flow of stroke patients through the Princess of Wales hospital
- Ongoing demand for acute beds and the challenges maintaining a ring-fenced stroke bed impact on the ability to admit to the stroke wards within 4 hours across the whole hospital site.
- Pressures within adult social care which result in delayed discharges and increased pressure across all inpatient areas.
- Continued self-presentations to the Royal Glamorgan Hospital (RGH), instead of specialist stroke sites. Demand for acute beds results in delays in subsequent transfer to acute stroke sites and access to specialist stroke services

What actions are we taking & when is improvement anticipated?

- Direct admission to acute stroke unit within 4 hours has been a challenge, although some progresss has been made in improving the availability of the beds in the acute stroke beds on both acute stroke unit sites
- Referrals to Bristol for thrombectomy are predominantly limited by Bristol's opening hours, although the Bristol service is persevering with is plans to become a 24/7 thrombectomy service by late Autumn 2023. From a CTM perspective timely referral to the service will be a challenge whilst the one 1 in 4 Stroke Consultant rota remains in place.
- We have recently implemented radiographer approved CT and CT angiograms, to minimise delays in getting CT angiograms in patients presenting with acute strokes.
- There is an ongoing project to implement Brainomix AI software reporting for CTs and CT angiograms, which would minimise delays in referral for thrombectomy, although there is currently no funding for this (£20k per annum).
- Established CTM Stroke Programme Board

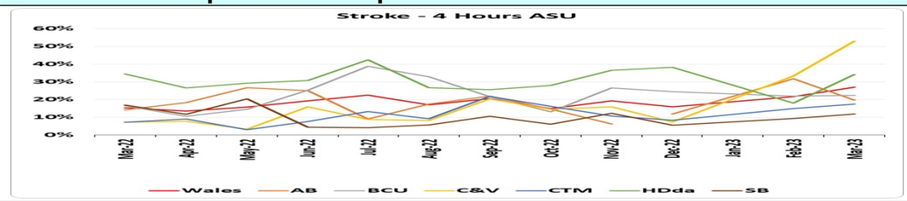
What are the main areas of risk?

The intended impact of the short, medium and long term actions, along with the regional and national stroke programmes, is to improve the quality, safety and experience of care for patients, their families and our workforce. CTM will develop an improvement plan, with ambitions to achieve a SSNAP rating of 'A'.

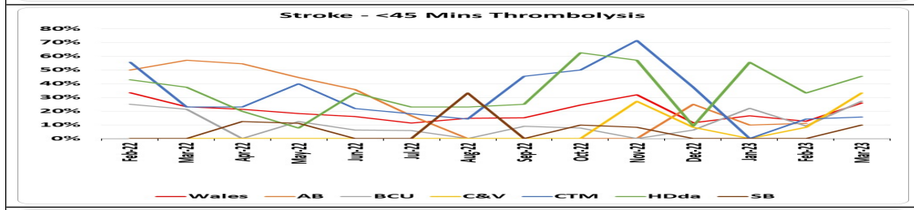
The main risks to achieving this rating are resource challenges and the wider patient flow challenges experienced in ED and throughout the hospital, which make it difficult to ring fence stroke beds, particularly affecting the 4 hour target. Bed pressures also impact the ability to transfer stroke patients from RGH in a timely manner in order to access specialist stroke care. This is part of the wider unscheduled care improvement programme and the wider performance management of the system.

In order for the national stroke care ambitions to be achieved, local services are required to deliver effective and efficient acute care and rehabilitation post-72 hours. Whilst some investment has been identified for 2023/24, it is not possible to allocate the volume of resource required to fully mobilise our plans.

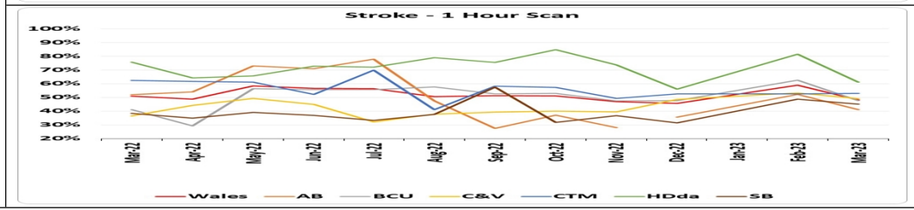
How do we compare with our peers?



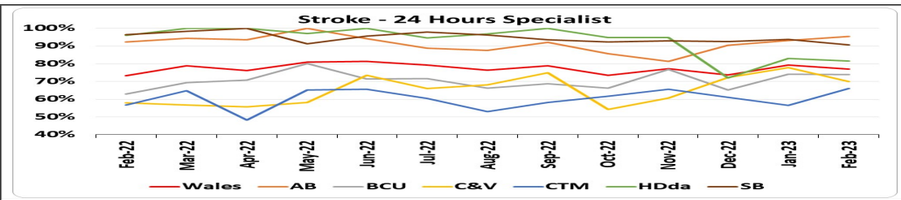
Status as at March 2023		
Health Board	**Compliance**	**Rank**
C&V	52.9%	1st
HDda	34.1%	2nd
BCU	22.4%	3rd
AB	19.6%	4th
CTM	**17.5%**	**5th**
SB	11.9%	6th



Status as at March 2023		
Health Board	**Compliance**	**Rank**
HDda	45.5%	1st
C&V	33.3%	2nd
BCU	27.3%	3rd
AB	20.0%	4th
CTM	**15.8%**	**5th**
SB	10.0%	6th



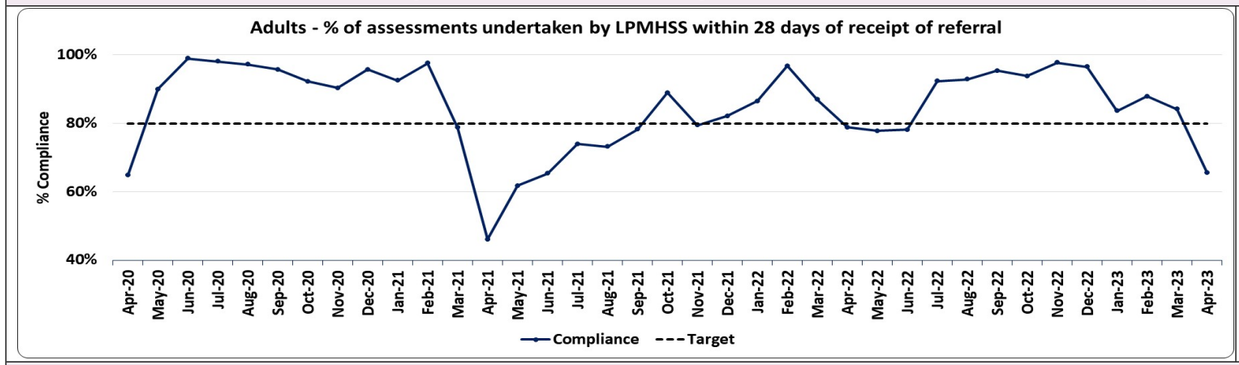
Status as at March 2023		
Health Board	**Compliance**	**Rank**
HDda	61.2%	1st
CTM	**53.0%**	**2nd**
C&V	49.1%	3rd
BCU	47.7%	4th
SB	45.2%	5th
AB	41.1%	6th



Status as at March 2023		
Health Board	Compliance	Rank
SB	97.6%	1st
HDda	87.8%	2nd
AB	85.7%	3rd
C&V	67.3%	4th
BCU	65.1%	5th
CTM	**52.0%**	**6th**

CTM Mental Health Services (excluding CAMHS) – April 2023

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (65.6%) - Target 80%



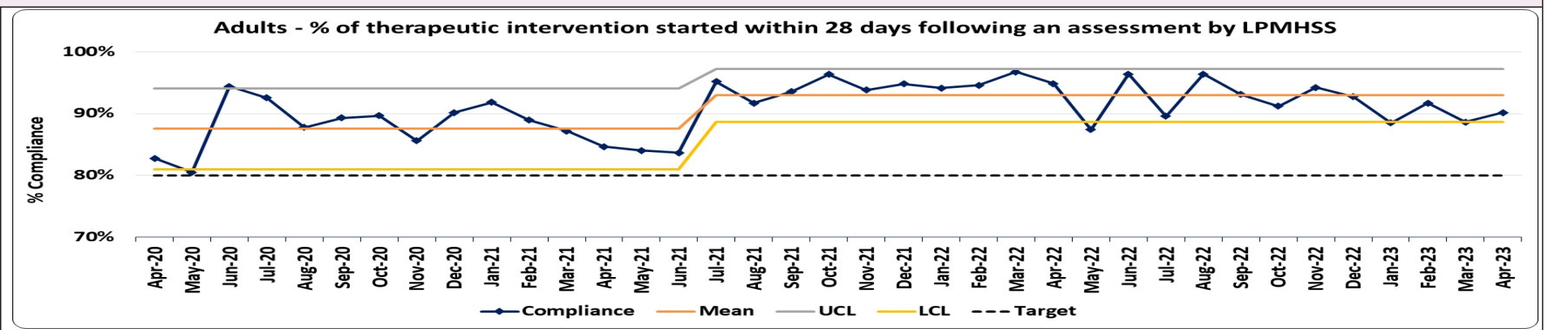
Part One of the Mental Health Measure relates to primary care assessment and treatment and has a target of 80% of referrals to be assessed within 28 days. The adult mental health services compliance for April fell by over 18 points from the previous month to 65.6% and falling below the 80% target for the first time since June 2022.

Referrals during April fell by 24% from the previous month, bringing the total to 679. The volume of referrals falls below the 12 month average is of 732 and continues to be lower than pre-Covid levels where referrals were in the region of 1,000 to 1,100.

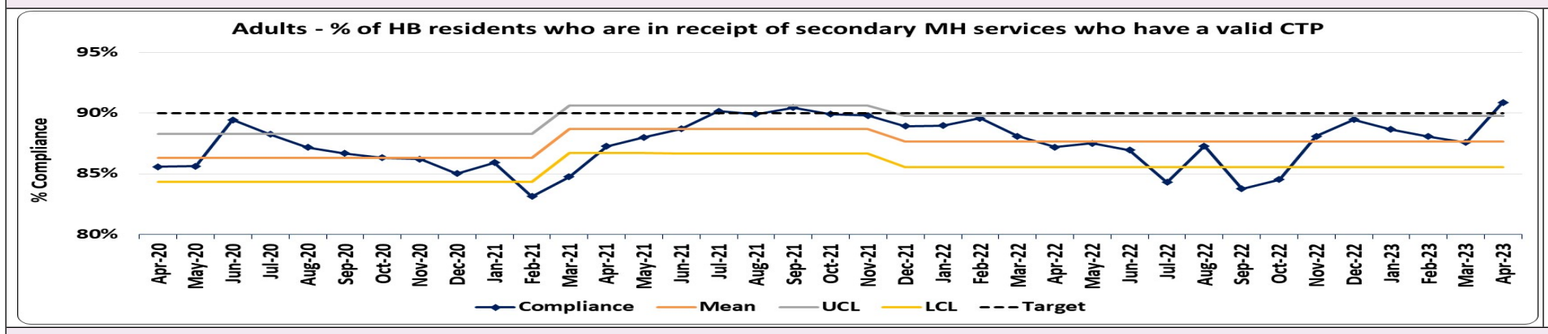
The Rhondda Taff Ely area position is linked to limited capacity in the service with a number of different vacancies (sickness, maternity leave and vacancies) meaning approx. 30% lost appointments. There was an increase in demand in March alongside this reduction in capacity. Whilst the Bridgend area position is linked partly to a reduction in capacity and increase in demand, but also some concerns around process and booking systems. There has been some concern around the quality of the data and validation on the position continues.

% of therapeutic intervention started within 28 days following an assessment by LPMHSS (90.2%) - Target 80%

Overall the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS was 90.2% during April (285/316), remaining above the WG target of 80%.



% of HB residents who are in receipt of secondary MH services who have a valid CTP (90.9%) - Target 90%



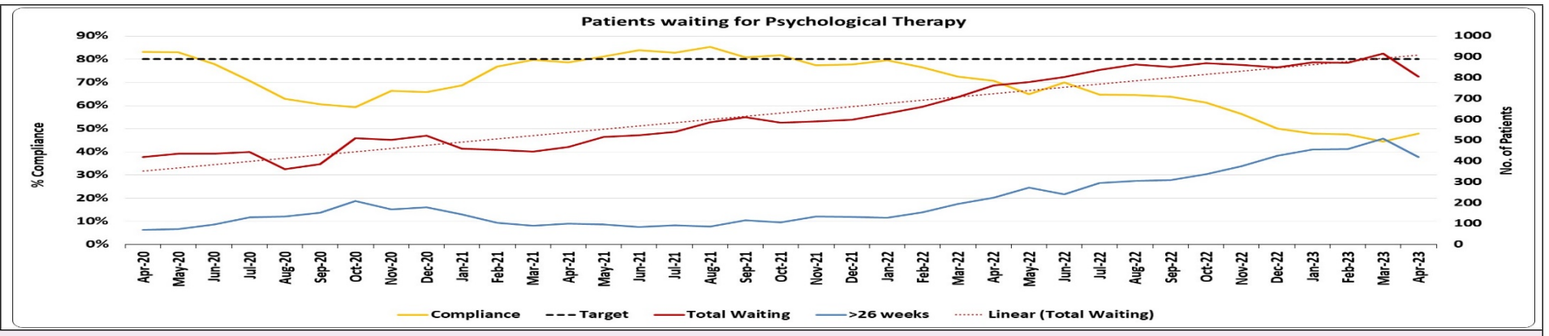
Part Two of the Mental Health Measure, i.e. % of residents who have a valid Care Treatment Plan completed by the end of each month rose to 90.9% during April. This is the first time that the 90% WG standard target has been met, since September 2021

Part 3: There were no outcome of assessment reports sent during April.

% of patients waiting less than 26 weeks to start a Psychological Therapy (47.8%) - Target 80%

During April, Psychological Therapies compliance improved from the previous month to 47.8%, remaining well below the 80% compliance threshold.

The chart to the right depicts the total waiting list volume (red) with the number of patients waiting more than 26 weeks for a Psychological Therapy (blue) and the proportion waiting less than 26 weeks (the WG target - yellow).



Adult Mental Health Services continued on the next page…

Cont'd…Mental Health Services (excluding CAMHS)

How are we doing and what actions are we taking?

Part 1a: Adult mental health services performance declined to 65.6% in April.

The Rhondda Taff Ely area have been offering overtime, although uptake has been limited. However, there has been an improvement in the sickness absence rate enabling an increase in capacity. Bridgend is doing further work to improve the processes linked to performance management and validation. The team also have a new senior nurse starting in June who will take a lead on improvement

Teams continue to forward plan and proactively manage the waiting times, maximising all available slots where possible. This has also included improving some of the booking processes and timescales linked to opt in for patients (previously giving 14 days to opt in whilst letter stated 7 days).

Part 1b: Performance continues to be above target at 90.2%.

Part 2: Compliance for both Adult, Older Adult and Learning Disability Services combined has increased to 90.9% and is above the target threshold of 90%

- Adult Services increased from 86% to 89.4%
- Older Adult Services increased from 90.9% to 94.8%
- Learning Disability Services has decreased from 96.8% to 95.7%

Psychological Therapies: There has been a reduction of 111 patients from the total waiting list, with an improved reduction of 88 patients waiting longer than 26 weeks. This reduction was linked to patients accessing treatment via our outsourcing service option and waiting list validation alongside additional capacity in the service due to a new member of staff commencing in post.

When is improvement anticipated and what are the main areas of risk?

Part 1a: The actions taken in the Rhondda Taff Ely area: weekly performance data indicates this area will achieve compliance in May. The work required in Bridgend is anticipated to take longer and involves change in leadership, so information shared indicates that this is expected into June.

Part 1b: Compliance continues to remain above target.

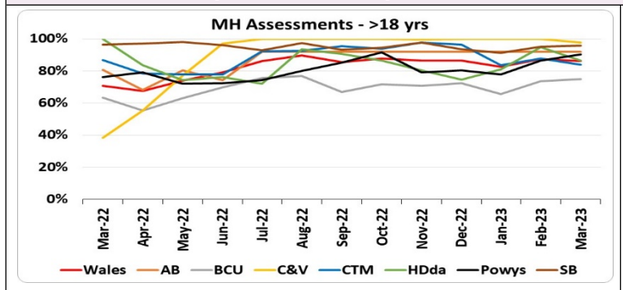
Part 2: Targeted work on non-compliant CTPs is continual. Work will continue with Community Mental Health Team leads and Local Authority partners to ensure any non-compliant CTPs are prioritised based on reducing risk. The primary risk to sustained improvements remains the reduction in staffing capacity caused by sickness and turnover. Managers are monitoring compliance weekly to mitigate reductions.

Senior Nurse action plans to increase compliance are monitored through Mental Health Planned Care Recovery Board. The focus of improvement is around the development of compliance across the multi-disciplinary care co-ordination team. Local teams have been asked to risk assess patients who do not have an up to date CTP in order to provide assurance that care is not adversely affected.

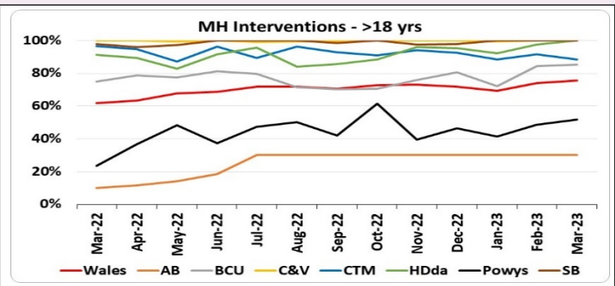
Psychological Therapies: Actions taken to improve position

- Detailed Psychological therapies recovery programme overseeing a number of improvement plans including development of a minimum dataset and a performance and accountability framework
- Ongoing waiting list and data validation including application of access policy
- Demand and capacity review
- Recruitment to vacant posts and use of locums to increase capacity
- Outsourcing of patients on the waiting list subject to available resource

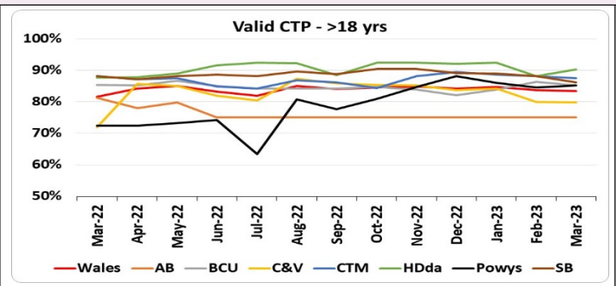
How do we compare with our peers?



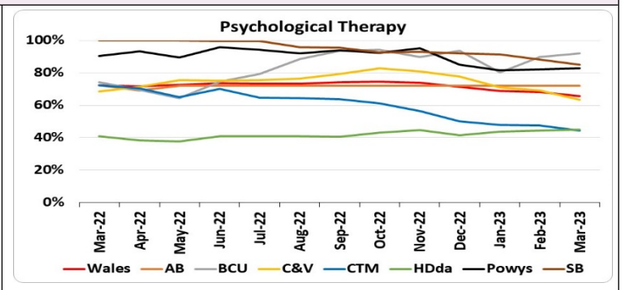
Status as at March 2023		
Health Board	Compliance	Rank
C&V	97.7%	1st
SB	96.0%	2nd
AB	91.9%	3rd
Powys	90.3%	4th
HDda	86.6%	5th
CTM	**84.0%**	**6th**
BCU	74.9%	7th



Status as at March 2023		
Health Board	Compliance	Rank
C&V	100.0%	1st
HDda	100.0%	2nd
SB	100.0%	3rd
CTM	**88.6%**	**4th**
BCU	85.3%	5th
Powys	51.8%	6th
AB	30.2%	7th



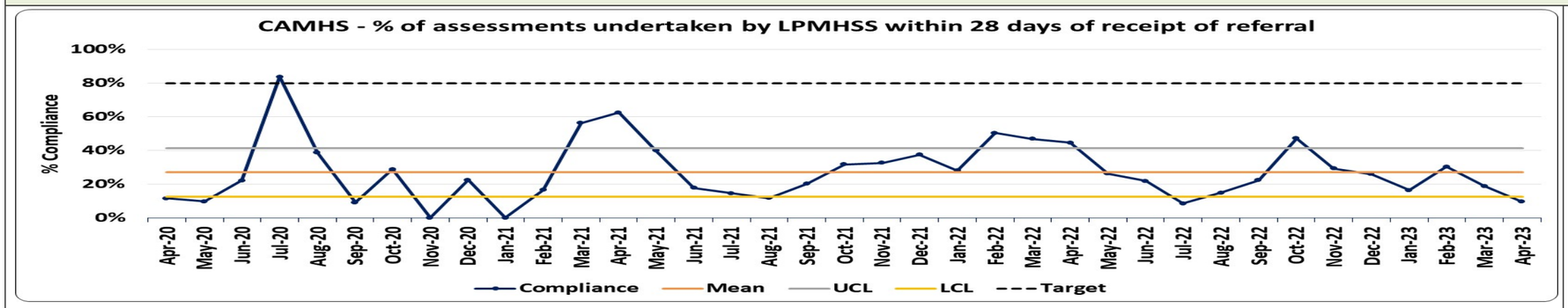
Status as at March 2023		
Health Board	Compliance	Rank
HDda	90.3%	1st
CTM	**87.6%**	**2nd**
SB	86.1%	3rd
Powys	85.3%	4th
BCU	85.1%	5th
C&V	79.9%	6th
AB	75.0%	7th

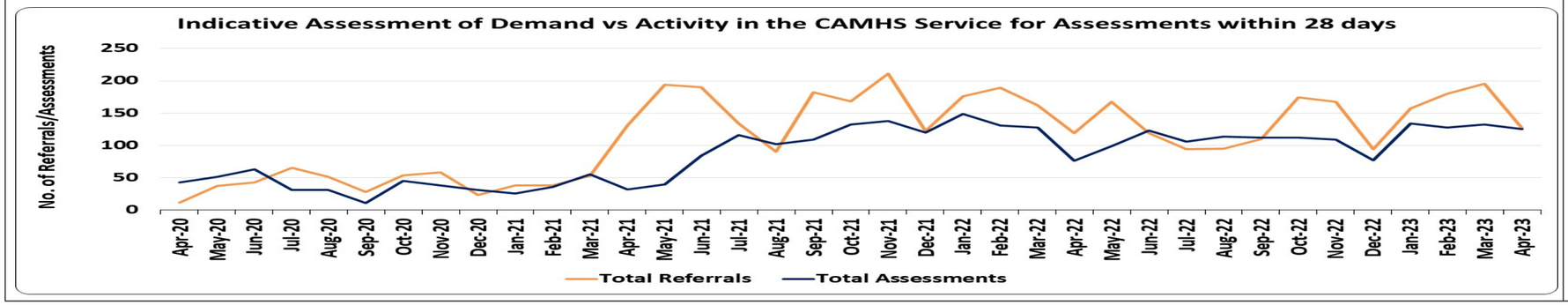


Status as at March 2023		
Health Board	Compliance	Rank
BCU	92.1%	1st
SB	85.1%	2nd
Powys	82.8%	3rd
AB	72.0%	4th
C&V	63.6%	5th
HDda	45.1%	6th
CTM	**44.5%**	**7th**

CTM Child & Adolescent Mental Health Services (CAMHS) – April 2023

% of assessments undertaken by LPMHSS within 28 days of receipt of referral (9.6%) - Target 80%





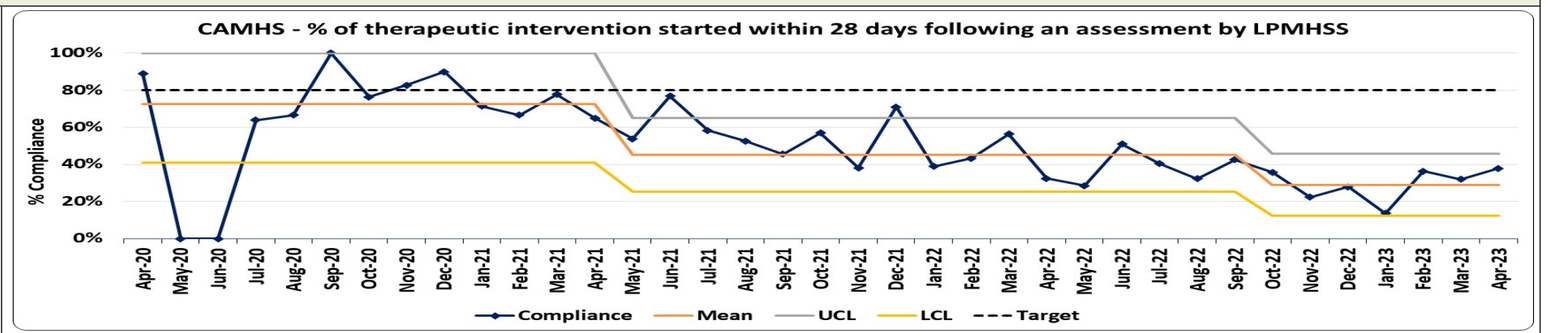
Only 9.6% of assessments were undertaken within 28 days of referral. Compliance has remained well below the WG's minimum expected standard of 80% and the last time the target was met was in July 2020.

% of therapeutic intervention started within 28 days following an assessment by LPMHSS (37.9%) - Target 80%

Overall the percentage of therapeutic interventions started within 28 days following an assessment by LPMHSS also remains low at 37.9% with just 22 of the 58 interventions during April commencing within 28 days.

Compliance continues to remain well below the 80% threshold and the last time the target was met was December 2020 (90%).

A reduction in the backlog of patients waiting for interventions, is leading to a gradual improvement in compliance



% of HB residents who are in receipt of secondary MH services who have a valid CTP (80.6%) - Target 90%

Part 2 of the Mental Health Measure, i.e. % of residents who have a valid Care Treatment Plan completed by the end of each month dropped slightly during April to 80.6%, after a much improved performance seen from January this year. For context the WG standard is 90%.

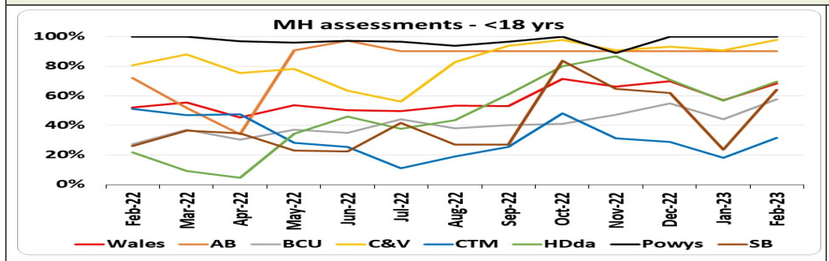
As seen in the chart to the left; from the start of the period to May 2021 the caseload volume had been fairly constant and compliance remained above the target threshold. Thereafter, caseload volumes increased incrementally until a sharp rise was seen in April 2022, where caseloads to December had grown, on average by 30 patients each month. From January 2023, we observe that caseloads have fallen, on average by 40% from the peak seen in November 2022 (462). The number of patients without a valid CTP at the end of the month stands at 54.

Part 3: There were no requests for a CAMHS assessment under Part 3 of the Mental Health Measure during April.

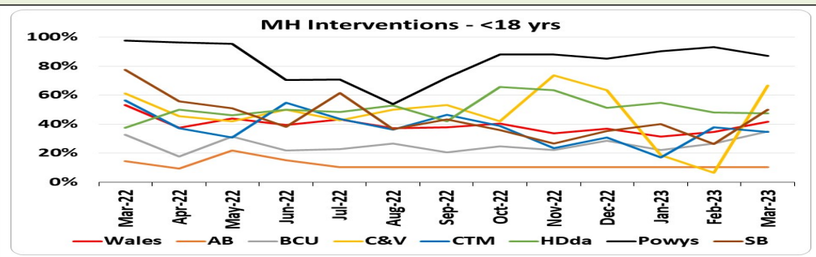
Cont'd…CAMHS

How are we doing and what actions are we taking?	When is improvement anticipated and what are the main areas of risk?
The service has maintained an increase in activity during April for new assessments. Whilst there has also been an increase in demand, the waiting list has reduced from 333 at the end of March, down to 284 at the end of April. The focus for the service is to continue to ensure patients are treated in order of longest waits to reduce the overall waiting times and backlog, unless there is clinical urgency. The service is working to sustain the increased activity over the next couple of months through the use of waiting list initiatives and the deployment of agency staff whilst vacancies are filled. As noted in previous updates, the increase in patients with a valid Care and Treatment Plan (CTP) is also being delivered whilst working with clinical colleagues to improve the quality of the service they provide. This involves work to develop individual understanding and awareness of the criteria for Part 2. **Actions being taken:** An improvement action plan and trajectories has been developed to improve compliance for all Mental Health Measures. Due to the focus on backlog and the recent increased demand for assessments during March, performance against the trajectory has fallen. These performance levels will recover going forwards as average waiting times for assessment reduce. Work progresses on the improvement action plan for Part 1a with a focus on recruitment to vacant assessor positions and a review of the referral pathway into CAMHS to ensure we reduce waiting times for assessment to a minimum. A workshop is planned to review the interface between our Single Point of Access and assessment teams. We are also exploring the use of digital assessment tools used elsewhere in Wales and across the UK, to help provide some further support for our assessment activity. With regards to Part 1b, additional resources have been deployed for interventions through the Mental Health Service Improvement Fund, and further work is underway to develop and improve our use of the third sector in this area. We are also considering the development of a referral pathway into Silver Cloud, which can provide access to online therapies. The In-Reach Service/Whole Schools Approach was implemented at the beginning of September 2022 and has been rolled out to 150 schools. This service will underpin early intervention and prevention in partnership with other organisations, supporting emotional wellbeing resilience in CYP and aim to prevent onward referrals into specialist CAMHS. We continue to focus on Part 2 compliance, involving focused work with individual care coordinators across a number of disciplines.	**Outputs of improvements** • **Part 1a:** average waiting times continue to reduce, which over time, as the backlog is removed, will help to ensure ongoing compliance. Whilst the trend of reduced waiting times for assessment continues, there was a slight increase during April. Current indicators show a further reduction in waiting times which will help to deliver compliance once the backlog has been worked through. • **Part 1b:** the improvement actions are helping to deliver performance, which for April, is above the agreed improvement trajectory. Current indicators suggest continued improvement going forward. • **Part 2:** There has been a focus on providing additional capacity and time to support care coordinators to complete CTPs with their patients. This has supported the increase in performance reported over the last 4 months. As part of the improvement plan, a revised operational policy has been developed. A central register of all care coordinated patients is now in place which helps facilitate ongoing monitoring. At the end of April there were 224 patients that had a valid CTP from a total caseload of 278, with a compliance of 80.6%. **Main areas of risk:** • The CAMHS service experiences regular fluctuations in demand, this can have a negative effect on waiting times for assessment and treatment. Going forward further work is required to better predict the impact of this fluctuating demand on the service. • The service is prioritising recruitment to vacant positions. The service needs to maintain high staffing levels to sustain performance in the three areas under review. • Clinical colleagues have reported rising acuity within their patient population, this may have an impact on delivery going forward.

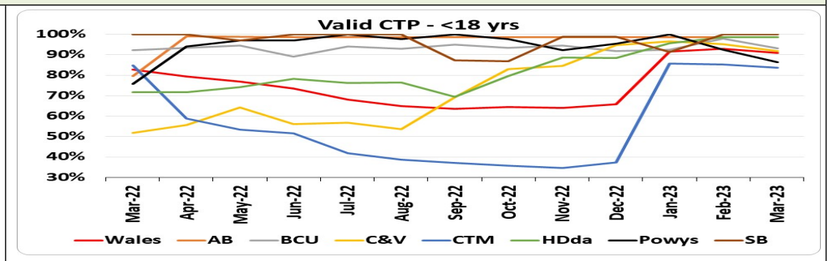
How do we compare with our peers?



Status as at March 2023		
Health Board	**Compliance**	**Rank**
Powys	94.8%	1st
C&V	92.7%	2nd
AB	90.1%	3rd
SB	73.6%	4th
HDda	72.2%	5th
BCU	61.6%	6th
CTM	**20.7%**	**7th**

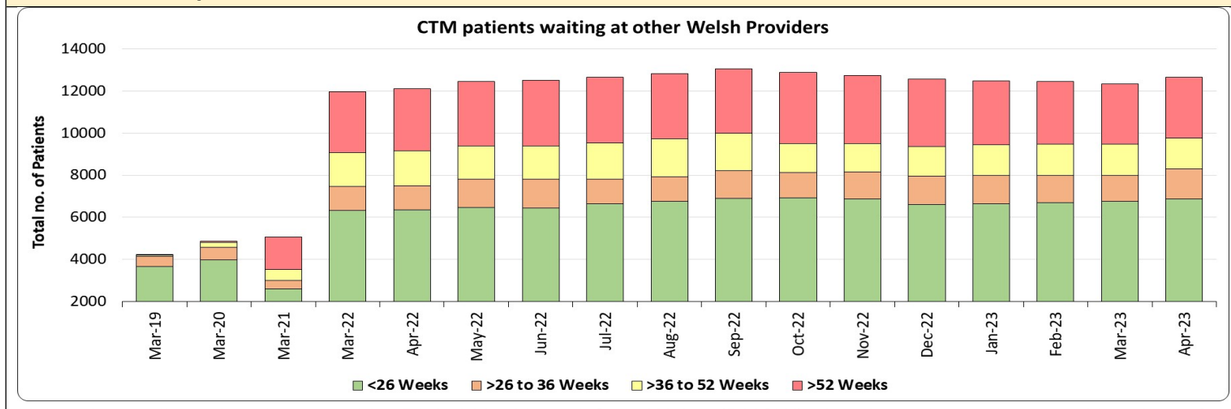


Status as at March 2023		
Health Board	**Compliance**	**Rank**
Powys	87.2%	1st
C&V	66.7%	2nd
SB	50.0%	3rd
HDda	47.4%	4th
BCU	35.1%	5th
CTM	**34.6%**	**6th**
AB	10.3%	7th



Status as at March 2023		
Health Board	**Compliance**	**Rank**
SB	100.0%	1st
HDda	98.7%	2nd
AB	98.6%	3rd
BCU	93.2%	4th
C&V	91.8%	5th
Powys	86.4%	6th
CTM	**83.7%**	**7th**

CTM Residents Waiting for Treatment at other Welsh Providers – **Please note that w.e.f. from June 2021, Swansea Bay UHB have applied a LHB residents code to their waiting list submission that has had the impact of revealing an increase in the number of CTM residents waiting for treatment at SB that were previously regarded as being their own residents. This does not affect the management of the patients as they have been reported on SB waiting lists and will continue to do so until the patients are treated.*



Using data collected and reported by Digital Health and Care Wales (DHCW), the chart above shows waiting times for CTM residents at other Welsh providers, though the actual Commissioner is not WHSSC in all instances.

Over 99% of the waiting lists for CTM residents awaiting services commissioned by WHSSC in other parts of Wales are in three Health Boards. The tables to the right provide the RTT, Diagnostic and Therapy waits for CTM patients waiting for treatment at three specific Welsh providers together with a specialty breakdown of the number of patients waiting.

The number of CTM patients waiting over 36 weeks (RTT) at these three Health Boards in April 2023 is 4,352 of which 2,896 are waiting more than 52 weeks. The number of patients waiting over 8 weeks for a diagnostic at these Health Boards is 367 and there are 2 patients waiting over 14 weeks for a therapy.

CTMUHB Patients waiting at Cardiff & Vale UHB
Referral to Treatment Times (RTT)

Specialty	>36 to 52 Weeks	>52 Weeks
Trauma & Orthopaedics	221	835
Neurology	270	417
Ophthalmology	107	224
Clinical Immunology And Allergy	56	149
General Surgery	40	81
Urology	19	49
Gynaecology	13	40
Paediatrics	43	30
General Medicine	26	25
Paediatric Surgery	24	24
Oral Surgery	19	19
ENT	15	18
Cardiology	6	10
Gastroenterology	9	8
Clinical Pharmacology	5	3
Dental Medicine Specialties	9	3
Orthodontics	1	2
Clinical Haematology	1	
Dermatology	3	
Geriatric Medicine	1	
Anaesthetics	6	
Cardiothoracic Surgery	2	
Nephrology	3	
Neurosurgery	5	
Paediatric Dentistry	9	
Paediatric Neurology	1	
Restorative Dentistry	1	
Grand Total	915	1937

Diagnostics

Service	Total Waits	>8 wks
Radiology	207	59
Cardiology	138	45
Endoscopy	84	53
Physiological Measurement	5	2
Imaging	2	0
Neurophysiology	1	0
Total	437	159

Therapies

Service	Total Waits	>14 wks
Physiotherapy	21	
Dietetics	16	
Occupational Therapy	6	
Podiatry	1	
Total	44	0

CTMUHB Patients waiting at Aneurin Bevan UHB
Referral to Treatment Times (RTT)

Specialty	>36 to 52 Weeks	>52 Weeks
Urology	11	48
Trauma & Orthopaedics	11	36
ENT	8	23
Ophthalmology	26	15
Oral Surgery	7	7
General Surgery	10	2
Orthodontics	3	1
Cardiology	1	
Dermatology	1	
Gastroenterology	3	
Gynaecology	2	
Neurology	1	
Rheumatology	1	
Endocrinology	1	
Grand Total	86	132

Diagnostics

Service	Total Waits	>8 wks
Endoscopy	33	22
Radiology	23	1
Physiological Measurement	2	2
Total	58	25

Therapies

Service	Total Waits	>14 wks
Physiotherapy	14	
Podiatry	1	
Audiology	2	2
Total	17	2

CTMUHB Patients waiting at Swansea Bay UHB
Referral to Treatment Times (RTT)

Specialty	>36 to 52 Weeks	>52 Weeks
Plastic Surgery	80	227
Oral Surgery	138	220
Trauma & Orthopaedics	66	169
Orthodontics	35	64
General Surgery	64	56
Gynaecology	24	26
Gastroenterology	1	19
ENT	5	14
Neurology	22	14
Paediatrics		8
Ophthalmology	3	5
Urology	8	5
Cardiology	1	
Clinical Haematology	1	
Dermatology	1	
Diagnostic	6	
Grand Total	455	827

Diagnostics

Service	Total Waits	>8 wks
Neurophysiology	199	124
Cardiology	76	17
Endoscopy	53	41
Physiological Measurement	1	1
Total	329	183

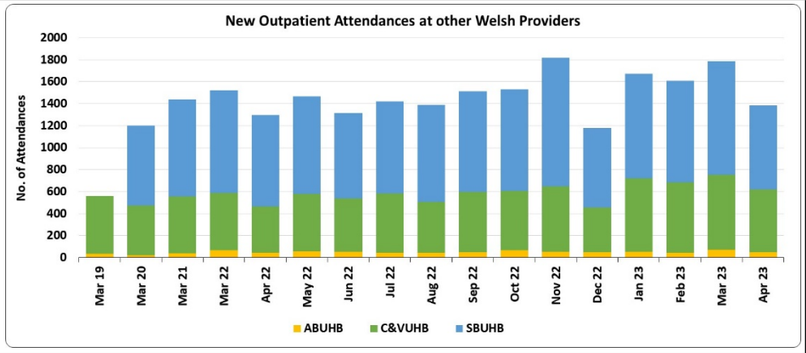
Therapies

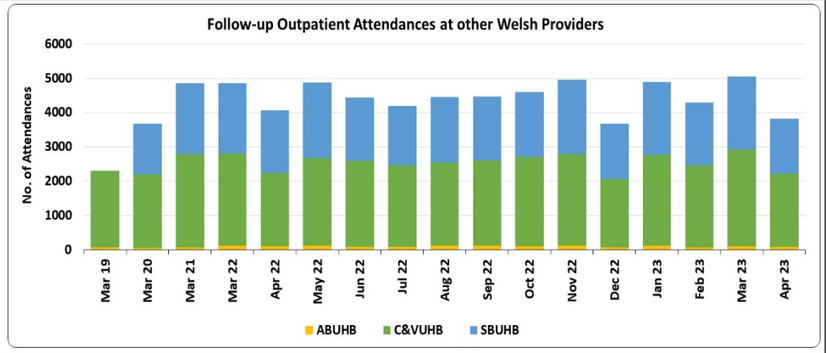
No patients waiting for a therapy

CTM patients waiting at specific health boards (RTT)

April 2023	Cardiff & Vale UHB		Aneurin Bevan UHB		Swansea Bay UHB	
<26 Weeks	3511	49.0%	380	55.9%	2966	61.8%
>26 to 36 Weeks	804	11.2%	82	12.1%	548	11.4%
>36 to 52 Weeks	915	12.8%	86	12.6%	455	9.5%
>52 Weeks	1937	27.0%	132	19.4%	827	17.2%
Total Waiting	7167		680		4796	
% of total waiting at other providers	56.5%		5.4%		37.8%	

CTM Outpatient Attendances at other Welsh Providers



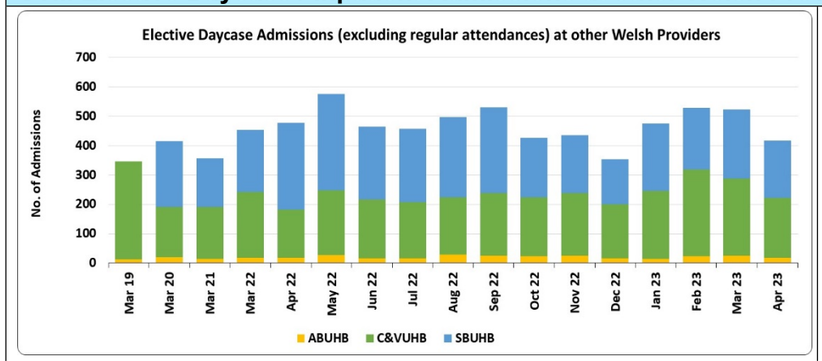


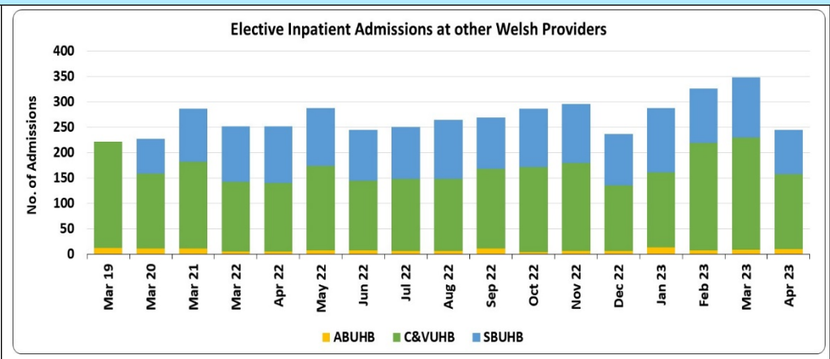
The May position (June reporting period) continues to show marginal change from the previous reported position.

There are two CTMUHB residents waiting up to 52 weeks for Cardiac Surgery at Cardiff and Vale UHB (one fewer than in the previous reporting period) but no patients waiting in excess of 52 weeks.

The performance of Neurosurgery has remained relatively stable, with no patients waiting more than 52 weeks currently. Five patients have waited between 36 and 52 weeks (an increase of 1 from the previous month). Neurology waits remain a significant concern with a total of 417 patients waiting more than 52 weeks (a growth of 17 since the previous reporting period).

CTM Elective Daycase / Inpatient Admissions at other Welsh Providers





Cardiff and Vale paediatric surgery waits are still over 52 weeks with 24 breaches currently, however this is a reduction from the previous reporting period.

Plastic Surgery remains an area of concern for Swansea Bay performance with very static status. The number of CTMUHB residents waiting over 52 weeks currently sits at 227 (a reduction of two since the previous month).

2.3 Finance update – Month 2

Updates on the financial position become available on the 9th working day of the month. Consequently there is no further update available to that provided in the last financial report.

- £3M of the accrual which is 6/ of £6.0m.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The key risks for the **Performance** quadrant are covered in the summary and main body of the report.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	A number of indicators monitor progress in relation to Quality, Safety and Patient Experience, such as Healthcare Acquired Infection Rates and Access rates.
Related Health and Care standard(s)	Choose an item.
	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes. The work reported in this summary and related annexes take into account many of the related quality themes.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not yet assessed

Legal implications / impact	Yes (Include further detail below)
	A number of indicators monitor progress in relation to legislation, such as the Mental Health Measure.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
	There are no directly related resource implications as a result of this report, although a number of improvement areas have underpinning financial plans.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Board/Committee is asked to **NOTE** the Integrated Performance Dashboard.

AGENDA ITEM
5.3

PLANNING, PERFORMANCE & FINANCE COMMITTEE

MENTAL HEALTH 2023-4 SERVICE IMPROVEMENT FUNDING & UPDATE ON 2022-23

Date of meeting	(27/06/2023)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Elaine Lorton – Service Director MH&LD Lisa Davies – Assistant Director of Strategic Transformation MH&LD
Presented by	Julie Denley – Deputy COO – Primary, Community & Mental Health
Approving Executive Sponsor	Chief Operating Officer (COO, DPCMH)
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
ANP	Advance Nurse Practitioner
CAAP	Clinical Associate in Applied Psychology
CAMHS	Children and Adolescent Mental Health Services
CTM UHB	Cwm Taf Morgannwg University Health Board
EIP	Early Intervention in Psychosis

HEIW	Health Education and Improvement Wales
LD	Learning Disability
MH&LD	Mental Health & Learning Disability
NDIP	Neurodiversity Improvement Programme
PA	Physician Associate
SIF	Service Improvement Funding
WG	Welsh Government

1. SITUATION/BACKGROUND

1.1 This paper provides an overview of the SIF awarded by WG for the years 2022-23 and 2023-24. It will address :

1.1.1 The purpose and expectations of the SIF.
1.1.2 An update on the projects supported 2022-23
1.1.3 An overview of the projects approved for 2023-24.
1.1.4 Utilisation of slippage for Planned Care Recovery.

1.2 **What is the SIF?** : Each year WG writes to the Health Board outlining what funding is available to support service improvement in mental health. The funding is provided on a recurrent basis subject to :

- Proposals aligning with defined WG priorities and being approved following bid submission
- Demonstrated delivery of projects, especially successful appointment to new posts or award of commissioned activity.

The priority areas were identified through the Together for Mental Health Strategy and Delivery Plan, which covered the period between 2019 and 2022. Welsh Government is in the process of refreshing the delivery plan to implement from 2024 with consultation due to commence in December.

It is expected that the funding is ring-fenced for the projects agreed by WG, where there is non-recurrent slippage, permission can be sought to use funding to support planned care recovery priority activity. The Planned Care Recovery Programme Board in the MH&LD Care Group provide oversight of this programme.

£1.7m of recurrent funding was received before 2022-23 and has been used to support a range of priorities and pressures, including £0.25m to support the upcoming ward skill-mix review.

1.3 **2022-23 SIF**: £3.3m was allocated against 14 priority areas however, only £2.09m of funding was released in year as not all delivery could be implemented for full year effect. 2.1 below provides an update against the use of this funding for 2023-24 and then recurrently (See Annex 2 for overview).

SIF was used to support the development of the Care Group Leadership Team as part of the Phase 1 Organisational Change Process, and has supported the financial position of the Care Group.

1.4 **2023-24 SIF:** On 22nd March 2023, WG wrote to all Health Boards outlining the allocation and process for bid submission for the year. The deadline for submission of bids was the 2nd May 2023 and the maximum allocation was £768,000.

A portion of SIF was top-sliced across Wales to support delivery of The strategic mental health workforce plan for health and social care (heiw.nhs.wales/files/mental-health-workforce-plan1/) resulting in a far smaller allocation for each Health Board.

Two mandatory priority areas for implementation were specified :

- 111 press 2
- Perinatal mental health services.

Non-mandatory but specified priority areas for consideration were:

- Children and Adolescent Mental Health Services (CAMHS)
- Increased access to psychological services
- Secure services review
- Early Intervention in Psychosis (EIP)
- Eating disorder support
- Liaison psychiatry services
- Primary care liaison and additional support for tier 0/1 services.

WG have been consistently clear that the SIF is intended to support the revenue costs of service improvements and this is usually through the development of the workforce or commissioned providers. Other costs, for example capital estate developments and IT, have not been supported.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 **SIF 2022-23 Update to WG**: Following the full submission for funding made to WG in 22/23, quarterly reports were sought and submitted to confirm spend against approved schemes. On 30th April 2023 we submitted to WG an outline of how we plan to fully utilise the full £3.3m allocation recurrently, reconfirming the plan submitted in 2022/23. The return required an overview of the posts that have been appointed to and plans for further implementation.

It is expected that £2.7m will be required for recurrent delivery against plans that were originally submitted in 22-23, and that there will be non-recurrent in year slippage of £0.6m while other posts are phased in. Approval was sought to utilise any slippage to support quality improvement and planned care recovery in year. (see 2.4).

On 17th May 2023, the following funding confirmation was received from WG:

On the basis of the information provided we note that you have robust plans in place to spend your full allocation this year and have mitigating actions in place to support recruitment of the remaining positions. We also note your intended use of non-recurring funding this year which we are supportive of as it meets current policy intent.

In light of this we have requested finance to process a resource uplift for 75% of your full year allocation (£3.301m) and will request a further update at the end of September in order to release the balance.

The 25% of funding not currently confirmed equates to £0.825m and it is proposed that the risk of not receiving this is low where we can provide evidence of spend.

SIF 2023-24 Proposals to WG: On 2nd May 2023 five proposals for the full allocation of £0.768m were submitted to WG. Due to the low level of additional funding, not all the recommended priority areas could be supported so those areas of greatest need in line with the Care Group Service Plan were prioritised. The proposal was submitted to the Executive Leadership Group prior to submission (see Annex 1).

The proposals include new ways of working, both with other providers and introducing new roles to the organisation.

No additional funding was sought for the second mandatory priority area and the Care Group concluded that the key requirements for perinatal mental health services have been met. However, further discussions will be held with the Children and Families Care Group to identify what further development and investment is required from 2024-25.

2.1.1 **111 Press 2:** 50% of the funding has been allocated to support the 111 press 2 service moving to the 24/7delivery model, this commenced in April 2023.

2.1.2 **Wellbeing Sanctuary Model:** A 'Once for CTM' wellbeing sanctuary model is in development following the success of the Bridgend pilot in 2021. This service is delivered by a third sector partner and has had a positive evaluation. The aim of the wellbeing sanctuary service is to provide safe space for individuals to receive out of hours support when experiencing mental health distress. This will provide a place for individuals to receive early support, potentially avoiding the need for further support from statutory services including Emergency Departments; Crisis teams and inpatient units. A second sanctuary will be supported with this funding in the Merthyr Cynon area.

2.1.3 **Psychology Clinical Associate in Applied Psychology (CAAPs):** This new role seeks to fill an identified skills gap between assistant psychologists and qualified clinical psychologists within the Local Primary Mental Health Support Services. This capacity will help improve adherence to the NHS Wales Delivery Framework and improvement against the specialist psychological therapies target. The Care Group supported this role on the basis the core service match funded to model the transition to new roles as part of business as usual.

2.1.4 **Physician Associate (PA)** : Two PAs are being sought through streamlining in order to enhance the quality of MDT provision in secure inpatient mental health services, particularly as part of the rehabilitation model. Physician associates are healthcare professionals with a generalist medical education and work alongside doctors providing medical are care as an integral part of the MDT. As above core funding matching was agreed as part of supporting this submission.

2.1.5 **KOOTH :** This proposal will support alternative digital platforms for children and young people across CTM UHB which focuses on earlier intervention and provides alternative service provision 24/7 including online counselling and support sessions. This service

provision aims to reduce demand on CAMHS services and will be promoted through the Whole School Approach across CTM UHB.

It is recognised that there are some key areas of challenge or areas for service development across the Mental Health and LD Care Group that could not be supported with the smaller allocation of funding in 2023/24. Throughout the year the MH&LD Planned Care Recovery Programme Board will seek to address capacity constraints in these services (see 2.4).

2.2 **WG Approval of SIF 23-24 proposals** : On 5th June 2023 WG confirmed full recurrent approval of the total £0.768m, however it noted that this funding would be allocated on a phased approach:

- Approved projects are agreed in principle and the full costs underwritten.
- Projects which are deemed to be waiting list initiatives or requiring non-recurrent funding will have the full amount released.
- All other projects will receive an initial allocation of 6 months of funding, with further allocations dependent on the Health Board's ability to recruit to related posts.

For CTMUHB this reflects an initial release of £0.384m with the full allocation remaining available for us to spend. A return will be commissioned in October to enable us to provide an update against delivery. If draw down of additional funding is required against delivery, this can be requested sooner.

It is projected that £0.539m will be utilised in 23-24 for agreed projects and £0.229m will be sought to support MH&LD Planned Care Recovery Board programmes (see 2.4).

2.3 **MH&LD Planned Care Recovery Programme Board:** The MH&LD Care Group have an established governance structure to focus on the utilisation of slippage funding to support delivery against performance targets. It is currently projected that slippage from 22-23 is £0.6m and slippage in 23-24 will be £0.229m, total of £0.829m.

The priority areas for improvement are :

- 26 week Psychology waiting list including active monitoring to support those waiting to "Wait Well"
- Mental Health Measure – Adults & Children's
- Memory Assessment Services Waiting List
- Interim Perinatal development (pending 24-25 proposal)

- Neurodiversity service redesign where the NDIP funding does not address the full need.

Proposals have already been submitted totalling £0.889m with £0.3m having been approved:

- Recruitment of assistant psychologists to support "waiting well"
- Outsourcing of therapy to reduce psychology 26 week waiting list
- CAMHS additional assessment and intervention capacity
- Recruitment into non-medical prescribing ANP role to support outpatient capacity

The MH&LD Planned Care Recovery Programme Board will scrutinise the remaining proposals to improve outcomes against the performance targets agreed with WG and prioritise appropriate investment. This will support both full utilisation and draw down of SIF but also deliver against expected performance targets.

2.4 **Future SIF Allocations:** Clarification has been sought from WG regarding future allocations and the timeline and general scale of these. At present this remains an annual allocation.

The MH&LD Care Group will be implementing a process for the submission and review of investment proposals throughout the year. This will enable the development of a considered priority list for any future allocations against the following priorities:

- Regional strategic fit
- Performance improvement
- Quality improvements
- Equitable service delivery pan-CTM
- Core service consolidation and stabilisation
- Workforce planning & reform
- Value for money
- Sustainability

The process will engage and include clinical teams as well as other partners and key stakeholders. We will be seeking to implement an approach, which takes feedback from our patients / population on the priorities identified.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 There is a low risk associated with agreeing Planned Care Recovery spend without confirmation of drawn down funding from WG. This is

mitigated by the stated support in WG letters and discussion of plans through Targeted Intervention meetings.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	This paper sets out the proposals to fund from the Additional Mental Health allocations which aim to improve the quality, safety and patient experience of mental health services across CTM UHB
Related Health and Care standard(s)	Staff and Resources
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	This paper sets out the proposal for the allocation of funding equating to £768,000 across key priority areas in the Mental Health and LD Care Group. For note: £92,131 from 22/23 allocation has been forecast to support control total in 2023/24. £484,611 from previous years plans has been forecast to support control total in 23/24.
Link to Strategic Goals	Creating Health

5. RECOMMENDATION

5.1 The Committee are asked to **NOTE** the additional mental health funding allocation and approach by the Mental Health and LD Care Group.

Annex 1 : SIF Projects 2023-24

Additional mental health funding priority area	Title of the proposal	Aim of investment	Amount of funding
Crisis care/out of hours provision	Implementation of 111 press 2 for mental health 24/7	To fund the staffing requirements to enable CTM UHB to meet the national requirements of providing the 111 press 2 24/7. 111 press 2 will be the 'front door to urgent mental health care' and aims to provide the right help at the right time	383,378
	Once for CTM UHB Wellbeing Sanctuary Model	To fund a safe space for individuals to receive out of hours support when experiencing mental health distress and to extend the current service to enable access to a small number of sanctuaries across CTM UHB	150,000
Children and Adolescent Mental Health Service (CAMHS)	Alternative digital children and adolescent mental health (CAMH) Service provided via Kooth to complement traditional CAMH services and treatment in CTM UHB	To fund an online mental health and wellbeing support service provision for children and young people across CTM UHB. This service provision will focus on intervention and alternative service provision that can be accessed out of hours and without referral to improve the emotional wellbeing of children and young people, with an aim of reducing demand on CAMHS	86,400
Increased access to psychological services	Investing in Psychology Clinical Associate in Applied Psychology (CAAPs)	To fund a Clinical Associate in Applied Psychology which will increase capacity and improve access to psychological services	61,010
Secure services Review	Investing in new professional roles to enhance the multi-disciplinary team (MDT) provision in secure inpatient services	To fund a Physician Associate to work in our rehabilitation wards to enhance the MDT and provide regular and consistent input in the review and monitoring of phyical health of mental health patients.	87,212
		To fund some quality improvement time and training to support our work across inpatient wards and focus around reducing restrictive practices	
		Total	**768,000**

Annex 2 : SIF Projects 2022-23

Additional mental health funding priority area	Title of the Proposal	Aim of Investment	Total Funding Approved
Early Intervention Psychosis	Developing EIP Services	Implementing care co-ordination, occupational therapy and support worker.	£111,812
Perinatal Services	Enhancing Nursery nurse provision	Implementing nursery nurse model as part of MDT.	£53,909
Crisis Provision	Forensic Response	Developing care co-ordination and enhancing case management.	£194,000
Sustainable service provision	ECT SLA	Supporting cost pressure	£65,786
Strengthening the MDT	Psychologically informed care	Psychology roles for LPMHSS and Older Adult MH.	£592,279
	Quality & Improvement Team	Strengthening clinical leadership. Quality improvement team	£96,400
	Care Group Strategic Leadership	Supporting the development of the Care Group for Phase 1 of the OCP	£286,817
Eating Disorders	Children, Young people & adults	Building a more robust team through recruitment of additional consultant, occupational therapy, dietician, psychotherapy and administrative support.	£353,366
Primary Care / Tier 0	Emotional & Mental Health in Primary Care	Supporting enhanced first contact provision through recruitment of MH practitioners, occupational therapy, cluster development.	£699,600
	Third sector commissioned care	Developing case management and lived experience engagement	£44,000
Alternatives to admission	6 Urgent & Emergency Care Goals Alignment	Development of 111 press 2 – pilot and up to 15 hours per day	£550,373
	Wellbeing sanctuary	Crisis retreat / wellbeing sanctuary in Bridgend	£33,000
TOTAL			**£3,301,342**

AGENDA ITEM
5.4

PLANNING, PERFORMANCE & FINANCE COMMITTEE

REGIONAL OPHTHALMOLOGY STRATEGY

Date of meeting	27/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Elizabeth Beadle, Assistant Director of Transformation
Presented by	Linda Prosser, Executive Director of Strategy and Transformation
Approving Executive Sponsor	Executive Director of Strategy and Transformation
Report purpose	ENDORSE FOR BOARD APPROVAL

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
South East Wales Regional Planning Portfolio Board	(14/02/2023)	SUPPORTED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Chief Executives for the South East Wales region (Cardiff and Vale University Health Board, CAVUHB, Cwm Taf Morgannwg University Health Board, CTMUHB and Aneurin Bevan University Health Board, ABUHB) renewed their commitment to joint working and regional

service provision where clinically appropriate. This is being supported through the Regional Portfolio Board.

1.2 This refreshed approach to the governance of regional working coordinates these efforts and each Health Board is taking the lead for a specific priority area;

1.2.1 ABUHB: Ophthalmology
1.2.2 CTMUHB: Diagnostics
1.2.3 CAVUHB: Orthopaedics

1.3 The purpose of this paper is to provide an update on the regional ophthalmology work, and to seek approval for the regional strategy which sets out the proposed regional approach to developing ophthalmic services.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 The focus of regional partnership arrangements directed by the programme has been on two priority areas of work which, although discrete at present, are intrinsically linked in the medium to long term.

2.2 The first is the development of a South East Wales regional care strategy which describes the wider medium / long term provision for eye care.

2.3 The second is the progression of regional cataract capacity expansion to support all Health Boards manage immediate waiting list pressures and anticipated demand levels in the coming years.

2.4 The strategy has been developed with clinical and operational input and sets out the intention for the future direction of regional ophthalmic services and is founded on four key principles.

2.5 The table below sets out the pattern of service delivery that is proposed by the strategy. This is founded on more straightforward

services being provided locally (within HB regions) and more complex and fragile services to be provided regionally. Screening, monitoring and (low-risk) follow up activity will be delivered in community settings wherever possible.

Specialty	On a regional level	At a local level	Community
Glaucoma	Surgical / complex Glaucoma	Medical Glaucoma	Stable treated Glaucoma, Ocular Hypotension
Uveitis	Complex Uveitis	Anterior Uveitis	Simple recurrent Uveitis
Emergency Eye Care:	Eye Casualty	Follow up clinics	Follow ups, Minor Ailments
Out of hours Care	Out of hours Care		
Cornea	Cross linking	Routine Cornea	Keratoconus Monitoring
Oculoplastic	Orbit, Complex	Lids, Minor ops	
Medical Retina	Retinal Dystrophies, Genetics, complex Medical Retina	Stable monitoring, injection services, stable diabetic eye disease	Diabetic screening and monitoring
Paediatrics and Orthoptics	Complex Paediatrics	Routine Paediatrics,, Adult Orthoptics, Paediatric Orthoptics	Screening
Neuro Ophthalmology	Neuro Ophthalmology		
Vitreo retinal	Emergency and routine procedures		
Cataracts	Cataracts Expansion	Cataracts	Follow ups

2.6 The cataracts business case and associated reports set out the work undertaken regionally, under the auspices of the regional ophthalmology programme to develop short-term options to deliver additional regional capacity for cataracts to reduce the number of long waiting patients and the length of time that patients wait across the south east Wales region for cataract treatment. The final business case is included as **Appendix 1**.

2.7 A number of proposals to increase regional capacity have been developed and subjected to robust option appraisal process with clinical, operational and planning leads. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working as set out in appendices 3 and 4.

2.8 Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%

- Access: 10%
- Deliverability: 20%

2.9 The six options identified were:

- **Option 1: Do nothing** - to do nothing and only retain the core capacity of 5,940 per year across the region.

- **Option 2: Maximising the use of Nevill Hall Hospital (NHH) and Princess of Wales Hospital (POWH) -** This option uses one theatre in NHH for 7 weekday sessions and 4 weekend sessions, and the twin theatre in POWH. The option also includes 2,000 outsourced patients. This option would provide total additional capacity of 8,668, which with the core capacity of 5,940 is 14,608 total capacity.

- **Option 3a: Vanguard and NHH -** This option uses one theatre in NHH for 4 weekend sessions and the twin Vanguard theatre, which is currently in situ at University Hospital for Wales and being deployed in quarter four of 2022-23 to provide treatment to patients across the HW. This option would provide total additional capacity of 7,700 plus a core capacity of 6,120 to create 13,820 total capacity.

- **Option 3b: Vanguard and Maximising NHH -** This option uses one theatre in NHH for 7 weekday sessions and 4 weekend sessions, and the twin Vanguard theatre in UHW. This option would provide total additional capacity of 9,310 plus a core capacity of 6,120 creating 15,430 total capacity.

- **Option 4: Weekend Insourcing and Outsourcing only-** This option uses one theatre in NHH for 4 weekend sessions and the twin theatre in POWH. The option also includes 2,000 outsourced patients. Through this option the total additional capacity is 5,000 plus a core capacity of 5,940 is 10,940 total capacity.

- **Option 5: Outsourcing activity to external provider(s) -** This option involves outsourcing 5,000 patients in 12 months. Through this option the total additional capacity is 5,000 plus a core capacity of 5,940 is 10,940 total capacity.

2.10 The outcome of the option appraisal both individually by Health Board and collectively for the region was that option 3b was the most optimal option on the basis of the criteria.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The regional ophthalmology strategy has been approved by the Regional Portfolio Board and was approved by the Cwm Taf Morgannwg University Health Board Strategic Leadership Group on 24th February 2023.

3.2 The PPF Committee approved the strategy on 28th February and also approved the business case in principle on this date, noting that the financial requirements would be presented following completion of the final assessment, for further ratification. This report and approach was endorsed in principle by the Board on 30th March 2023.

3.3 The identification of option 3b as the preferred option for the regional cataracts business case development has been ratified by the Regional Portfolio Delivery Board on 9th February and the Regional Portfolio Oversight Board on 14th February and was endorsed by the PPF Committee on 28th February 2023 and the Board on 30th March 2023.

3.4 The next phase for the regional cataracts business case was the fuller financial appraisal and identification of funding mechanisms has been completed. The business case with the required funding confirmed has been approved at the following fora.

- Regional Ophthalmology Programme Board - 13th February 2023
- Regional Portfolio Delivery Board – 6th April 2023
- Regional Portfolio Oversight Board – 13th April 2023
- Management Executives ABUHB – 13th April 2023
- Investment Group CVUHB – 18th April 2023
- Strategic Leadership Group CVUHB – 4th May 2023
- Management Executives CTMUHB (Executive Leadership Group) – 9th May 2023

3.5 Key points to note for Cwm Taf Morgannwg University Health Board are:

3.5.1 The cost to Cwm Taf Morgannwg University Health Board of the proportionate commissioner share has increased from the previous assessment. The costs were originally anticipated to be c£4m but have been confirmed to be £5.1m (£5,125,028). This is in the main related to Cwm Taf Morgannwg University Health Board having 49% of the long waiting cataract patients and consequently requiring the largest share of the activity from the regional solution. There was also a movement in the costs of the business case of an additional £500,000 which is to cover a 5% increase in pay costs for the NHH service.

3.5.2 The proposed mechanism for funding the regional cataract business case collectively is the regional funding held by Welsh Government for planned care recovery and performance improvement. The £5.1m requirement for the Cwm Taf Morgannwg University Health Board commissioner share has been included in the collective South East Wales regional funding proposal that was submitted to Welsh Government in May 2023.

3.5.3 Confirmation of the outcome of the funding proposal has not been received but is expected during late June 2023. Should the full funding be approved this will be used to fund the Health Board's share of the costs of the cataract business case.

3.5.4 Should Welsh Government allocate a lesser amount of funding, the business case will require revision to fit with available resources as agreed by the South East Wales Portfolio Oversight Board. (26th June 2023).

3.5.5 Work is being undertaken on a memorandum of understanding that reflects all parties' (Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg University Health Board) requirements and it is intended that this would include the Cwm Taf Morgannwg University Health Board position that funding would be only to the value of the allocation received from Welsh Government.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	Delivery of this strategy is intended to improve access to ophthalmic services and to improve outcomes for patients.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:

	Timely Care Effective Care
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Any service change/development proposals arising from the strategy will have equality impact assessments.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1.1 The committee is asked to note the contents of the report and associated appendices and to:

5.1.2 Consider the financial impacts associated with the regional cataracts business case for delivery of option 3b, noting that if the full request to Welsh Government is not authorised, the business case would be revised to reflect the funding envelope available.

5.1.3 Endorse for Board Approval support of the regional cataract business case as set out in section 3.5 and recommendation 5.1.1.

Offthalmoleg Ardal De-ddwyrain Cymru
South East Wales Regional Ophthalmology

Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg

University Health Boards

Business Case

Title	Regional Cataracts Expansion Business Case		
		Date Last Updated	12/05/2023
Accountable Executive	Director of Planning (AB)	**Lead /Project Manager**	Programme Manager
Clinical Service		Planned Care, Ophthalmology	

1. Executive Summary

This Business Case seeks to provide a 14 month solution for additional 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.

This additional capacity will provide a service for health board patients from Aneurin Bevan, Cwm Taf Morgannwg and Cardiff and Vale University Health Boards.

Aims

The aims of the regional solution outlined in this business case are

- to enact a collaborative regional approach to recovery
- to provide additional regional capacity for cataract outpatient and inpatient stages
- to demonstrate optimal utilisation of our assets and resources across the region
- to address current waiting list backlogs
- to reduce clinical risk on an equitable basis across the region

The Regional Ophthalmology Programme Board have also agreed a set of regional working principles on which the approach to expanding cataract capacity will be based.

- Treating the longest waiters first, regardless of their 'home' health board
- Using the outsourcing, insourcing, evenings and weekends capacity for less complex patients
- Adopting best practice guidance in all sites
- Adopting shared waiting list (PTL) management arrangements

Each health board is at a different starting point for their waiting list and this is reflected in the trajectories and projections. It is anticipated that as a result of this business case the following trajectories will be met:

- Aneurin Bevan: no patients waiting over 104 weeks for an outpatient appointment by the end of the funding period
- Cwm Taf Morgannwg: no patients waiting over 104 weeks for an outpatient appointment by the end of the funding period
- Cardiff and Vale: no patients waiting over 78 weeks for an outpatient appointment by the end of the funding period

Staged Delivery

The Regional Ophthalmology Programme Board have agreed the following staged approach to delivering sustainable cataracts solutions in the region, whilst balancing the need to activate capacity quickly and reduce the rate that the backlog is growing. This business case represents the first stage.

- Stage 1 – A Business Case for maximising our existing assets and increasing capacity with a focus on recovery activity and reducing waiting lists to run for 14 months.
- Stage 2 – Developing sustainable staffing and clinical models for the region. For cataracts and VR in University Hospital Wales (UHW), Cardiff, and cataracts and VR referral pathways across the region. To include new staffing models, new clinical models and costings, this model will be operational on the conclusion of stage 1.

Demand and Capacity

The region is presented with a sizable challenge for backlog, demand and capacity. Demand continues to outstrip capacity and is forecast to grow year on year.

- The total number of patients waiting for assessment and treatment for cataracts is forecast to reach over 19,000 by the end of March 2023.
- Demand across the region has returned to pre-pandemic levels and is forecast to be 9,960 per year for 23/24

- The projected combined core capacity across the region for 23/24 with no further intervention is 5,940 treatments and assessments per year, broken down as follows
    - Aneurin Bevan UHB – 2,400
    - Cardiff and Vale UHB – 1,440
    - Cwm Taf Morgannwg UHB – 2,100

Eliminating the waiting list backlog in 23/24 would require a capacity of 28,960 in one year, almost five times the projected combined core capacity. With no further intervention the projected waiting list of 19,000 in March 2023 would therefore be over 23,000 by March 2024.

Delivery Assumptions

Shared PTL

To support a regional approach, the three health boards have agreed to pool their patient treatment lists (PTL) and adopt shared waiting list management arrangements for the allocation of the additional regional capacity. This will be supported by a regional booking team who will also manage the shared patient waiting list ensuring that the patients who have been waiting the longest are treated first, regardless of their 'home' health board.

North and South Hubs

The geography of the region lends itself to distributing the capacity is across a North and South Hub model. This model that will keep service delivery closer to home and reduce patient travel as far as possible.

Insourcing and Outsourcing

The capacity across the region can be rapidly increased by utilising the local opportunities for insourcing and outsourcing. These arrangements make the best use of our assets across the region for short-term flexible arrangements that protect our core capacity.

Patient Second Offer and Travel

Patients will be offered the opportunity to travel to receive their assessment and treatment as part of the additional capacity arrangements where thy may be able to be treated sooner. At a maximum travel would be 40 miles and 55 minutes by private car under normal traffic conditions and most of the patient travel will be shorter. Patients unable or unwilling to travel will keep their place on the waiting list and receive treatment from their home health board. A recent survey of 140 patients across the region shows that 71% of patients would be willing to travel.

Allocation by Health Board

The table below shows the numbers of patients waiting and how this is split proportionally across the region. Data relates to August 2022 and includes the total number of patients waiting in each health board.

Patient Waits	Total			Over 52 weeks	
AB	7041	39%		2175	36%
CAV	4066	22%		891	15%
CTM	7103	39%		2939	49%
	18210			6005	

As a proportion of the patients waiting, 39% are from AB. 39% from CTM and 22% from CAV. When this is viewed as patients waiting at the end of the lists the proportions change and it is from this pool of patients that the additional capacity would be targeted.

Of this group of longer waiters 49% are from CTM, 36% from AB and 15% from CAV and this indicates how the additional capacity will be used.

Options

To achieve the stated aims of the business case, the options need to:

- Be mobilised quickly
- Be deliverable with the resources available
- Protect the viability of the core capacity
- Keep patient travel to a minimum

The options are:

- **Option 1: Do nothing**
  - Core capacity 5,940 only

- **Option 2: Maximising the use of NHH and POWH**
  - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (3,558, for 1 NHS session and Evenings and Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 8,668 (plus 5,940 core is 14,608 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 3a: Vanguard and NHH**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 7700 (plus 6,120 core is 13,820 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 3b: Vanguard and Maximising NHH**
  - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
  - North Hub: in NHH (1,500 Weekend Insourcing)

  - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 9,310 (plus 7,140 core is 16,450 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 4: Weekend Insourcing and Outsourcing only**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 5: Outsourcing activity to external provider (s)**
  - Outsourcing (5,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)

Options Summary

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH **	Option 4 Weekends	Option 5 Outsourcing
North Hub: NHH Weekdays NHS Staff		1610		1610		
North Hub: NHH Weekends Insourcing		1500	1500	1500	1500	
South Hub: Vanguard Weekdays NHS Staff			2700	2700		
South Hub: Vanguard Weekends Insourcing			1500	1500		
South Hub: POWH Evenings insourcing (+1 NHS session)		2058				
South Hub: POWH Weekends Insourcing		1500			1500	
Outsourcing		2000	2000	2000	2000	5000
Total Additional	0	8668	7700	9310	5000	5000
Plus Core	5940	5940	6120	7140	5940	5940
Total	**5940**	**14608**	**13,820**	**16450**	**10940**	**10940**

*Yellow – Provision on AB site, Blue – provision on CAV site, Green – provision on CTM site

**Option 3b is for 14 months

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m
Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*
***Costing for this option include 5% increase on all pay costs*

Waiting List Changes

The table below shows the impact of each of the options on the total size of the waiting list. The start position for each option is 19,000 patients waiting.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Waiting list project end	23,046	14,352	15,186	14,168	18,483	18,483
Waiting list change from 19,000 baseline	+4,046	-4,648	-3,814	-4,832	-517	-517

Options Appraisal

The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.

Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

Preferred Option

The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH

- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

Preferred Option Financials

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

Host Health Board	Delivery	Pre Go Live costs	2023/24 Patients	2023/24 Patients	2023/24 Total Estimated Costs	Cost per Patient	2024/25 Host Health Board	2024/25 Delivery	2024/25 Patients	2024/25 Patients	TOTAL ACTIVITY Patients	TOTAL COST Patients
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW	**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS	**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the 'long waiters' commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as 'pre go live'. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The 'regional operational team' meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

Contents

2. Introduction and Background

2.1 Regional Working

The Regional Portfolio is made up of three main programmes, Orthopaedics, Diagnostics and Ophthalmology. The three University Health Boards in South Eat Wales, Aneurin Bevan, Cardiff and Vale and Cwm Taf Morgannwg have agreed to work together regionally and adopt for following regional working principles

- To reduce unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level.
- To improve resilience.
- To make effective use of capacity and capability in whichever organisation it sits.
- To create critical mass for effective high quality care delivery when and where it makes sense to do so accepting that my not reside in every organisation.
- Take all opportunities to use the evidence base and best practice to improve quality, efficiency, productivity, and use of finite resources.
- To enable clinical leaders, and others, to work together, lead together and learn together.
- Distributed leadership (The SRO maybe from organisation A, clinical lead from org B and delivery of service in B and C.)
- Approach collaboration with benign intent, honesty, transparency, and integrity in order to build trusting and effective relationships.
- To agree approaches to engagement and communications together.
- To avoid leaving anyone behind and learn from the past and progress in an open, honest and humble way.

2.2 Regional Ophthalmology Programme and Clinical Summit

The Regional Ophthalmology Programme has been running for 4 years in South East Wales with a pause for the pandemic and restarted with a renewed focus in summer 2021. The Programme aligns strongly with national priorities and is designed around delivering solutions on a regional basis where this would provide the best care to patients. The three Health Boards in the region are committed to working together, sharing resources and solutions across Ophthalmology, where working together would add value for patients and the workforce. The Programme includes active clinical and management representation from Cwm Taf Morgannwg, Cardiff and Vale and Aneurin Bevan University Health Boards.

A Clinical Summit was held in December 2021 where clinical staff were engaged in discussing and agreeing key issues and priorities for Ophthalmology services in South East Wales. It was agreed that a new regional strategy should be developed to inform the future direction of the programme, including agreement regarding the ophthalmic specialties that would benefit from a collaborative regional approach

2.3 Regional Ophthalmology Strategy

A Regional Ophthalmology Strategy has been developed with clinical staff to set out the high level direction for the Regional Programme. The principles set out in the strategy are:

The Strategy has a number of delivery themes that reflect the issues and priorities identified in the Clinical Summit and now inform the future direction for the service on a regional footprint, these are set out below

1. Regional Model: Adoption of a regional model would bring together ophthalmic services under the umbrella described as a Regional Centre of Excellence network model. This will provide additional regional cataracts capacity and will use the network model approach to bring experts together to provide the best care for patients and sector-leading teaching and education expertise.
2. Sustainable Services: There are many services that cannot be sustained on a health-board only level and need to be brought together on a regional footprint. These include Vitreo-Retinal (VR) services, Corneal Cross linking and out of hours and emergency cover as requiring the most urgent attention.
3. Workforce: There is a significant skills shortage across the Ophthalmic disciplines and the strategy will also work to address the training and development of key staff to deliver a regional sustainable workforce with strong succession planning, teaching, training and development.
4. Research, Innovation and Development: Key to attracting workforce and achieving the other aspects of the strategy over the longer term is a Regional Clinical Research Facility allowing delivery of high quality clinical research trials which will increase income and quality of care for patients whilst building links with industry partners with strong consultant support.

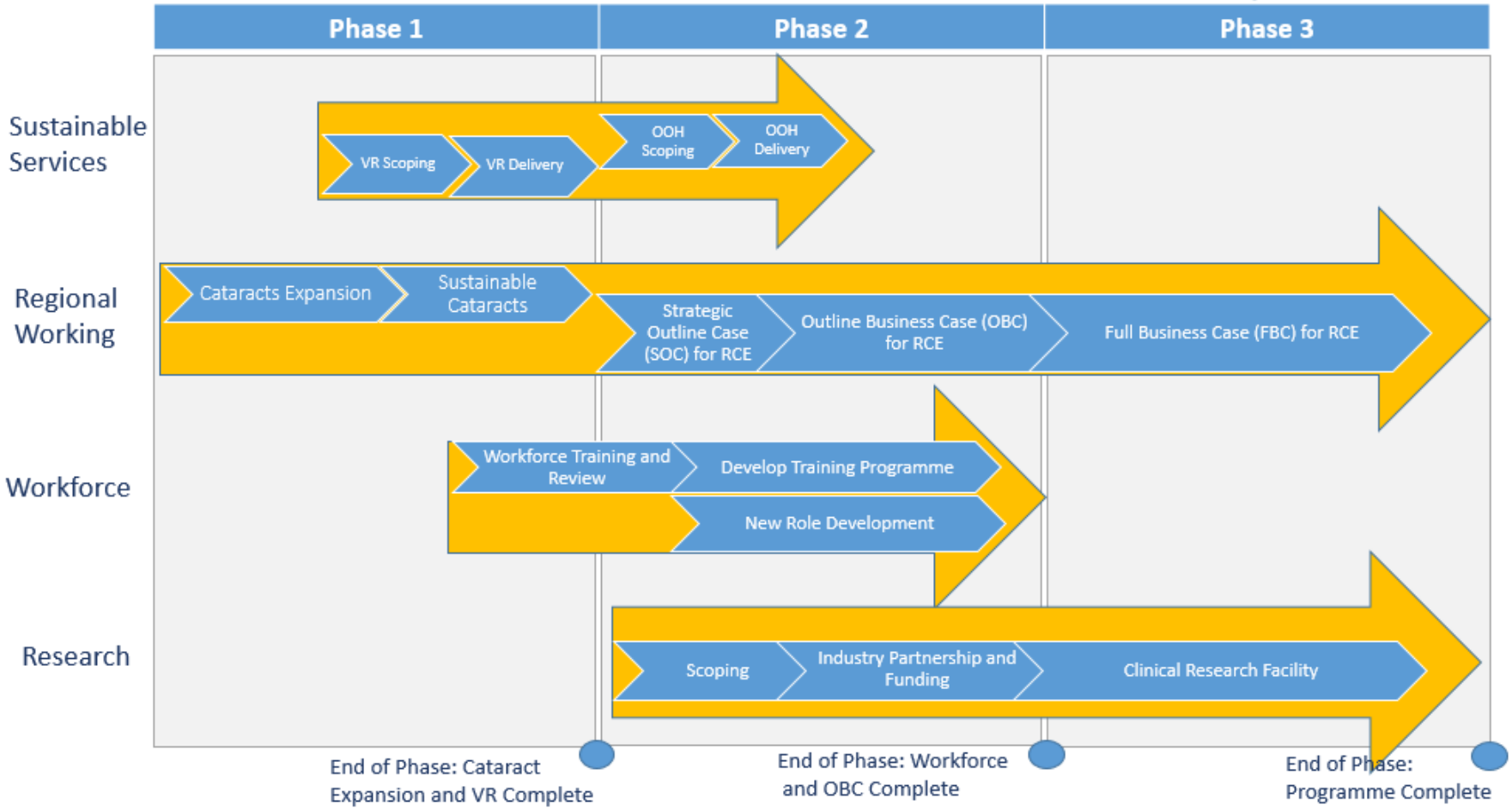
Regionalising Services to ensure their sustainability and offer the best services to patients aligns with *A Healthier Wales*, *The National Clinical Framework* and Royal College

of Ophthalmologists Clinical Guidance and best practice. The long term goal is a South East Wales regional centre of eye care excellence which can co-ordinate and provide the services identified above at a tertiary level. This will enable the region to care for all complex eye care procedures, for specialist clinicians to share and enhance their skills and to reduce the need for patients to travel outside Wales for certain specialist treatment.

2.4 Programme Plans and Phased approach

The diagram below represents the timeframes for the implementation of the strategy through a programme approach. Regional working starts first with the cataracts solution, closely followed by Vitreo Retinal hub and out of hours arrangements. The plans for the Regional Centre of Excellence will be developed through the 3 stage business case process alongside workforce developments and a research and innovation facility.

High Level Programme Plan



2.5 Cataracts Sustainability Staged Approach

The Regional Ophthalmology Programme Board have agreed the following staged approach to delivering sustainable cataracts solutions in the region, whilst balancing the need to activate capacity quickly and reduce the rate that the backlog is growing. This business case represents the first stage.

- Stage 1 – A Business Case for maximising our existing assets and increasing capacity with a focus on recovery activity and reducing waiting lists to run for 12 months.
- Stage 2 – Developing sustainable staffing and clinical models for the region. For cataracts and VR in University Hospital Wales (UHW), Cardiff, and cataracts and VR referral pathways across the region. To include new staffing models, new clinical models and costings, this model will be operational on the conclusion of stage 1.

3. The Case for Change

3.1 National Drivers for Change

Throughout the United Kingdom ophthalmic services are under considerable pressure. The Way Forward[1] document produced by the Royal College of Ophthalmologists in 2017 indicate

- Cataract surgery alone represents 6% of all surgery carried out in the UK, with an expected growth within 10 years of 25%.
- 35% of patients over the age of 65 have visually significant cataract.
- 10% of all out-patient appointments within the UK (9 million appointments) are for eye clinics, and the demand on our services is expected to increase by 40% over the next 20 years.
- Overall, the economic burden of sight loss in the country was estimated to be £28 billion.
- In 2019 UK wide there was a shortfall of 230 consultants, and 67% of eye units were using locums to fill 127 vacant posts.
- 85% of units depended on waiting list initiatives in out-of-hours sessions to try and meet their demand.
- 22 patients a month were losing vision from hospital-initiated system delays.

All of these statistics pre-date the Covid pandemic, during which things have grown considerably worse (External Review of Eye Care Services in Wales, 2021[2]).

3.2 Planned Care

The Welsh Government April 2022 document “Our programme for transforming and modernising planned care and reducing waiting lists in Wales” states 5 planned care goals

[1] The Way Forward | The Royal College of Ophthalmologists (rcophth.ac.uk)
[2] External Review of Eye Care Services in Wales (rcophth.ac.uk)

And 7 Planned Care priorities to support and influence recovery planning and investment decisions:

- Transformation of outpatients.
- Prioritisation of diagnostic services.
- Focus on early diagnosis and treatment of suspected cancer patients.
- Implementing a fair and equitable approach to patient prioritisation to minimise health inequalities.
- Eliminating long waiters at all stages of the pathway.
- Build sustainable planned care capacity across the care pathway.
- The provision of appropriate information and support to people.

This business case, and the long term proposals that it supports in stage 2 align closely with the Planned Care priorities, in particular the patient prioritisation and the long waiters.

3.3 Getting It Right First Time (GIRFT)

The Ophthalmology GIRFT Programme National Specialty Report 2019[3] also considers the challenging context for Ophthalmic services in the UK with demand for services across primary and secondary care increasing by over 10% in a 5 year period to 2019 and further increases expected. The report notes that workforce has not grown in line with demand and that Ophthalmology departments are cramped with little room for expansion. This review

[3] Ophthalmology (gettingitrightfirsttime.co.uk)

makes some cataract specific recommendations including making optimum use of theatre time

This business case and the longer-term approach planned for cataract provision across the region addresses the points raised in the report.

3.4 Royal College of Ophthalmologists, External Review of Eye Care Services in Wales

An External Review of Eye Care Services in Wales[4] published in 2021 makes ten recommendations for Wales including Data Management, a reduction in patients transferred to England for treatment and more frequent sharing of best practice. Recommendation 8 is about Cataract Service Redesign and increased use of high-volume surgery. This will reduce waiting times and also - but as the report notes - encourage improvements in the end to end process where surgery is just one part.

This business case aims to address this recommendation for South East Wales and provide an increased number of high volume lists. The longer term approach identified in section 2.5 above will then address other areas for improvements.

3.5 Patient Harm

Cataracts can lead to progressive visual loss and if left untreated can lead to almost total vision loss with the sufferer only being able to perceive light and dark. Prior to Covid-19, vision loss of this nature was an unusual occurrence however, in the current climate this is alarmingly becoming more common.

A significant proportion of patients waiting for this surgery have been rendered severely sight impaired because of the delay to the treatment albeit in a reversible manner. Furthermore, the surgical complexity and time taken to perform cataract surgery increases in such cases. This reduces the number of cases that can be completed on a list, but also increases the risk of a serious complication that could lead to a second or third surgery being needed at a specialist centre.

The disability that cataracts cause has a significant impact on the sufferer. Driving is impossible leading to loss of independence. The ability to work or carry out activities of daily living may also be impaired. Poor mental health in people with vision impairment is an all too familiar problem. Furthermore, it has been identified that falls and the resulting injury and morbidity are significantly increased in this vulnerable population, thereby significantly adding to the trauma load and the hospitalisation that inevitably accompanies it.

Evidence suggests sight impairment in older people is associated with increases in the incidence of falls and hip fractures. Compared to the general older population, this group is

[4] External Review of Eye Care Services in Wales (rcophth.ac.uk)

1.7 times more likely to fall, 1.9 times more likely to have multiple falls and 1.3–1.9 times more likely to experience hip fractures. Often the patients may be a carer for their family, and their preventable visual impairment begins to make this impossible, further increasing the burden on social care.

3.6 Service issues and gaps

There are some significant service issues and gaps that further evidence the need for increased capacity of cataracts procedures across the region. These include:

- Demand across the region being greater than the cataract capacity across the region - with no additional capacity the total number of patients waiting by March 2024 will be over 23,000
- Shortage of trained ophthalmology staff at all levels. All health boards have vacancies they cannot fill
- Burn out amongst staff
- Due to long waits, case mix can be more challenging
- Currently limited ability to share resources across the region for cataract surgery
- Patients waiting longer and are at greater risk of coming to additional harm

4. Current Service Provision

This section sets out the current activity and capacity assumptions for cataract surgery across AB, CAV, and CTM UHB's.

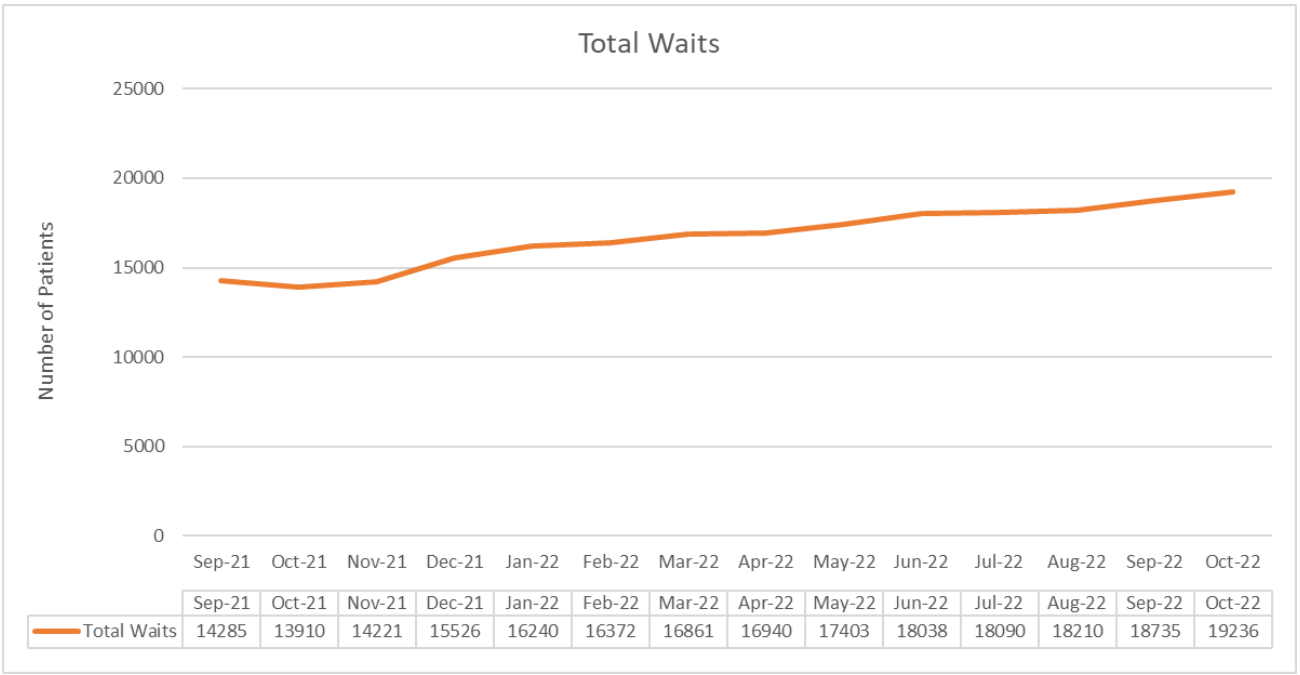
4.1 Current Situation Background

During the covid-19 pandemic, the ability to operate on cataracts patients was reduced significantly. This has resulted in a considerable backlog of patients waiting to be seen for both assessments and surgery. Cataract surgery is the most frequently performed surgery within the NHS. Quality of life gains following successful surgery are amongst the highest of any procedure in Ophthalmology. With an ageing population the demand for the service across the region has steadily grown and demand outstrips the resources available to delivery capacity at current levels.

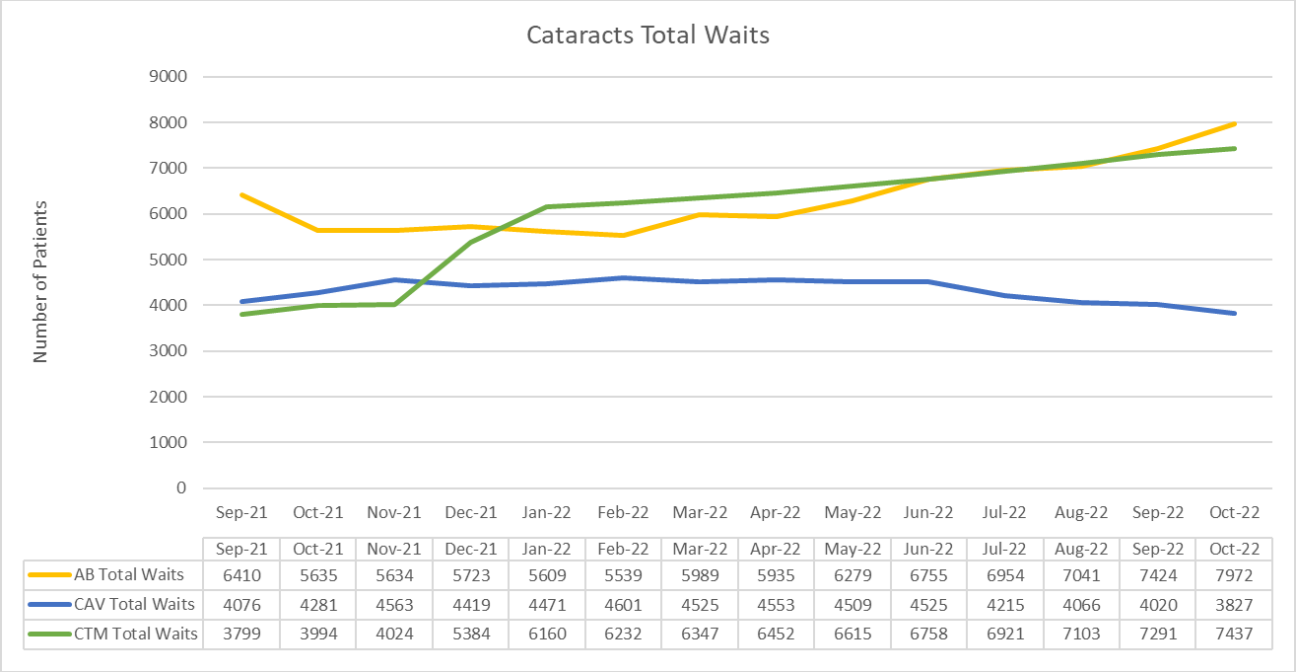
Current demand for cataract surgery is high. Across the region there are over 830 new cataract referrals every month and the current capacity across the region is struggling to cope with this level of demand. Across the region approximately 735 surgical procedures are undertaken per month. This will reduce to 495 per month From April 2023 if there is no further regional investment.

4.2 Current Waiting Lists

Waiting times are high for patients and are increasing across the region as capacity is consistently not able to meet the current demand. The total number of patients waiting across the region as at October 2022 is 19,236 and of these 6,163 (32%) have been waiting longer that 52 weeks



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Total Waits	14285	13910	14221	15526	16240	16372	16861	16940	17403	18038	18090	18210	18735	19236



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
AB Total Waits	6410	5635	5634	5723	5609	5539	5989	5935	6279	6755	6954	7041	7424	7972
CAV Total Waits	4076	4281	4563	4419	4471	4601	4525	4553	4509	4525	4215	4066	4020	3827
CTM Total Waits	3799	3994	4024	5384	6160	6232	6347	6452	6615	6758	6921	7103	7291	7437

4.3 Pre-pandemic Referral Levels and Demand

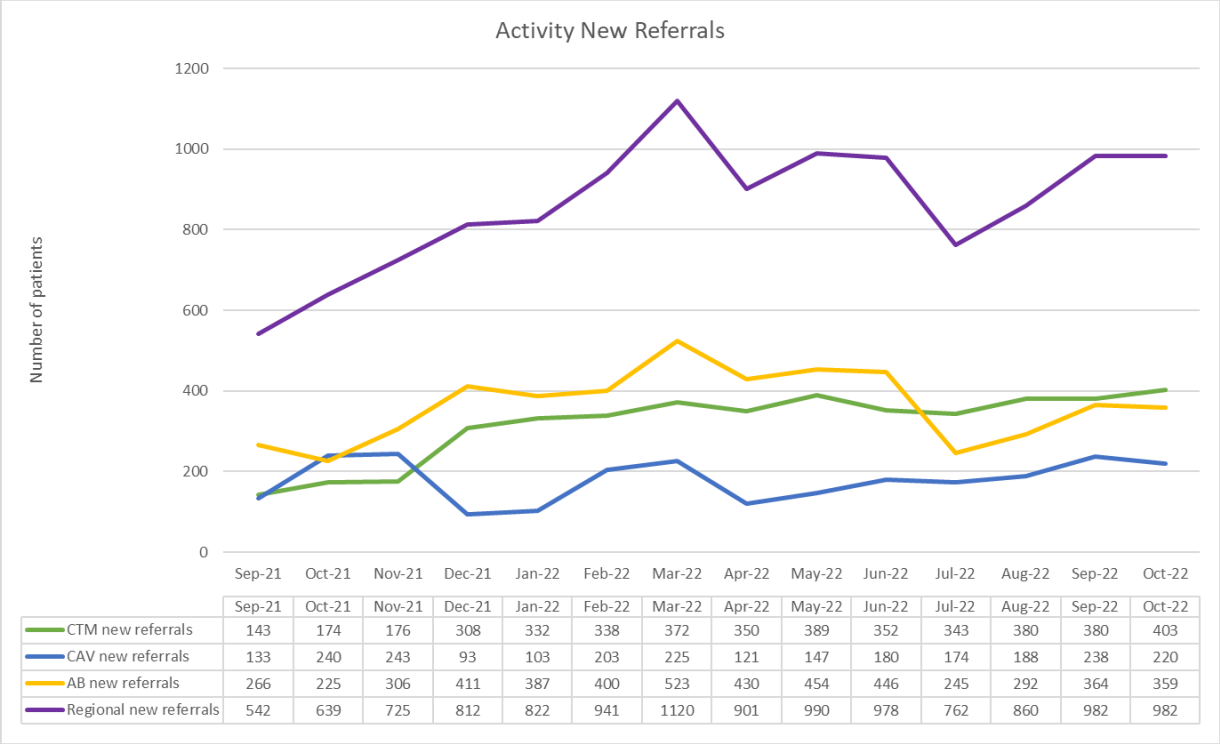
The referrals for cataracts are expected to return to pre pandemic levels once the referrals delayed through covid are received into the system. For planning purposes projections suggest that 830 referrals is the monthly level across the region. This results in approximately 10,000 referrals across the region per year.

Pre pandemic referral levels for cataracts are shown below:

Year	CTM	AB	CAV	Total	Average per Month
2018/19	3705	3571	2205	9481	790
2019/20	4438	3594	2094	10126	844

4.4 Current Referral Levels / Demand

The rate of new referrals in the region is further extending the waiting times for patients, as more patients are added to the list per month than are treated. New referrals have been steadily climbing since September 2021, reaching a peak of over 1,100 in March 2022. From arch 22 onwards referral levels stop climbing and provide a better basis for planning future demand. Between March 2022 and November 2022 inclusive, average demand across the region is Since For the last 5 months the referrals have been returning to pre covid levels or an average of 850 per month across the region.



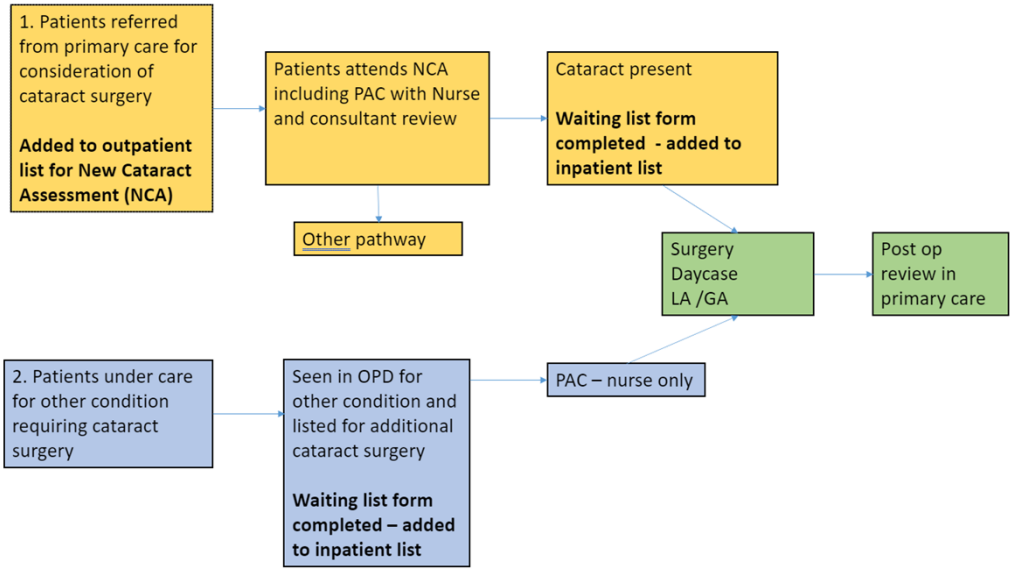
	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
CTM new referrals	143	174	176	308	332	338	372	350	389	352	343	380	380	403
CAV new referrals	133	240	243	93	103	203	225	121	147	180	174	188	238	220
AB new referrals	266	225	306	411	387	400	523	430	454	446	245	292	364	359
Regional new referrals	542	639	725	812	822	941	1120	901	990	978	762	860	982	982

For the purposes of this business case the demand is forecast for 2023/24 as shown below:

Health Board	Monthly	Annual
AB	340	4080
CAV	150	1800
CTM	340	4080
Regional Total	**830**	**9,960**

Current referral rates are now slightly higher than pre pandemic levels, indicating that there is still some latent demand coming through the system, however most of the demand that presented by mid-2022 is in line with pre pandemic referral levels for the service.

4.5 Patient Pathway and Case mix



The diagram above demonstrates the patient pathway and the outpatient and inpatient sections of the pathway. Many of the patients are waiting to start this pathway at the outpatient stage and 19% are waiting for the inpatient stage.

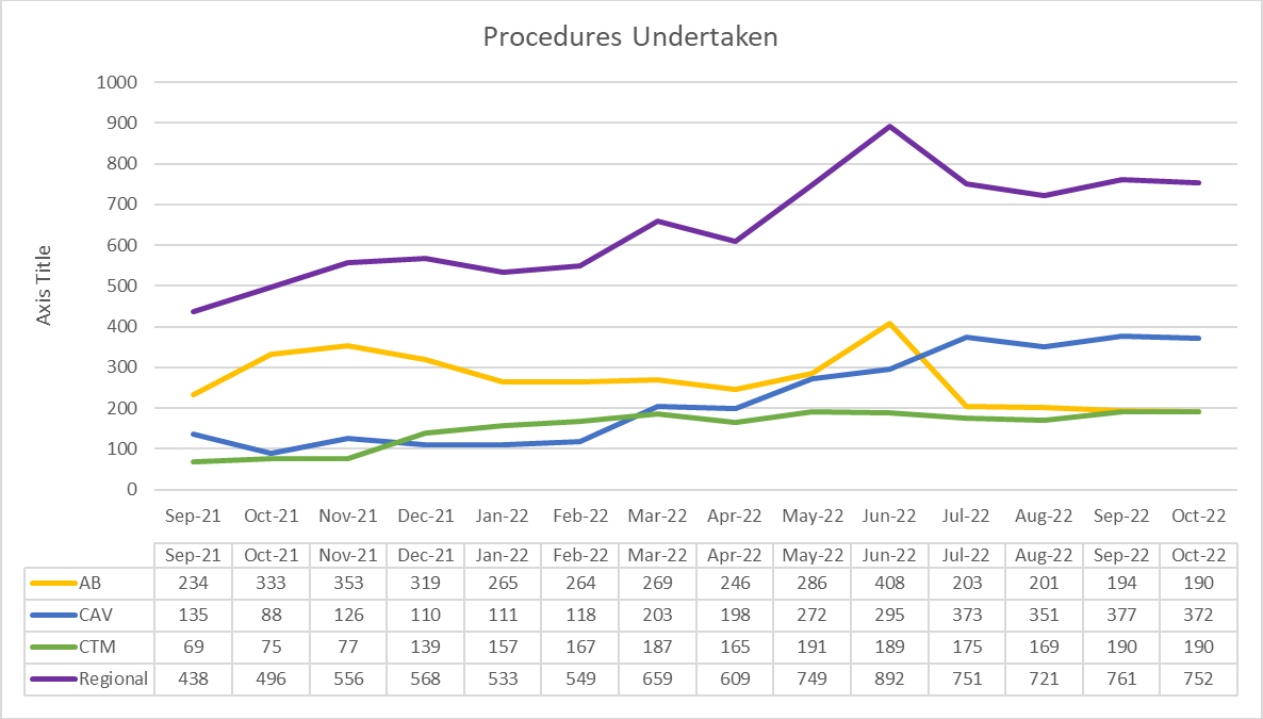
The case mix of the patients at the end of the waiting list has been clinically assessed as:

- 50% complex patients
- 30% non-complex (high flow)
- 20% no further action on cataracts pathway

It is anticipated that the increased capacity that this business case will provide will reduce the percentage of complex patients as backlogs are addressed. The case mix will then move towards a greater proportion of non-complex patients. This will in turn will release core capacity within Health Boards to provide optimal care for the remaining complex cases.

4.6 Current Activity Inpatient and Outpatient

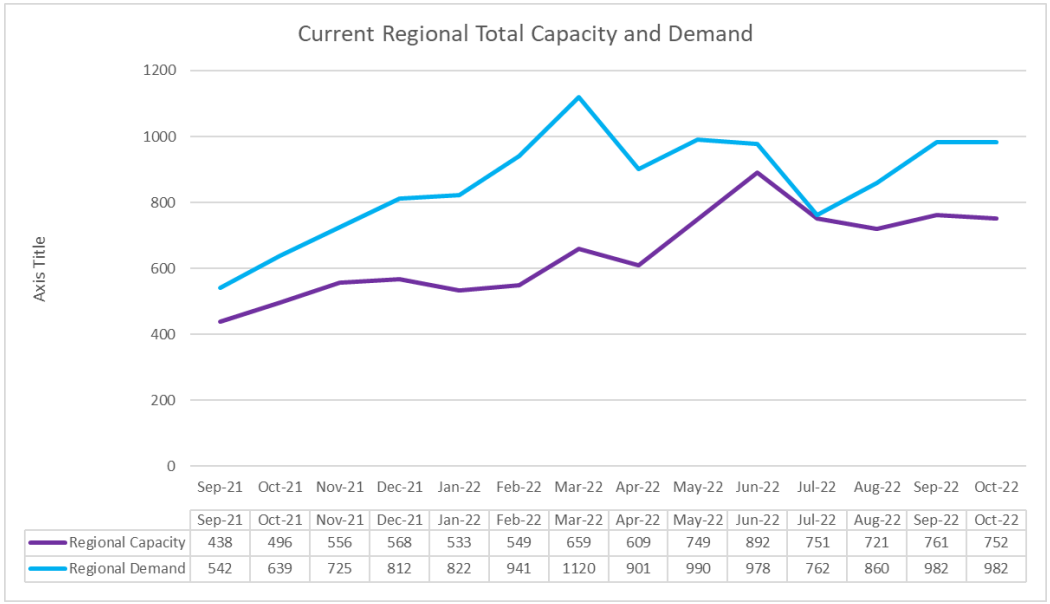
Activity across the region has been increasing, as operational teams and clinical staff work hard to restore sessions and undertake additional sessions to build back capacity post-COVID. The addition of the Vanguard mobile twin theatre unit in Cardiff has also had a big impact towards increasing the activity the teams are able to provide. The Vanguard Unit opened in January 2022 and reached full capacity by March 2022. In September 2021 the regional inpatient activity including outsourcing was 438 procedures per month and in May 2022 including outsourcing, increasing capacity and opening the Vanguard theatres the activity was 749 procedures per month, an increase of 71% capacity in 8 months and demonstrating the work of the operational teams to increase capacity. Outpatient activity to prepare patients for surgery is also a critical step in the pathway. Outpatient activity was 1,038 in September, increasing to 1,564 in May 2022.



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
AB	234	333	353	319	265	264	269	246	286	408	203	201	194	190
CAV	135	88	126	110	111	118	203	198	272	295	373	351	377	372
CTM	69	75	77	139	157	167	187	165	191	189	175	169	190	190
Regional	438	496	556	568	533	549	659	609	749	892	751	721	761	752

Row Labels	Sum of Sep-21	Sum of Oct-21	Sum of Nov-21	Sum of Dec-21	Sum of Jan-22	Sum of Feb-22	Sum of Mar-22	Sum of Apr-22	Sum of May-22	Sum of Jun-22	Sum of Jul-22	Sum of Aug-22	Sum of Sep-22	Sum of Oct-22
AB	**234**	**333**	**353**	**319**	**265**	**264**	**269**	**246**	**286**	**408**	**203**	**201**	**194**	**190**
procedures outsourced	66	121	130	175	163	115	54	100	100	267	0	0	0	0
Procedures undertaken	168	212	223	144	102	149	215	146	186	141	203	201	194	190
CAV	**135**	**88**	**126**	**110**	**111**	**118**	**203**	**198**	**272**	**295**	**373**	**351**	**377**	**372**
procedures outsourced	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Procedures undertaken	135	88	126	110	111	118	203	198	272	295	373	351	377	372
CTM	**69**	**75**	**77**	**139**	**157**	**167**	**187**	**165**	**191**	**189**	**175**	**169**	**190**	**190**
procedures outsourced	12	18	20	20	15	20	20	20	15	15	15	15	15	15
Procedures undertaken	57	57	57	119	142	147	167	145	176	174	160	154	175	175
Regional	**438**	**496**	**556**	**568**	**533**	**549**	**659**	**609**	**749**	**892**	**751**	**721**	**761**	**752**
procedures outsourced	78	139	150	195	178	135	74	120	115	282	15	15	15	15
Procedures undertaken	360	357	406	373	355	414	585	489	634	610	736	706	746	737

The gap between demand and capacity is growing, as shown in the chart below.



4.7 Workforce

Workforce

The current session planning and job planning arrangements include some sessions that are assigned as cataract only lists and some theatres sessions that run mixed lists where cataracts procedures are on the same surgical list as other ophthalmic procedures. Running mixed lists does enable the service to use any available theatre time to undertake cataract surgery but makes identifying the exact workforce assigned to cataract surgery more difficult.

As an illustration, the workforce typically required to undertake cataract surgery, and the outpatient pre-operative assessment is shown below.

Outpatient Pre-Operative assessment

During 1 session the workforce can see approximately 7 patients on a list, however the numbers may reduce if the patients are more complex. Workforce for 1 session includes a Consultant, 2 pre-assessment Nurses, 2 Health Care Support Workers and a Receptionist. There is also workforce required for booking and for notes retrieval and typing after the session.

Theatre Session

During 1 theatre session there will be up to 6 patients booked on a theatre list, depending upon case complexity. Workforce for 1 session includes a Consultant, Anaesthetist, 2 Scrub Nurses, 1 ODP, 2 Health Care Support Workers and 2 Nurses for the recovery area and a Receptionist. There is also workforce required for booking and for notes retrieval and typing after the session.

Workforce Gaps

The vacancy levels across the region for Ophthalmology services have been identified as shown below. This information helps to demonstrate that in the short term the capacity can only be increased by an insourcing and outsourcing model.

CTMU

- 0.7 WTE Corneal consultant
- 1 WTE Specialty Doctor
- 1 WTE Band 6 nurse
- 1 WTE band 5 qualified nurse

ABUHB

- 1x Band 3 Scheduler & 1 x Band 3 Outpatient booking Clerk- Both Full time posts
- 5.8 WTE Band 5 Nurses

- 3.4 WTE Band 6 Nurse Practitioners,
- 4.7 WTE Band 2 HCSW
- 1 WTE Consultant

CVUHB

- 1 x trainee vacancy
- 2.5 x Band 3 admin vacancies
- 1 x Band 2 nursing vacancy
- 2 x Band 5 Directorate Support Managers

4.8 Service Improvements

All service provision is being reviewed on a continuous basis to identify where small changes can be made to improve the way the service is delivered. These changes will ensure optimal utilisation of existing core capacity in Health Boards, while this business case sets out the further additional capacity required to support cataracts recovery. Actions include:

CTMUHB

- All vacancies within theatres are in the process of being filled, which will ensure all available space can be adequately staffed.
- A Health Board theatre utilisation group has been formed to look at how we can maximise the theatre space we have in both areas, as well as looking at late starts and early finishes.
- IPC regulations are due to change, allowing the department to fill lists at short notice, which will help with utilisation when patients cancel at short notice.
- Eye bay nurse staffing is also being looked at with support from the main nursing hub being sought so that ophthalmic nurses can be utilised elsewhere, such as pre-assessment clinics.
- The concept of a 'golden list' has been developed, involving optimal circumstances of efficiency, flow and patient attendance. This will be rolled out to as many clinicians as possible

ABUHB

- Start and finish times of Theatre sessions are being monitored with reasons being audited for improvements to be identified.
- A patient "Stand by list" is being generated to utilise any very short notice cancellations.
- All patient biometry is being uploaded to Clinical Workstation for Consultants to review patients sooner to prevent delays to treatment and to reduce day of admission cancellations.

CVUHB

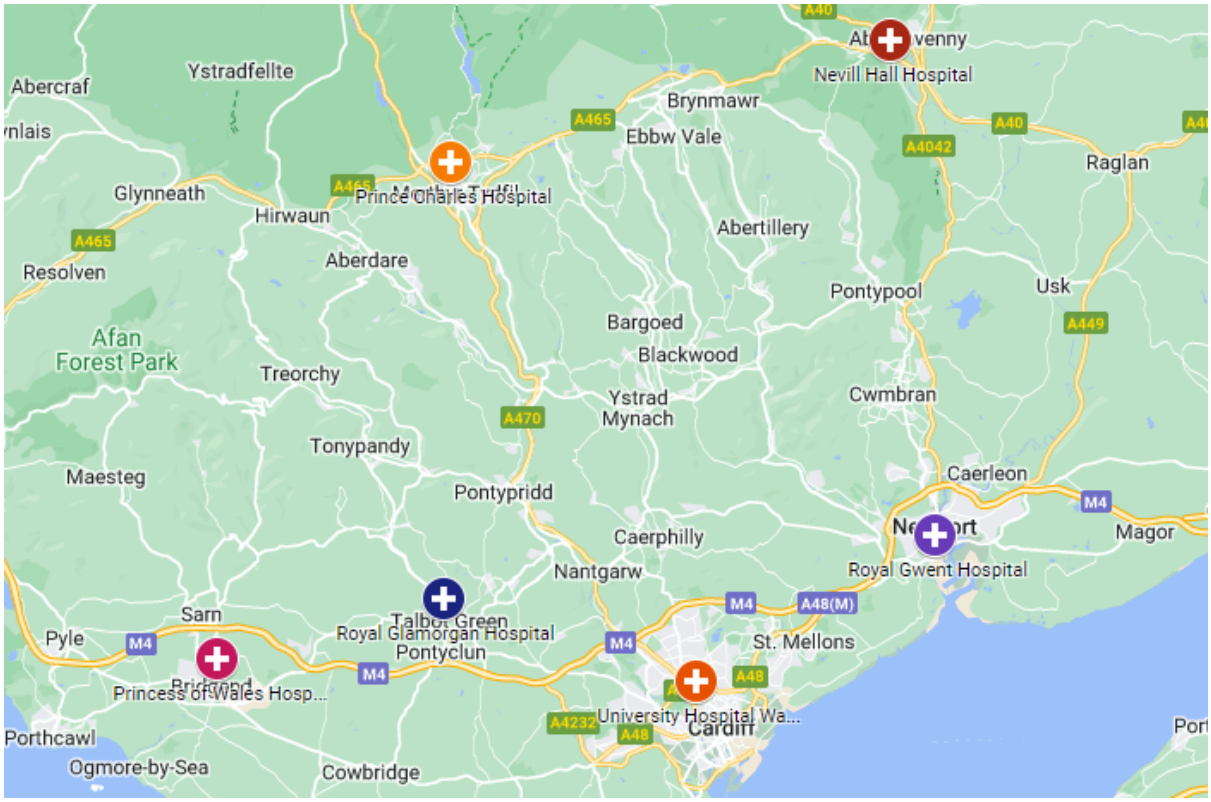
- Maximising utilisation by ensuring templates are booked to agreed capacity and backfilled as necessary when cancellations occur.
- Theatre utilisation – both booking and in-session – is monitored with the scheduling team on a weekly basis.

- HVLC lists are run where appropriate cases are identified, with performance and utilisation monitored with the scheduling team on a weekly basis

5. Cataracts and the opportunities for collaboration across the region

5.1 North and South Hubs and Patient Travel

The large geographical area of South East Wales, the road network and the position of the hospitals lends itself to a North / South split that can reduce patient travel across the region by providing hubs in the North and South of the region. These hub have the potential to provide additional capacity.



Geographical options for Cataracts in the North are Prince Charles Hospital (PCH) and Nevill Hall Hospital (NHH). There is no opportunity for expanding provision in PCH due to existing theatre usage and NHH is the remaining North option where 1 theatre is available. In Nevill Hall Hospital in Abergavenny as there is potential theatre space available to the region. The population in the North of the region is approximately 500,000 people and includes North Cwm Taf Morgannwg and North Aneurin Bevan.

In the South the Hub is proposed to be either University Hospital of Wales or Princess of Wales Hospital depending on the option taken forward both sites use a twin theatre model. The population of the South of the region is approximately 1,000,000 people and includes South Cwm Taf Morgannwg, Cardiff and Vale and South Aneurin Bevan.

Travel Times By Car (From the centre of the town to the hospital site)

North Hub	South Hub	South Hub
To Abergavenny NHH	To Cardiff Vanguard	To Bridgend POWH
From Cwmbran = 30 minutes / 15 miles	From Newport = 30 minutes / 13 miles	From Pontypridd = 35 minutes / 25 miles
From Merthyr = 30 minutes / 18 miles	From Blackwood = 40 minutes / 23 miles	Treorchy = 35 minutes / 15 miles
From Blackwood = 35 minutes / 20 miles	From Bridgend = 45 minutes / 20 miles	From Newport = 40 minutes / 30 miles
From Aberdare = 45 minutes / 25 miles	From Aberdare = 50 minutes / 23 miles	From Cardiff = 40 minutes / 25 miles
From Newport = 40 minutes / 30 miles	From Treorchy = 55 minutes / 22 miles	From Aberdare = 55 minutes / 40 miles

Through the use of the North and south model no patient would travel further than 40 miles or for longer than 55 minutes by private car in normal traffic conditions.

The North and South hub model enables the additional 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.

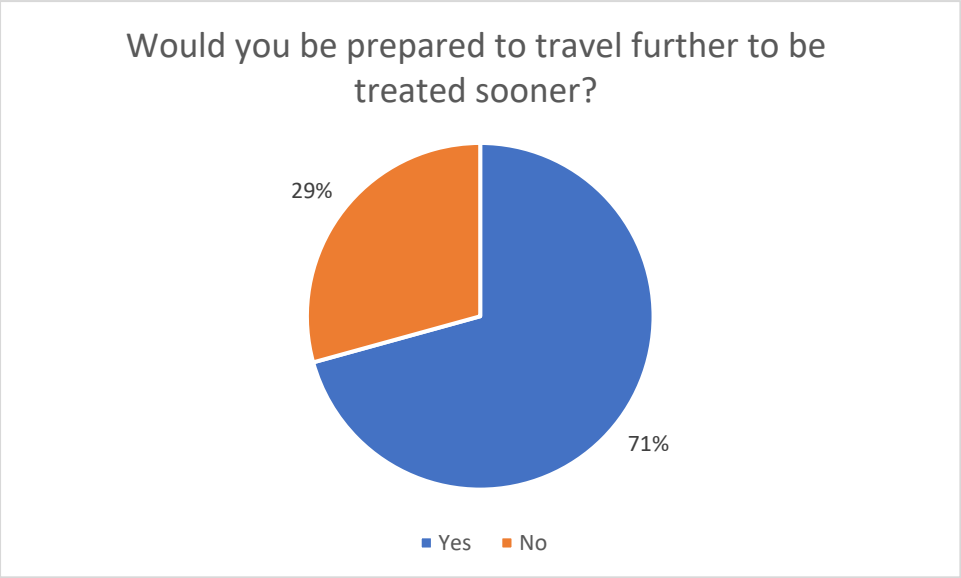
Patient Second Offer and Travel

Patients will be offered the opportunity to travel to receive their assessment and treatment as part of the additional capacity arrangements where thy may be able to be treated sooner. At a maximum travel would be 40 miles and 55 minutes by private car under normal traffic conditions and most of the patient travel will be shorter. Patients unable or unwilling to travel will keep their place on the waiting list and receive treatment from their home health board.

Patient travel Survey

A patients travel questionnaire was undertaken in Princess of Wales Hospital on 5th January, Royal Gwent Hospital on 11th January, and University of Wales Hospital on 12th January 2023. A total of 140 patients attending appointments on those day were asked questions about their travel to hospital and their willingness to travel to another hospital for treatment. All respondents were anonymous. An extract of the survey is shown below. Full results are in appendix ten

Would you be prepared to travel further if you could have been treated sooner?



Would you be prepared to travel further to the treated sooner?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Yes	25 (71%)	27 (77%)	47 (67%)	99 (71%)
No	10 (29%)	8 (23%)	23 (33%)	41 (29%)
Grand Total	**35**	**35**	**70**	**140**

Where would you travel to?

- From Princess of Wales Hospital in Bridgend, of the 25 patients willing to travel 25 would go to Cardiff and 19 to Swansea
- From Royal Gwent Hospital in Newport, of the 27 patients willing to travel 19 would be willing to travel to Cardiff and 25 to Abergavenny
- From University Hospital of Wales in Cardiff, of the 47 patients willing to travel 38 would be willing to travel to Bridgend and 41 to Newport

Where would you travel to?	From Princess of Wales Hospital	From Royal Gwent Hospital	From University Hospital of Wales
Bridgend / POWH		7	38
Cardiff / UHW	25	19	
Newport / RGH	11		41
Abergavenny / NHH	5	25	30
Bristol	5	6	10
Swansea	19	3	10
Further in the UK	5	3	4
Grand Total	**70**	**63**	**133**

**patients could provide multiple answers to this question*

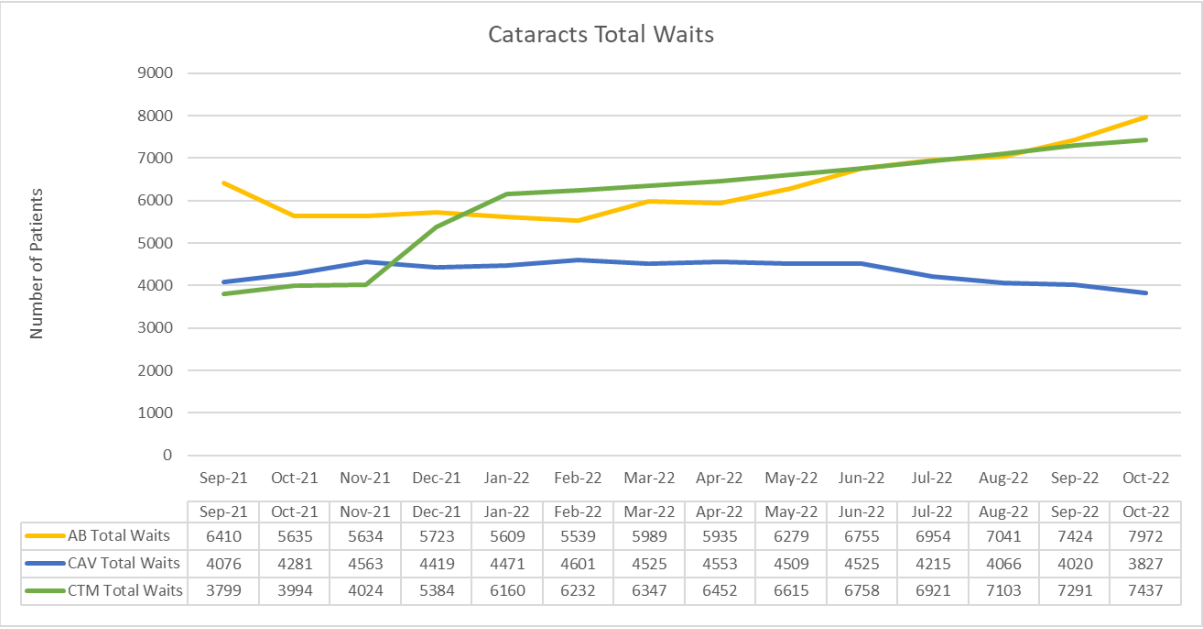
5.2 Regional Working Principles

The Regional Ophthalmology Programme Board have endorsed the following regional working principles

- Treating the longest waiters first, regardless of their 'home' health board
- Using the outsourcing, insourcing, evenings and weekends capacity for less complex patients
- Adopting best practice guidance in all centres
- Adopting shared waiting list management arrangements

The three Health Boards have committed to working as a region and understand that this does not necessarily mean sharing the provision requested in this business case equally, but equitably across the region and allocating this provision to the patients of greatest need regardless of their 'home' health board.

The chart below shows the waits for outpatient and inpatient appointments across the region and the variation across Health Boards. Both AB are approaching 8,000 total patients waiting and CTM 7,500. CAV have under 4,000 patients waiting with trajectories moving towards reducing this figure each month.



	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
AB Total Waits	6410	5635	5634	5723	5609	5539	5989	5935	6279	6755	6954	7041	7424	7972
CAV Total Waits	4076	4281	4563	4419	4471	4601	4525	4553	4509	4525	4215	4066	4020	3827
CTM Total Waits	3799	3994	4024	5384	6160	6232	6347	6452	6615	6758	6921	7103	7291	7437

5.3 Insourcing and Outsourcing

The capacity across the region can be rapidly increased by utilising the local opportunities for insourcing and outsourcing. These arrangements make the best use of our assets across the region for short-term flexible arrangements that protect our core capacity.

5.4 Shared Patient Treatment List (PTL)

As an agreed principle of this regional model, the three health boards have agreed to work together to share waiting list management (see section 5.4) and ensure that capacity is distributed across the region to the patients who have been waiting the longest and require this treatment.

The three health boards will share their patient treatment lists through a regional team and those patients at the end of the list that are suitable for this type of treatment will be assessed and treated as part of this regional capacity.

The table below shows the numbers of patients waiting and how this is split proportionally across the region. Data relates to August 2022 and includes the total number of patients waiting in each health board.

Patient Waits	Total			Over 52 weeks	
AB	7041	39%		2175	36%
CAV	4066	22%		891	15%
CTM	7103	39%		2939	49%
	18210			6005	

As a proportion of the patients waiting, 39% are from AB. 39% from CTM and 22% from CAV. When this is viewed as patients waiting at the end of the lists the proportions change and it is from this pool of patients that the additional capacity would be targeted.

Of this group of longer waiters 49% are from CTM, 36% from AB and 15% from CAV and this indicates how the additional capacity will be used.

5.5 Regional Waiting List Management

Also see section 5.3 (shared PTL)

5.5.1 Shared waiting list management arrangements

All health Boards have agreed to share waiting lists and treat the longest waiters from across the region first.

The waiting lists could be shared via a SharePoint which is supported from an information governance perspective as access is only via NADEX numbers so access can be limited and monitored. To ensure that longest waiters are treated first, the three spreadsheets could be merged.

In terms of how patients are removed from waiting lists once treated, this would be managed in the same way that patients are treated in Spire/Nuffield. The NHH/UHW centres would be added as options for removal on a drop down list a feature which is on the CTM and C&V waiting lists.

The regional team will hold the shared list and the patients waiting the longest will be treated first, any issues will be managed by the regional team and demonstrated with the data.

SLA type arrangements will be in place for sharing data and resolving issues

5.5.2 Regional Booking and Scheduling

There will be a joint Regional Booking and Scheduling Team across the region to book all the additional capacity patients into outpatient appointments and schedule them for surgery. This team will be hosted by a Health Board but work for the region to support this additional service for the patients. Bringing this team together offers resilience in the service and flexibility to book into the North and South hubs via access to all the systems operated by each of the Health Boards.

The manager of this team will also oversee the data integrity for the joint waiting list arrangements with the three regional Ophthalmology Directorate Managers.

5.6 IT and Data Systems

North Hub

Patients booked and scheduled for assessment and treatment in the North Hub will be assigned an AB patient number and recorded on the AB systems as AB patients. Records will be shared with other health boards via Welsh Clinical Portal (WCP). CTM and CAV patients treated in the North hub will be recorded as ‘outsourced’ on the CTM and CAV systems (see below)

South Hub

Patients booked for outpatient appointments in the South Hub will attend POWH for their appointment and, if required, UHW for surgery. Upon funding approval, the specific details for sharing information across the two health boards for patients will be developed and delivered as part of the implementation plan

Outsourcing

There are established practices to follow for recording outsourced patients already as outsourcing is a continuing practice in health boards within the region. Patients are listed as outsourced on the home system and information is shared between the outsourcing provider and the home health board via Welsh Clinical Portal (WCP)

Uploading on to the Welsh Clinical Portal upload records between the Health Boards

IT and data systems will require more full scoping when funding is agreed.

5.7 Additionality

The service model represents additional capacity established in the region when compared to the core base capacity that was provided before the pandemic. In Cardiff and Vale, there were 7.5 cataract sessions per week and the Vanguard Unit has increased this to 20 sessions per week. Through this business case 62.5% (12.5 out of 20 sessions) of the Vanguard Unit would be available for regional use, returning the Cardiff and Vale capacity to pre pandemic levels.

In Aneurin Bevan the way services are delivered has been reconfigured but the total capacity for cataract surgery remains unchanged from pre pandemic levels, demonstrating that this business case represents additional capacity across the region.

6. Benefits, Risks and Governance

6.1 High Level Benefits

The high-level benefits associated with undertaking the additional capacity are demonstrated below. Through the do-nothing option, these benefits will be foregone.

Patient Benefits

- Reduced waiting times for patients
- Improved quality of life (measured through PROMS/PREMS)

Wider Regional and Health Board Benefits

- Increased Capacity across the region
- Reduced waiting list size
- Making the best use of regional resources

Health gain

- Reducing sight loss
- Reducing complications and other relating to sight loss e.g. falls
- Improving outcomes for patients
- Improving timely clinical care and patient experience

Equity

- Equity of service provision and access across the region
- Capacity for the longest waiters

6.2 High Level Risks

The high level risks associate with undertaking the additional capacity are demonstrated below.

High-level Risks to Delivery

Delivery of the business case is dependent on the following risks being managed and mitigated:

Risk	Assessment	Mitigation
Reliability of providers to deliver services: that the service provider cannot fulfil the staffing required to meet the sessions they are contracted for	Prob: 1 Impact: 3 Score: 3 (low)	Contract management and open communication with the provider to manage any changes in the volumes and arrange times to increase capacity in future weeks/months
Availability of additional support service and equipment, trays, HSDU: That the additional capacity on weekends compromises the core capacity and there	Prob: 2 Impact: 3 Score: 6 (Medium)	Early modelling of requirements and ordering of supplies with longer lead in times. Detailed planning of these

Risk	Assessment	Mitigation
is not enough equipment to service the whole capacity required		resources and close monitoring of all usage and risk areas
Booking and scheduling staff appointments: That there is not enough booking and scheduling time to manage the additional patients and that the additional capacity is not fully utilised	Prob: 1 Impact: 4 Score: 4 (Low)	Planning for resource required and bringing them together into a regional team to enable cross cover and resilience to the service.
Ensuring equity of provision across the region: That the regional provision does not go to the patients waiting longest and HB's benefit disproportionately	Prob: 1 Impact: 4 Score: 4 (Low)	Regular and robust waiting lists management processes and pooled lists that adjust and review on a monthly basis to manage the lists as a whole
Reduction in core capacity: That core capacity is reduced or compromised because the regional solution is in place	Prob: 3 Impact: 3 Score: 9 (Medium)	Regular monitoring and early corrective actions towards additional capacity and core capacity alongside waiting list reductions in size and waiting times
IT systems and record keeping: that IT systems can't share information across HB boundaries and that patient records get lost through manual processes	Prob: 3 Impact: 4 Score: 12 (High)	Bring additional IT support into the programme to provide expertise and enable accurate record keeping and sharing through system and maintenance of information governance
Contracting impacting on core capacity: That staff take on contracting shifts and are then not able to provide the core capacity required to maintain Health Board levels of activity	Prob: 3 Impact: 3 Score: 9 (Medium)	Working with the provider to limit impacts on HB staff and planning schedules in advance and communicating this widely. Monitoring sickness levels
Clinical Risk: That staff do not have the appropriate qualifications and experience	Prob: 2 Impact: 5 Score: 10 (Medium)	Clinical Governance processes and working with provider to ensure every member of staff is suitable qualified and experienced.
Clinical Risk: That unsuitable patients are referred for insourcing and outsourcing and are routed back into core capacity making the patient journey longer	Prob: 1 Impact: 4 Score: 4 (Low)	Clear and clinically agreed criteria for referring patients for insourcing and outsourcing treatment routes
Clinical Risk: That patient cancellation rates are high and the insourcing and outsourcing efficiency is compromised	Prob: 1 Impact: 3 Score: 3 (Low)	Communication with patients prior to referral and follow ups of cancelling patients for feedback/reasons

Low Risk 1-5, medium 6-10, High 12-20

6.3 Contracting arrangements

Local Health Boards will utilise the expertise of the All Wales Procurement team to undertake a tender process on behalf of all three Health Boards. Depending on their technical advice the intention would be to undertake one procurement exercise for both insourcing and outsourcing recognising that these will be awarded to separate providers. In

addition, given the scale of the volumes required, the awards may include a multitude of providers to enable flexibility of patients and to promote patient choice.

The procurement timetable will need to include a full 30 days tender advertisement given the volumes and financial value involved. The procurement process will be undertaken by the All Wales team, with the detailed specification around clinical requirements, patient pathways, governance and processes etc led by a small working group comprised of all three Health Boards and involving expertise from all relevant disciplines. This will confirm the contractual arrangements around the awarding and management of the contracts. Tenders will then be evaluated by a team drawn from all Health Boards and awarded to the successful providers.

Contracts are awarded on a cost per case basis with the expectation that the full number of procedures will be delivered by the Provider. The award of any new contracts would be underpinned by an activity plan, with clear timescales for delivery, and any appropriate scaling back of insourced activity in line with the implementation plan for the sustainable regional solution.

6.4 Clinical Governance

The Clinical Governance arrangements will be mainly managed through the contracting arrangements. The contracting will include all the clinical staffing required to undertake outpatient assessments and inpatient procedures.

Specific areas of attention for clinical governance are:

Surgeon Competence

Insourced and Outsourcing contracts need to ensure that surgeons are of an appropriate competence and quality and have comparable complication rates to consultant surgeons on the National Ophthalmic Database. Processes for checking and ageing the competence of surgeons will be in place as part of the contracting and implementation of the business case.

Follow Ups and Complications

As part of core Health Board delivery of this type of surgery, any complications are the responsibility of the operating surgeon and follow up arrangements of this nature will be included in the insourcing contracting details. If follow ups cannot be rectified by the operating surgeon (or insourcing company) then they will be invoiced for the follow up treatments required.

Clinical Processes

Insourcing staff will be expected to follow the clinical processes of the site on which they are working including incident reporting. There may be occasions where clinical policies vary across sites and the implementation of the business case will aim to address areas of

significant variation by aligning guidance across sites as far as practicable, although in the short term this will not be possible in every case.

6.5 Waiting List Modelling

The Regional Ophthalmology Programme have been working with the Delivery Unit to develop a mathematical model to inform the planning of the additional cataracts capacity. Data to feed into the model has been sourced from health boards and operational colleagues have been refining and testing the model with the Delivery unit and have finalised the model for this purpose. The model ensures that there is balance between the outpatient and inpatient capacity based on the following assumptions.

- There is a waiting list of 19,000 patients (forecast position end of March 2023)
- 80% of patients referred as suitable for surgery
- 18% of patients are not suitable for surgery
- 2% of patients DNA
- Patients are reviewed by primary care post-surgery within 3 weeks
- None of the outpatient appointments undertaken on patients expire
- 20% of patients require surgery on a second eye
- One outpatient appointment will cover both eyes
- Second eye surgery is undertaken at least 10 weeks after first eye surgery

In section 4.5 the case mix discusses that 20% of the patients who move through the outpatient stage will not require surgery. However, 20% of the patients who require surgery require it for both eyes and so the demand for surgery/inpatient stage is then in line with the demand for the outpatient stage.

7. Options

The business case considers six options to achieve the following key aims:-

- to enact a collaborative regional approach to recovery
- to provide additional regional capacity for cataract outpatient and inpatient stages
- to demonstrate optimal utilisation of our assets across the region
- to address current waiting list backlogs
- to reduce clinical risk on an equitable basis across the region

To achieve the stated aims of the business case, the options need to:

- Be mobilised quickly
- Be deliverable with the resources available
- Protect the viability of the core capacity
- Keep patient travel to a minimum
- Deliver value for money

The options are:

- **Option 1: Do nothing**
    - Core capacity 5,940 only

- **Option 2: Maximising the use of NHH and POWH**
    - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
    - North Hub: in NHH (1,500 Weekend Insourcing)
    - South Hub: in POWH (3,558, for 1 NHS session and Evenings and Weekend Insourcing)
    - Outsourcing (2,000)
    - Total additional 8,668 (plus 5,940 core is 14,608 total)
    - One theatre in NHH and twin theatres in POWH

- **Option 3a: Vanguard and NHH**
    - North Hub: in NHH (1,500 Weekend Insourcing)
    - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)
    - South Hub: in UHW (1,500 Weekend Insourcing)
    - Outsourcing (2,000)
    - Total additional 7700 (plus 6,120 core is 13,820 total)
    - One theatre in NHH and twin theatres in Vanguard

- **Option 3b: Vanguard and Maximising NHH**
    - North Hub: in NHH (1,610, weekdays NHS staff recruitment)
    - North Hub: in NHH (1,500 Weekend Insourcing)
    - South Hub: 12.5 sessions of Vanguard Unit (2,770 weekdays NHS staff)

  - South Hub: in UHW (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 9,310 (plus 7,140 core is 16,450 total)
  - One theatre in NHH and twin theatres in Vanguard

- **Option 4: Weekend Insourcing and Outsourcing only**
  - North Hub: in NHH (1,500 Weekend Insourcing)
  - South Hub: in POWH (1,500 Weekend Insourcing)
  - Outsourcing (2,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)
  - One theatre in NHH and twin theatres in POWH

- **Option 5: Outsourcing activity to external provider (s)**
  - Outsourcing (5,000)
  - Total additional 5000 (plus 5,940 core is 10,940 total)

Theatres Available

- University Hospital of Wales: The Vanguard Unit is a twin theatre set up based in the car park in UHW. This will be used for the weekday and the weekend sessions.
- Princess of Wales Hospital: In Bridgend Eye theatres there is a twin theatre set up. This would be used for the weekend and evening sessions. The 1 NHS session in POWH would be run as a single theatre set up.
- Nevill Hall Hospital: One theatre is available in the main theatres block in NHH. The weekday sessions and the weekend sessions will be run from this theatre.

Options Summary

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH **	Option 4 Weekends	Option 5 Outsourcing
North Hub: NHH Weekdays NHS Staff		1610		1610		
North Hub: NHH Weekends Insourcing		1500	1500	1500	1500	
South Hub: Vanguard Weekdays NHS Staff			2700	2700		
South Hub: Vanguard Weekends Insourcing			1500	1500		
South Hub: POWH Evenings insourcing (+1 NHS session)		2058				
South Hub: POWH Weekends Insourcing		1500			1500	
Outsourcing		2000	2000	2000	2000	5000
Total Additional	0	8668	7700	9310	5000	5000
Plus Core	5940	5940	6120	7140	5940	5940
Total	**5940**	**14608**	**13,820**	**16450**	**10940**	**10940**

*Yellow – Provision on AB site, Blue – provision on CAV site, Green – provision on CTM site

**Option 3b is for 14 months

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m

Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*
***Costing for this option include 5% increase on all pay costs*

Waiting List Changes
The table below shows the impact of each of the options on the total size of the waiting list. The start position for each option is 19,000 patients waiting.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Waiting list project end	23,046	14,352	15,186	14,168	18,483	18,483
Waiting list change from 19,000 baseline	+4,046	-4,648	-3,814	-4,832	-517	-517

Options Appraisal
The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.
Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing

Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

Preferred Option

The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

8. Option 1 - Do Nothing

This option involves providing no further funding and resources to cataract surgery across the region at this stage. Each health board will continue with only their planned core capacity and there will be no sharing of patient treatment lists (PTL's). The Vanguard rental will end on 30th June 2023 following the short term regional extension arrangement.

8.1.1 Core capacity

The annual core capacity of each Health Board is shown below

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	**Regional Total Core**	Regional Demand	Difference
Annual capacity	2400	1920	180	1440	5940	9,960	-4,020

8.1.2 Option Assumptions

This option is based on the following assumptions

- Use of Vanguard ends by 30th June 2023
- Capacity in CTM and AB for 23/24 remains at 2022 activity levels
- CAV have 7.5 sessions in main theatres to undertake core cataracts activity, reverting to pre-Vanguard capacity.

8.2 Option 1 – Option Appraisal

8.2.1 Option 1 Benefits

The high level benefits identified above (section 6.1) are foregone in this option. The benefits identified for this option are listed below

- No changes to the way that services are currently run
- No management capacity required to organise additional services
- No direct costs

8.2.2 Option 1 Risks

The specific risks associated with option 1 are:

- Demand continues to outstrip supply (high risk as business case is mitigation action)
- Backlogs will continue to grow (high risk as business case is mitigation action)
- Planned Care target will be missed (high risk as business case is mitigation action)
- Increased proportions of higher complexity patients as waiting times are increased (medium risk as business case is mitigation action)
- Loss of experienced and well trained staff at the Vanguard Unit (medium risk as business case is mitigation action)

- Reduction in training capacity across the region (medium risk as business case is mitigation action)
- Increases the backlog by 4,046 patients (high risk as business case is mitigation action)

8.2.3 Option 1 Patient Considerations

Through this option all patients will continue to be treated by their home health board. They will be treated within their own health board boundary but are likely to have to wait more than 1 year for assessment and treatment. As patient waits lengthen, the risk increases of patients coming to harm while waiting.

8.2.4 Option 1 costs

There are no direct costs associated with this option

Indirect costs include:

- Increased reliance on WLI's / agency staff
- Increased patient complaints
- Multiple patient referrals as primary care escalate patients due to deterioration
- Additional waiting list validation required
- Increased costs of complications as patient complexity increases

8.2.5 Option 1 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 5,940 cataracts procedures per year (114 per week, 495 per month)
- 5,940 outpatients per year (114 per week, 495 per month)
- 9,960 referrals per year (192 per week, 830 per month)

After 52 weeks of the total capacity of 5,940 per year the waiting list is increased from 19,000 across the region to 23,046

9. Option 2 – Maximising the use of NHH and POWH

Option 2 is an NHS recruitment, insourcing and outsourcing option involving a two-hub model of NHH in the North and POWH in the South. At both sites the weekday and weekend capacity is utilised, along with outsourcing in the following volumes over a 12 month period:

- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 3,558 (2,058 weekdays plus 1,500 weekends) outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 8,668 additional**
- **Total capacity 14,608 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs: £12.4m
- Cost per patient: £1,436

9.1. Option 2 - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

9.1.1 Clinical Service Model North Hub (NHH)

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits. There is 1 theatre available in NHH that will be used for 7 sessions in the week by NHS staff and both days on the weekend by an insourcing team.

Delivery Plan for NHH Sessions

Delivery Plan Outpatients

	Month 1	Month 2	Month 3	Month 4	Months 5-11	Month 12		Total

Patients per list	6	7	8	8	8	8		
Sessions per week	5	5	5	5	5	5		
weeks	4	4	4	4	25	1		42
total patients	120	140	160	160	1000	40		1620

Delivery Plan Inpatients

	Month 1	Month 2	Month 3	Month 4	Months 5-11	Month 12		Total
Patients per list	4	5	6	6	6	6		
Sessions per week	4	5	5	7	7	5		
weeks	1	4	4	4	28	1		42
total patients	16	100	120	168	1176	30		1610

Delivery Plan for Insourcing Sessions in NHH

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50
total patients	1504	1500

9.1.2 Clinical Service Model South Hub (POWH)

Through Option 2 the South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital site on weekdays and weekends via an insourcing company with one weekday session per week provided by NHS staff.

Delivery Plan

weekdays

Outpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
1 day session	Insourcing	8	1	8	38	304
Evenings	Insourcing	8	6	48	38	1824
Total				**56**		**2128**

Inpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
1 day session	NHS Staff	7	1	7	42	294

Evenings	Insourcing	7	6	42	42	1764
Total				**49**		**2058**

weekends

Outpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	8	4	32	32	1024
Sunday	Insourcing	8	2	16	31	496
Total				**48**		**1520**

Inpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	7	4	28	36	1008
Sunday	Insourcing	7	2	14	36	504
Total				**42**		**1512**

9.1.3 Outsourcing Arrangements

Option 2 Outsourcing @ 2,000 cases per year

9.1.4 Booking and scheduling For Option 2 (Maximising the use of NHH and POWH):

In one year the team will need to book 6,700 outpatient appointments across both the North and South Hubs and schedule 6,700 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 15,400 patient bookings per year. A Regional booking and scheduling team are required for these patient volumes, along with a POWH Eye Unit Manager and NHH Eye Unit Manager to ensure capacity levels are maximised.

9.1.5 Option 2 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed

- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

9.2 Option 2 – Option Appraisal

9.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Regional	**Total**	Average Demand	Difference
AB	2400	36%	3121	**5521**	4080	1441
CAV	1440	15%	1300	**2740**	1800	940
CTM	2100	49%	4247	**6347**	4080	2267
Regional Total	5940		8668	**14608**	9960	4648

9.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
Capacity	2400	3121	5521

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
Capacity	1920	180	4247	6347

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
Capacity	1440	1300	2740

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	5521	2740	6347	14608

9.2.3 Option 2 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Recruiting additional NHS workforce for NHH
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the POWH Eye Unit 7 days per week
- Enables a greater reduction in the backlog
- No additional capital required
- Reduces the backlog by 4,648 patients waiting

9.2.4 Option 2 Risks

The specific risks associated with option 2 are:

- High volumes of surgery through POWH Eye Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

9.2.5 Option 2 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

9.2.6 Option 2 costs

Option 2: POWH and NHH

Revenue Costs **2023/24**

Provider Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Aneurin Bevan	Weekday Capacity	1,610	£184,342	1,610	£1,659,078	£1,843,420
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
Cwm Taf	Insource Weekday	2,058		2,058	£2,671,284	£2,671,284
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£934,145
TOTAL		**8,668**	**£758,374**	**8,668**	**£10,754,006**	**£12,446,525**

Indicative Cost per Patient £1,436

9.2.7 Option 2 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 14,608 cataracts procedures per year (281 per week, 1217 per month)
- 14,608 outpatients per year (282 per week, 1224 per month)

After 52 weeks of the total capacity of 14,608 per year the waiting list is reduced from 19,000 across the region to 14,352

Further details on Option 2 can be found in Appendix Four

10. Option 3a –Vanguard and NHH

Option 3a is an insourcing and outsourcing option involving a two-hub model of NHH in the North and the Vanguard Unit in the South with the following volumes over a 12 month period:

- South Hub: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 6,120
- **Plus 7,700 additional**
- **Total capacity 13,820 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs 23/24: £12.9m
- Cost per patient: £1,672

10.1 Option 3a - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

10.1.1 Maximising the Use of the Vanguard Unit in UHW

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is currently contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday with this arrangement running until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit will be extended until 31st March 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service. The Vanguard Unit requires capital funding.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

10.1.2 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits. There is 1 theatre available in NHH that will be used on both days on the weekend by an insourcing team.

Delivery Plan for Insourcing Sessions in NHH

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50
total patients	1504	1500

10.1.3 Clinical Service Model South Hub

Through this option The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The Vanguard Unit would be used 7 days per week.

On weekdays the twin theatre unit will be staff by NHS staff in a continuation of current practice. These 20 sessions will be split, 7.5 for CAV and 12.5 for regional patients. On the weekends the provision in the vanguard unit will be staffed via an insourcing company.

Weekdays

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekdays	NHS Staff	8	7.5	60	46	2760

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients (less CNA's)
Weekdays	NHS Staff	5	12.5	62.5	48	2700

Weekends

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekends	Insourcing	8	6	48	32	1536

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekends	Insourcing	7	6	42	36	1500

10.1.4 Outsourcing Arrangements

Outsourcing @ 2,000 cases per year

10.1.5 Booking and scheduling For Option 3a (Vanguard Capacity and North Hub NHH Weekends):

In one year the team will need to book 5,900 outpatient appointments across both the North and South Hubs and schedule 5,900 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 13,800 patient bookings per year. A Regional booking and scheduling tam are required for these patient volumes, along with a Vanguard Unit Manager and NHH Eye Unit Manager to ensure capacity levels are maximised.

10.1.6 Option 3a Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

10.2 Option 3a – Option Appraisal

10.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	2772	**5172**	4080	1092
CAV	1620	15%	1155	**2775**	1800	975
CTM	2100	49%	3773	**5873**	4080	1793
Regional Total	6120		7700	13820	9960	3860

10.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
Capacity	2400	2772	5172

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
Capacity	1920	180	3773	5873

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
Capacity	1620	1155	2775

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	5172	2775	5873	13820

10.2.3 Option 3a Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[5]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[6]
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the Vanguard unit 7 days per week
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 3,814 patients waiting

10.2.4 Option 3a Risks

The specific risks associated with option 3a are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

10.2.5 Option 3a Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

[5] Insourcing and Outsourcing will take the less complex patients

[6] Vanguard offers the opportunity for more training lists that are shorter in size

10.2.6 Option 3a Costs

Option 3a: Use of NHH weekends and Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale	Insource Weekend	1,500		1,500	£2,831,000	£2,831,000
Cardiff and Vale	NHS Weekday	2,700		2,700	£1,944,000	£1,944,000
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£899,438
TOTAL		**7,700**	**£574,032**	**7,700**	**£8,998,144**	**£10,471,614**

Revenue: Indicative Cost per Patient £1,360

Capital Costs

Temporary Theatre @UHW	**£2,400,000**
Indicative Cost per Patient	£1,672

10.2.7 Option 3a Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 13,820 cataracts procedures per year (266 per week, 1152 per month)
- 13,820 outpatients per year (266 per week, 1152 per month)

After 52 weeks of the total capacity of 13,820 per year the waiting list is reduced from 19,000 across the region to 15,186

Further details on Option 3a can be found in Appendix Five

11. Option 3b –Vanguard and maximising NHH

This is the preferred option

As the preferred option this option has been developed in more detail than the other options.

Realistic assumptions have been made about the feasibility of delivery and the model has been designed to be distributed over 14 months split across 23/24 and 24/25.

Option 3b

As option 3a but with the addition of 7 weekday NHS sessions in NHH

Option 3b is an insourcing and outsourcing option involving a two-hub model of NHH in the North and the Vanguard Unit in the South with the following volumes over a 14 month period:

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

11.1 Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

11.1.1 Maximising the Use of the Vanguard Unit in UHW

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is currently contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday with this arrangement running until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit will be extended until 30th June 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service. The Vanguard Unit requires capital funding.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

11.1.2 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits using an additional theatre in NHH on weekdays, staffed by NHS staff and on both days on the weekend by an insourcing team

Delivery Plan for NHH Sessions Weekdays NHS Staff

Delivery Plan Outpatients

Delivery from months 3-14 of the plan

	Month 3	Month 4	Month 5	Month 6	Months 7-13	Month 14		Total
Patients per list	6	7	8	8	8	8		
Sessions per week	5	5	5	5	5	5		
weeks	4	4	4	4	25	1		42
total patients	120	140	160	160	1000	40		1620

Delivery Plan Inpatients

Delivery from months 3-14 of the plan

	Month 3	Month 4	Month 5	Month 6	Months 7-13	Month 14		Total
Patients per list	4	5	6	6	6	6		
Sessions per week	4	5	5	7	7	5		
weeks	1	4	4	4	28	1		42
total patients	16	100	120	168	1176	30		1610

Delivery Plan for Insourcing Sessions in NHH Weekends

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50
total patients	1504	1500

11.1.3 Clinical Service Model South Hub

Through this option The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The Vanguard Unit would be used 7 days per week.

On weekdays the twin theatre unit will be staff by NHS staff in a continuation of current practice. These 20 sessions will be split, 7.5 for CAV and 12.5 for regional patients. On the weekends the provision in the vanguard unit will be staffed via an insourcing company.

Weekdays

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekdays	NHS Staff	8	7.5	60	46	2760

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients (less CNA's)
Weekdays	NHS Staff	5	12.5	62.5	48	2700

Weekends

Outpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients

Weekends	Insourcing	8	6	48	32	1536

Inpatients

Time	Delivery	patients Per list	Sessions	patients per week	Weeks	Total Patients
Weekends	Insourcing	7	6	42	36	1500

11.1.4 Outsourcing Arrangements

Outsourcing @ 2,000 cases per year

11.1.5 Booking and scheduling For Option 3a (Vanguard Capacity and North Hub NHH Weekends):

In one year the team will need to book 7,310 outpatient appointments across both the North and South Hubs and schedule 7,310 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 16,620 patient bookings per year. A Regional booking and scheduling team are required for these patient volumes, along with a Vanguard Unit Manager and NHH Eye Unit Manager to ensure capacity levels are maximised.

11.1.6 Delivery Plan

The delivery will run for 14 months and individual streams of activity will start and finish as follows:

- Month 1 to month 12
    - Vanguard Weekdays
- Month 2 to month 12
    - Vanguard Insourcing
- Month 2 to month 13
    - NHH Insourcing
    - Outsourcing
- Month 3 to month 14
    - NHH Weekdays

11.1.7 Option 3b Assumptions

- NHH Workforce can be fully recruited
- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement

- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- CTM continue with their current levels of outsourcing (15 per month)
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

11.2 Option 3b – Option Appraisal

11.2.1 Additional Regional Capacity

Capacity	Core 14 months	Additional Capacity %	Additional Regional	**Total**	14 months demand	Difference
AB	2800	36%	3352	**6152**	4760	1392
CAV	1890	15%	1397	**3287**	2100	1187
CTM	2440	49%	4562	**7002**	4760	2242
Regional Total	7140		9310	**16450**	11620	4830

11.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages.

Delivery is split over 2 financial years as follows:

- 9 months of 23/24 from 1st July 2023 to 31st March 2024
- 5 months of 24/25 from 1st April 2024 to 31st August 2024

AB Patients

	Core: AB In House	AB 39%	AB Total from this business case
1st July 2023 to 31st March 2024	1800	2313	4113
1st April 2024 to 31st August 2024	1000	1039	2039
Total Allocation	2800	3352	6152

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
1st July 2023 to 31st March 2024	1215	964	2179

1st April 2024 to 31st August 2024	675	433	1108
Total Allocation	1890	1397	3287

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
1st July 2023 to 31st March 2024	1440	135	3148	4723
1st April 2024 to 31st August 2024	800	75	1414	2289
Total Allocation	2240	210	4562	7012

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
1st July 2023 to 31st March 2024	4113	2179	4723	11014
1st April 2024 to 31st August 2024	2039	1108	2289	5436
Total Allocation	6152	3287	7012	**16450**

11.2.3 Option 3b Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[7]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[8]
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the Vanguard unit 7 days per week
- Greater proportion of cataracts surgery undertaken by NHS staff
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 4,832 patients waiting

11.2.4 Option 3b Risks

The specific risks associated with this option are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing

[7] Insourcing and Outsourcing will take the less complex patients

[8] Vanguard offers the opportunity for more training lists that are shorter in size

capacity (low risk following mitigation actions)

11.2.5 Option 3b Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

11.2.6 Option 3b Costs

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

			2023/24					2024/25			TOTAL ACTIVITY	TOTAL COST
Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient	Host Health Board	Delivery	Patients	Patients	Patients	Patients
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW		**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS		**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the 'long waiters' commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as 'pre go live'. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The 'regional operational team' meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

11.2.7 Option 3b Activity Modelling

This scenario is based on the following assumptions:

- 9,960 referrals per year (192 per week, 830 per month)
- 15,430 cataracts procedures per year (297 per week, 1286 per month)
- 15,430 outpatients per year (297 per week, 1286 per month)

Over 14 months this would be:

- 11,620 referrals per year
- 16,450 cataracts procedures per year
- 16,450 outpatients per year

After 14 months the total capacity of 16,450 per year the waiting list is reduced from 19,000 across the region to 14,168

Further details on Option 3b can be found in Appendix Six

12. Option 4 – Weekend Insourcing and Outsourcing Only

The Insourcing and outsourcing option involves a two hub model of NHH in the North and the use of POWH in the south for outpatients and Inpatients, along with outsourcing in the following volumes over a 12 month period:

- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**
- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £7.5m
- Cost per patient: £1,504

12.1 Option 4 – Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

12.1.1 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits. There is 1 theatre available in NHH that will be used on both days on the weekend by an insourcing team.

Delivery Plan for Insourcing Sessions in NHH

	Outpatients	Inpatients
Patients per list	8	7.5
Sessions per week	4	4
Patients per week	32	30
weeks per year	47	50

total patients	1504	1500

12.1.2 South Hub

Through this Option the South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital in Bridgend on weekends via an insourcing company

weekends

Outpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	8	4	32	32	1024
Sunday	Insourcing	8	2	16	31	496
Total				**48**		**1520**

Inpatients

Session Type	method	patients per list	Sessions	patients per week	Weeks	Total Patients
Saturday	Insourcing	7	4	28	36	1000
Sunday	Insourcing	7	2	14	36	500
Total				**42**		**1500**

12.1.3 Outsourcing Arrangements

This Option will deliver an additional 2,000 cases per year. Outsourcing arrangements and costs include patient travel.

12.1.4 Booking and scheduling for Option 4 (Weekend Insourcing and Outsourcing)

In one year the team will need to book 3,000 outpatient appointments across both the North and South Hubs and schedule 3,000 inpatient procedures in addition to facilitating 2,000 outsourced patients totalling 8,000 patient contacts per year. A Regional booking and scheduling tam are required for these patient volumes.

12.1.5 Option 4 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements

- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

12.2 Option 4 – Option Appraisal

12.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

12.2.2 Regional Capacity by expected patients treated

Reviewing the end of the list, 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
Capacity	2400	1800	4200

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
Capacity	1920	180	2450	4550

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
Capacity	1440	750	2190

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	4200	2190	4550	10940

12.2.4 Option 4 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Reduces the backlog by 517 patients waiting

12.2.5 Option 4 Risks

The specific risks associated with this option are:

- Loss of experienced and well trained staff at the Vanguard Unit (low risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)

12.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

12.2.7 Option 4 Costs

Option 4 costs are shown here

Option 4: POW and NHH weekends without Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
External	Outsource	2,000	316,000	2,000	2,379,333	2,695,333
Regional Operational Team						£524,453
TOTAL		**5,000**	**£574,032**	**5,000**	**£6,423,644**	**£7,522,129**

Indicative Cost per Patient £1,504

Costing assumptions-

- Cost assumptions are based on locally provided figures
- Insource cost estimates are based on Framework expectation of PbR plus 10% but will depend on casemix and provider
- Outsourcing estimates are based on PbR with an element for transport but dependent on casemix and provider

12.2.8 Option 4 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 10,940 cataracts procedures per year (202 per week, 874 per month)
- 10,940 outpatients per year (202 per week, 874 per month)

After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Further details on Option 4 can be found in Appendix Seven

13. Option 5 – Outsourcing

The option involves outsourcing the whole additional capacity. By using outsourcing only, the demands on the regional booking and scheduling team also reduce. It is unlikely that one supplier would be able to fulfil the whole 5,000 procedures per year and so it would be split across different providers with the following volumes over a 12 month period:

- An additional 5,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**
- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £7m
- Cost per patient: £1,410

13.1 Option 5 – Clinical and Service Model

13.1.1 Outsourcing Arrangements

Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Through this option 5,000 cases are outsourced. Outsourcing arrangements and costs include patient travel.

Patients are reviewed by a non-clinical administrator for their suitability for outsourcing and then referred on to the outsourcing company for assessment and treatment. Communication with the patient about booking and scheduling and locations are conducted by the outsourcing company. Follow ups post-surgery are conducted in primary care. Hospital patient records are updated.

13.1.2 Booking and scheduling For Option 5 (Outsourcing)

In one year the team would need to facilitate 5,000 outsourced patients and ensure records are kept up to date and that these patients are suitable for the outsourcing route.

13.1.3 Option 5 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Outsourcing contracting will be done at a National level
- Outsourcing may be through a number of providers

- That outsourcing capacity will be available in the market through contracting arrangements
- Outsourcing company(ies) to carry out enough outpatient assessments to treat 5,000 patients
- Effective clinical governance arrangements

13.2 Option 5 – Option Appraisal

13.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity (outsourced)	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

13.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
Capacity	2400	1800	4200

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
Capacity	1920	180	2450	4550

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
Capacity	1440	750	2190

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
Capacity	4200	2190	4550	10940

13.2.4 Option 5 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Additional capacity delivered at reduced costs from insourcing
- Reduces the backlog by 517 patients waiting

13.2.5 Option 5 Risks

The specific risks associated with option 2 are:

- Loss of experienced and well trained staff at the Vanguard Unit (medium risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)
- Increased number of patients required to travel further for treatment

13.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels.

This option is for outsourcing activity where patients who meet the criteria for this additional capacity would be directed to outsourcing for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and outsourcing capacity provision. This option also includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity does not include patient travel contributions.

13.2.7 Option 5 Costs

Option 5: Outsourcing Only

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	5,000	£790,000	5,000	£5,948,333	£6,738,333
Regional Operational Team						£312,427
TOTAL		**5,000**	**£790,000**	**5,000**	**£5,948,333**	**£7,050,760**

Indicative Cost per Patient £1,410

13.2.8 Option 5 Activity Modelling

The assumptions used in this option are the same as in option 4, as the capacity stays the same but the mode of delivery changes.

After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Further details on Option 5 can be found in Appendix Eight

14.Preferred Option

14.1 Preferred Option

The preferred option in this business case is Option 3b Vanguard and Max NHH

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

14.2 Options Appraisal

The six options have been through an options appraisal process. An exercise was undertaken with each health board individually to score and assess each option against the business case aims and the principles of regional working in section 2.1 below and appendix two.

Weighting for the scoring was allocated as follows:

- Quality and Safety: 35%
- Effective use of resources: 10%
- Strategic Fit: 10%
- Sustainability: 15%
- Access: 10%
- Deliverability: 20%

Results of the appraisal process are shown below. All three health boards have selected the same option as the highest scoring option against the criteria. Results are shown below. Scores are out of 5, with the regional total out of 15.

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard	Option 4 Weekends	Option 5 Outsourcing

				and Max NHH		
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Regional Total	5.05	10.75	11.00	12.15	6.30	5.80

14.3 Option Costs

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

			2023/24					2024/25			TOTAL ACTIVITY	TOTAL COST
Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient	Host Health Board	Delivery	Patients	Patients	Patients	Patients
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW		**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS		**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the ‘long waiters’ commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as ‘pre go live’. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The ‘regional operational team’ meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

15.Summary

The business case demonstrates a clear need for additional capacity for cataracts assessment and surgery in the South East Wales Region. By working together the three health boards can provide this capacity for patients and deliver the benefits described in the case.

This business case has strong strategic links with the National Planned Care goals, the Ophthalmology GIRFT Programme report and the Royal College of Ophthalmologists External Review of Eye Care Services in Wales and contributes towards the delivery of reducing waiting times for patients.

The additional capacity addresses the significant backlog in this area and provides the headroom necessary to plan and implement longer term sustainable solution and to demonstrate the successes of regional working. This business case enables the region to maximise the existing capacity available on our hospital sites and more provide timely care to patients regardless of where they live within the region.

The table below summarises the options

High level Financials

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH*	Option 4 Weekends	Option 5 Outsourcing
Core Capacity	5,940	5,940	6,120	7,140*	5,940	5,940
Additional Regional Capacity	0	8668	7,700	9,310	5,000	5,000
Total Capacity	5,940	14,608	13,820	16,450	10,940	10,940
Total Revenue Costs	£0	£12.4m	£10.5m	£12.9m**	£7.5m	£7m
Total Capital Costs	£0	£0	£2.4m	£2.4m	£0	£0
Total Costs (Capital + Revenue)	£0	£12.4m	£12.9m	£15.3m	£7.5m	£7m
Cost per patient	n/a	£1,436	£1,672	£1,640	£1,504	£1,410

**Option 3b is for 14 months*

***Costing for this option include 5% increase on all pay costs*

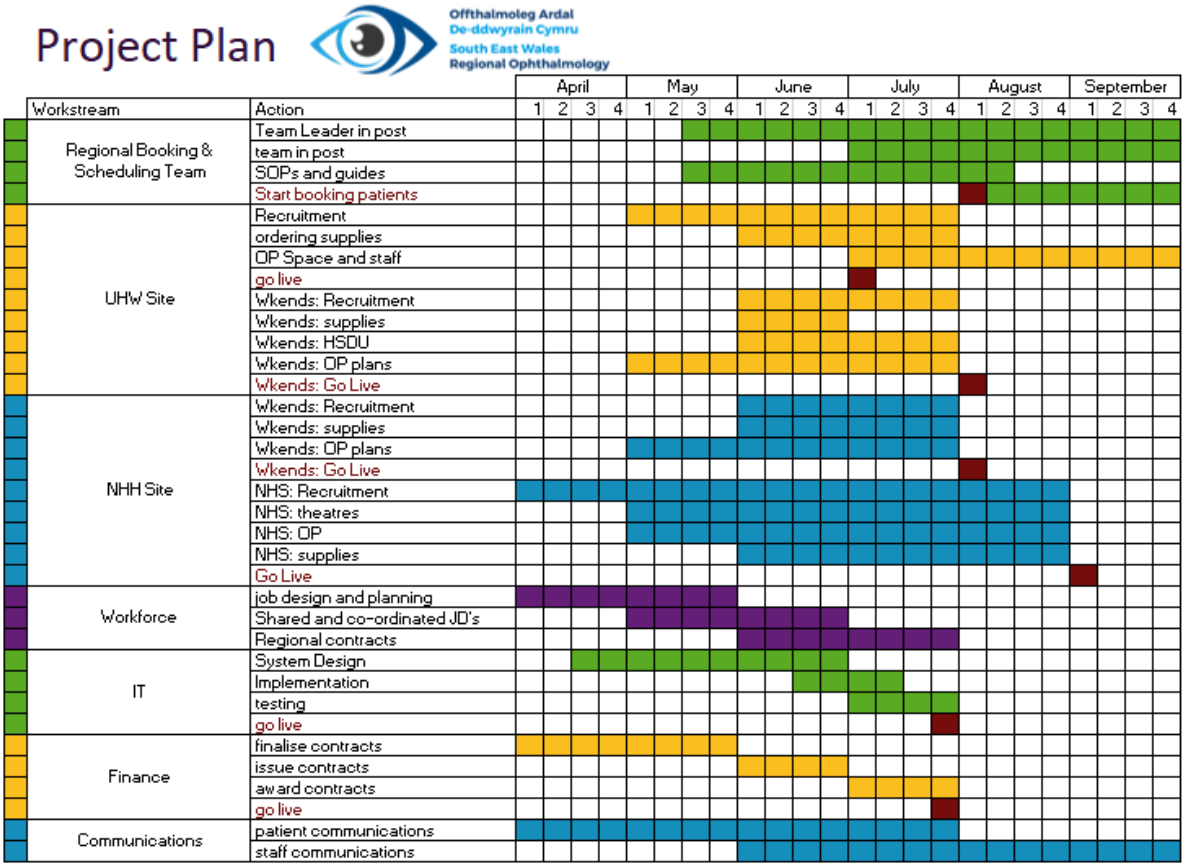
16.Interdependencies

The interdependencies identified through this work are:

- Stabilising and protecting core capacity in CAV
- Stabilising and protecting core capacity in CTM
- Stabilising and protecting core capacity in AB
- Commissioners –appropriate commissioning frameworks to be developed
- Capital funding required for Vanguard.

17.Implementation Plans

The implementation plan for the business case is shown below.



Implementation

The Implementation of this business case is a priority across Health Boards and the outline plan above is for the implementation phase. This will be an intensive phase of activity across the health boards and will require an additional project manager to work full time on this work as part of the programme. There will likely be a soft launch of the additional capacity and time will be required to embed the new models and make improvements to processes. As part of the wider Regional Programme proposals for a regional Vitreo-Retinal hub service need to be planned and implemented early in the calendar year to support the complications arising from the cataract service and so additional project support and a dedicated clinical lead is required for the programme.

18.Approvals

Milestone	Date	Decision
Completion by the working group	Wednesday 16th November	Agreement to go forward to Ophthalmology Programme Board
Ophthalmology Programme Board	12th December	Approved to go forward to next stage
Regional Portfolio Delivery Board	6th April 2023	Approved to go forward to next stage
Regional Portfolio Oversight Board	13th April 2023	Approved to go forward to next stage
Management Execs AB	13th April 2023	Approved to go forward to next stage
Investment Group CAV	18th April 2023	Approved to go forward to next stage
Management Execs (SLB) CAV	4th May 2023	Approved to go forward to next stage
Management Execs CTM	9th May 2023	Approved to go forward to next stage
Welsh Gov Submission	12th May	
Board Meeting AB	24th May 2023	
Board Meeting CAV	25th May 2023	
Board Meeting CTM	25th May 2023	

Appendix One: Financials

Option 3b - Preferred Option

Option 3b: Use of NHH weekends and weekdays and Vanguard

Revenue Costs

			2023/24				2024/25		TOTAL ACTIVITY	TOTAL COST
Host Health Board	Delivery	Pre Go Live costs	Patients	Patients	Total Estimated Costs	Cost per Patient	Host Health Board	Delivery	Patients	Patients	Patients	Patients
Provider			Activity	Cost		Cost per case excl capital and pre go live			Activity	Cost	Activity	Cost
Cardiff and Vale	Insource Weekend		1,090	£1,731,622	£1,731,622	£1,589	Cardiff and Vale	Insource Weekend	410	£651,344	1,500	£2,382,967
Cardiff and Vale	Weekday		2,025	£1,643,721	£1,643,721	£812	Cardiff and Vale	Weekday	675	£547,907	2,700	£2,191,628
Aneurin Bevan	Insource Weekend	£125,784	1,000	£1,328,411	£1,454,195	£1,328	Aneurin Bevan	Insource Weekend	500	£664,206	1,500	£2,118,401
Aneurin Bevan	Weekday Capacity	£163,522	940	£1,082,215	£1,245,737	£1,151	Aneurin Bevan	Weekday Capacity	670	£771,366	1,610	£2,017,103
External	Outsource		1,334	1,861,757	£1,861,757	£1,396	External	Outsource	666	£929,483	2,000	£2,791,240
Regional Operational Team		£50,642		£871,566	£922,208		Regional Operational Team			£443,449		£1,365,656
TOTAL		**£339,948**	**6,389**	**£8,519,293**	**£8,859,241**		**TOTAL**		**2,921**	**£4,007,754**	**9,310**	**£12,866,995**

Capital Costs Assumed to convert to revenue

Temporary Theatre @UHW	**£1,600,000**	**£800,000**	**£2,400,000**
TOTAL COSTS	**£10,459,241**	**£4,807,754**	**£15,266,995**

Anticiptaed Utilisation and commissioner share

AB	36%	**£3,765,327**	**£1,730,792**	**£5,496,118**
CAV	15%	**£1,568,886**	**£721,163**	**£2,290,049**
CTM	49%	**£5,125,028**	**£2,355,800**	**£7,480,828**

Financial Assumptions

Key Assumptions

- Activity and cost is assumed to be utilised as per the ‘long waiters’ commissioner split in the business case. An indicative commissioner share of cost and activity is in the attached
- Some costs are now fully expected in 2023/24 where these are required as ‘pre go live’. These relate to revenue equipment costs in AB.
- Vanguard and procurement costs are estimated based on current agreements and are therefore subject to possible variation
- The ‘regional operational team’ meets workforce expectations for the structure and requirements
- There is risk of recurrent recruitment costs if staff are permanently employed for a time limited project however there is an expectation of future service development
- Delivery plans and costings are estimated on the case mix complexity as outlined in the business case

Option 1 – Do nothing

Do nothing – no additional costs

Option 2 – Maximising NHH and POWH

Option 2: POWH and NHH

Revenue Costs **2023/24**

Provider Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Aneurin Bevan	Weekday Capacity	1,610	£184,342	1,610	£1,659,078	£1,843,420
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
Cwm Taf	Insource Weekday	2,058		2,058	£2,671,284	£2,671,284
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£934,145
TOTAL		**8,668**	**£758,374**	**8,668**	**£10,754,006**	**£12,446,525**

Indicative Cost per Patient £1,436

Option 3a Costs vanguard and NHH Weekends

Option 3a: Use of NHH weekends and Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale	Insource Weekend	1,500		1,500	£2,831,000	£2,831,000
Cardiff and Vale	NHS Weekday	2,700		2,700	£1,944,000	£1,944,000
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£899,438
TOTAL		**7,700**	**£574,032**	**7,700**	**£8,998,144**	**£10,471,614**

Revenue: Indicative Cost per Patient £1,360

Capital Costs

Temporary Theatre @UHW	**£2,400,000**

Indicative Cost per Patient £1,672

Option 4 - Weekend Insourcing and Outsourcing Only

Option 4: POW and NHH weekends without Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Aneurin Bevan	Insource Weekend	1,500	£258,032	1,500	£1,843,811	£2,101,843
Cwm Taf	Insource Weekend	1,500		1,500	£2,200,500	£2,200,500
External	Outsource	2,000	316,000	2,000	2,379,333	2,695,333
Regional Operational Team						£524,453
TOTAL		**5,000**	**£574,032**	**5,000**	**£6,423,644**	**£7,522,129**

Indicative Cost per Patient £1,504

Option 5 - Outsourcing

Option 5: Outsourcing Only

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	5,000	£790,000	5,000	£5,948,333	£6,738,333
Regional Operational Team						£312,427
TOTAL		**5,000**	**£790,000**	**5,000**	**£5,948,333**	**£7,050,760**

Indicative Cost per Patient £1,410

Appendix Two: Options Appraisal details

The following six options were considered as part of the options appraisal.

Business Case
Options Appraisal Criteria

Offthalmoleg Ardal
De-ddwyrain Cymru
South East Wales
Regional Ophthalmology

The options developed in the business case will be assessed through separate financial and non-financial appraisals. The proposed criteria for assessing non-financial options in the business case is set out below

Domain	Weight	Principles	Business Case Aims
Quality & safety	35%	Evidences a reduction in unwarranted variation and inequality in health outcomes, access to services and experience at a regional population level. Evidences patient safety, quality and/or compliance issues Evidences any poor benchmarking indicators across the region are being addressed.	to address current waiting list backlogs to reduce clinical risk on an equitable basis across the region
Effective use of resources	10%	Makes effective use of capacity and capability across the region Evidences a direct link to one or more operational 'targets' for HBs and/or region	to provide additional regional capacity for cataract outpatient and inpatient stages to demonstrate optimal utilisation of our assets across the region Deliver value for money
Strategic Fit	10%	Evidence of fit with national clinical strategies and professional reviews Evidences a direct link to improving population health Evidences a direct link to key national policy / frameworks / legislation	to enact a collaborative regional approach to recovery
Sustainability	15%	Evidences improved sustainable service resilience. Evidences a link to the NHS Wales decarbonization agenda	Protect the viability of the core capacity
Access	10%	To agree approaches to engagement and communications together.	Keep patient travel to a minimum
Deliverability	20%	Evidence that benefits, measures and a critical path for delivery is understood and achievable.	Be mobilised quickly Be deliverable with the resources available

Method: There are six options in the business case, each Health board will assess each option against each domain and award a score between 1-5 (5 fully meets, 1 does not meet). The scores will be combined to determine the preferred option.

Results of the Options appraisal are shown below

	Option 1 Do Nothing	Option 2 POWH and NHH	Option 3a Vanguard and NHH	Option 3b Vanguard and Max NHH	Option 4 Weekends	Option 5 Outsourcing
Cardiff and Vale	1.65	3.10	4.00	4.25	1.85	1.65
Cwm Taf Morgannwg	1.60	4.30	3.70	4.35	2.30	2.00
Aneurin Bevan	1.80	3.35	3.30	3.55	2.15	2.15
Total	5.05	10.75	11.00	12.15	6.30	5.80

Appendix Three: Option 1 Details

This option involves providing no further funding and resources to cataract surgery across the region at this stage. Each health board will continue with only their planned core capacity and there will be no sharing of patient treatment lists (PTL's). The Vanguard rental will end on 31st March 2023 following the two month short term regional arrangement.

8.1.1 Core capacity

The annual core capacity of each Health Board is shown below

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	**Regional Total Core**	Regional Demand	Difference
2023/24	2400	1920	180	1440	5940	9,960	-4,020

8.1.2 Option Assumptions

This option is based on the following assumptions

- Use of Vanguard ends by March 31st 2023
- Capacity in CTM and AB for 23/24 remains at 2022 activity levels
- CAV have 7.5 sessions in main theatres to undertake core cataracts activity, reverting to pre-Vanguard capacity.

8.2 Option 1 – Option Appraisal

8.2.1 Option 1 Benefits

The high level benefits identified above (section 6.1) are foregone in this option. The benefits identified for this option are listed below

- No changes to the way that services are currently run
- No management capacity required to organise additional services
- No direct costs

8.2.2 Option 1 Risks

The specific risks associated with option 1 are:

- Demand continues to outstrip supply (high risk as business case is mitigation action)
- Backlogs will continue to grow (high risk as business case is mitigation action)
- Planned Care target will be missed (high risk as business case is mitigation action)
- Increased proportions of higher complexity patients as waiting times are increased (medium risk as business case is mitigation action)

- Loss of experienced and well trained staff at the Vanguard Unit (medium risk as business case is mitigation action)
- Reduction in training capacity across the region (medium risk as business case is mitigation action)
- Increases the backlog by 4,046 patients (high risk as business case is mitigation action)

8.2.3 Option 1 Patient Considerations

Through this option all patients will continue to be treated by their home health board. They will be treated within their own health board boundary but are likely to have to wait more than 1 year for assessment and treatment. As patient waits lengthen, the risk increases of patients coming to harm while waiting.

8.2.4 Option 1 costs

There are no direct costs associated with this option

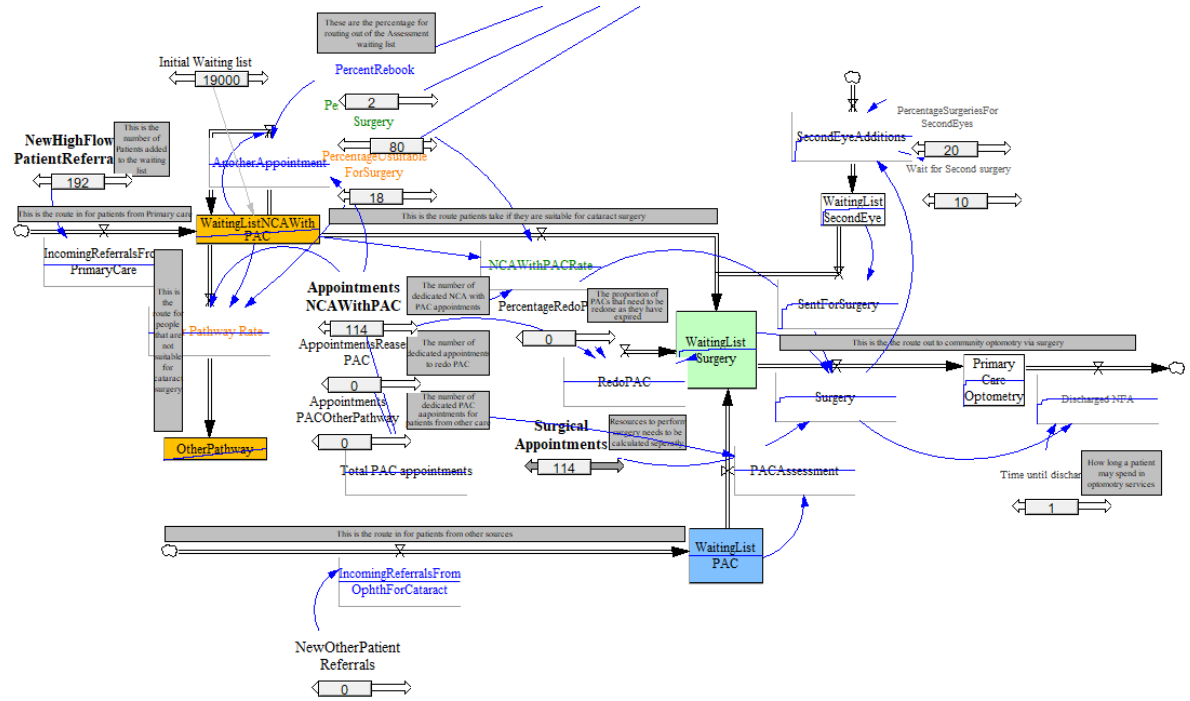
Indirect costs include:

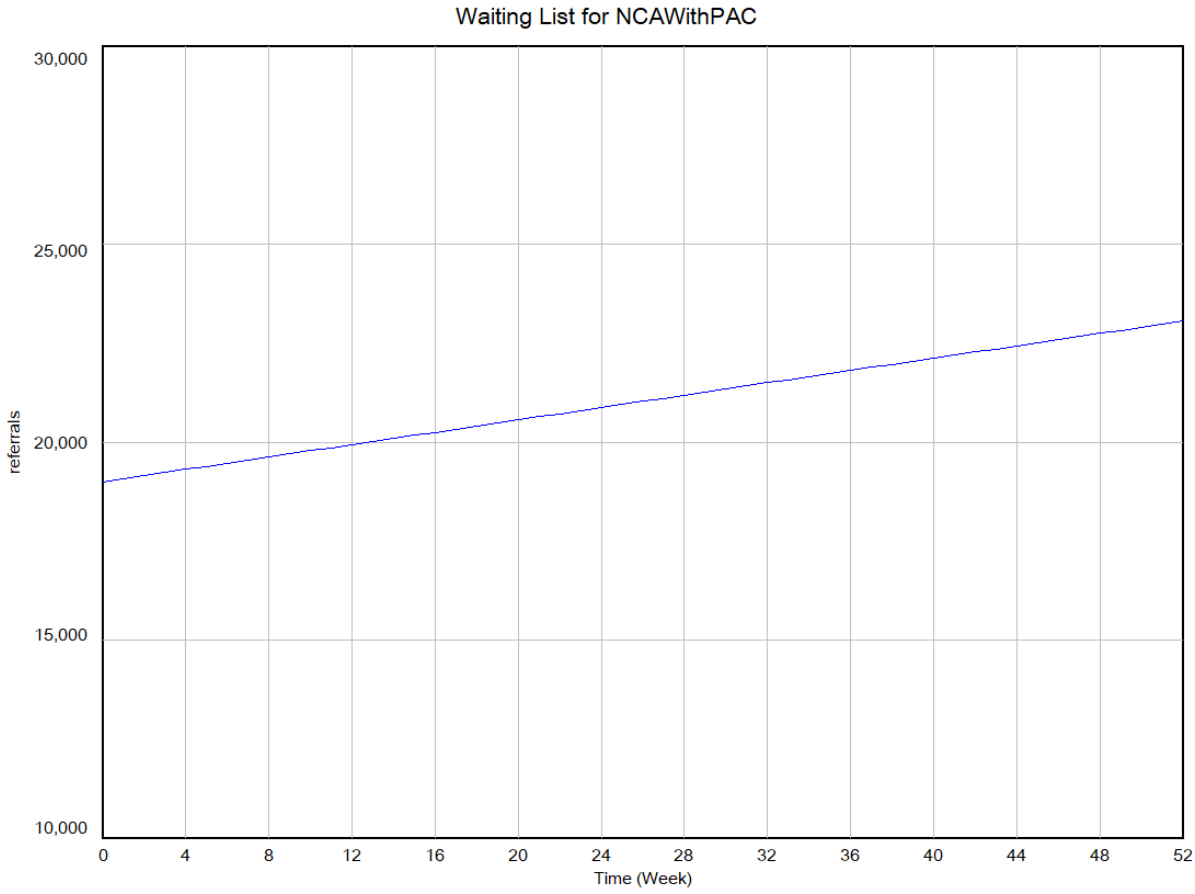
- Increased reliance on WLI's / agency staff
- Increased patient complaints
- Multiple patient referrals as primary care escalate patients due to deterioration
- Additional waiting list validation required
- Increased costs of complications as patient complexity increases

8.2.5 Option 1 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 5,940 cataracts procedures per year (114 per week, 495 per month)
- 5,940 outpatients per year (114 per week, 495 per month)
- 9,960 referrals per year (192 per week, 830 per month)





After 52 weeks of the total capacity of 5,940 per year the waiting list is increased from 19,000 across the region to 23,046

Appendix Four: Option 2 Details

Option 2 is an NHS recruitment, insourcing and outsourcing option involving a two-hub model of NHH in the North and POWH in the South. At both sites the weekday and weekend capacity is utilised, along with outsourcing in the following volumes over a 12 month period:

- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 3,558 (2,058 weekdays plus 1,500 weekends) outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 8,668 additional**
- **Total capacity 14,608 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs 23/24: £12.4m
- Cost per patient: £1,436

9.1. Option 2 - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

9.1.1 Clinical Service Model North Hub (NHH)

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits.

Weekdays: Outpatients Stage (NHS Staff)

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 135 outpatient appointments per month (38 per week, 1,620 per year) the sessions will be a ‘one stop shop’ model, held on weekdays in the OP dept in NHH.

4 consulting rooms will be required plus a waiting area. This weekday activity will be staffed through recruitment of NHS staff for all of the clinical and not clinical staff required.

Weekends: Outpatient Stage (Insourcing Staff)

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 125 outpatient appointments per month (30 per week, 1,500 per year) the sessions will be a 'one stop shop' model, held on a Saturday in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area. This will be staffed thought an insourcing company

Assuming that the required clinical staff including Consultants, PAC nurse and biometry staff will be provided by the Insourcing provider, the following additional staff will also be required to run weekly Saturday OP clinics for 1 year:

- 0.5 WTE Receptionist Band 2 £15,780
- 0.5 WTE Health Records Clinical Notes Band 2 £15,780
- 0.5 WTE Governance Nurse band 6 £29,372

Other non staff requirements for the OP sessions are

- Cleaning (Saturday) £7500

Lenses will be also ordered at this point if the patient is suitable for surgery. Costs of lenses will be included in the Inpatient section.

Outpatients Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Weekdays; Inpatient Stage (NHS Staff)

Patients attending the weekday regional capacity for cataract surgery in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub weekday arrangements in NHH with NHS staff.

In order to undertake 38 procedures per week (135 per month, 1,610 per year) the procedures will be undertaken in Main Theatres at NHH on weekdays, Mondays and Wednesday to Friday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity.

Weekends: Inpatient Stage (Insourcing Staff)

Patients attending the weekend regional capacity for cataract surgery in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub weekend arrangements in NHH with insourcing staff.

In order to undertake 30 procedures per week (125 per month, 1,500 per year) the procedures will be undertaken in Main Theatres at NHH on Saturdays and Sundays.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity.

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6 WTE Governance Nurse band 6 £35,246

Non-Staff Requirements

Other non-staff requirements for the Inpatient sessions are:

Weekends
Cleaning / Waste / Facilities - £47,883

HSDU costs (Including transport) - £30,000 Purchase of additional surgical trays and equipment - £38,284 Stellaris Handpieces- £87,500 Pharmacy costs, Lens and consumables - £224,310 Additional lens costs £7,716

9.1.2 Clinical Service Model South Hub (POWH)

Through Option 2 the South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital site on weekdays and weekends via an insourcing company with one weekday session per week provided by NHS staff.

Weekdays: Outpatient Stage

During Weekdays the outpatient stage will be undertaken through insourcing with all clinical staff provided by the insourcing company. Outpatient assessments will be carried out during evenings on the POWH site. Two pre assessment rooms are available.

Weekends: Outpatient Stage

The POWH site has two pre-assessment rooms which can be used concurrently during weekends during 2023/24. Each room would house one pre-assessment nurse each, and both could be serviced with one doctor in clinic. All the clinical staff would be provided through the insourcing company. In one session using two PAC nurses concurrently, 10 patients could be assessed.

Staff Recruitment

In addition the staffing costs for running outpatient clinics evenings and weekends would be:

Weekends
• 0.5 WTE B2 Receptionist • 0.5 WTE B3 Booking • 0.5 WTE B6 Governance Nurse

Non- staffing costs

- Cleaning for evenings and weekends

Outpatient Clinical Model

Patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Weekdays: Inpatient Stage (Insourcing, plus 1 NHS staffed session)

Patients accessing the additional capacity for weekday insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their OP assessment through the South hub weekday arrangements in POWH.

POWH has a twin theatre set up and the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen in a morning. Weekday capacity in POWH will be achieved through 1 weekday 'in hours' session to be staffed by NHS staff and 3 evenings per week to be staffing through insourcing.

By running the two theatres on three evenings per week on weekdays, 42 patients can be seen in the evenings (total 6 sessions) plus the additional day session with 7 patients on a list totalling 49 patients per week on evenings and the 1 day session.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Weekends: Inpatient Stage (Insourcing)

Patients accessing the additional capacity for weekend insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their OP assessment through the South hub weekend arrangements in POWH.

POWH has a twin theatre set up and the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen

in a morning. By running the two theatres on Saturdays all day and Sunday mornings, 42 patients can be seen in a weekend (total 6 sessions). This model can run for 36 weeks to treat the 1,500 patients through the insourcing.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Staff Recruitment

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

Weekends
• 0.6 WTE Receptionist Band 2 £18,936 • 0.6 WTE Health Records Clinical Notes Band 2 £18,936 • 0.6WTE Governance Nurse band 6 £35,246

Non Staff Requirements

Other non-staff requirements for the Inpatient sessions are:

Weekends
• Cleaning / Waste / Facilities - £47,883 • HSDU costs (Including transport) - £30,000 • Purchase of 45 additional surgical trays and handpieces - £239,682 • Pharmacy costs, Lens and consumables - £225,000 - This is based on a consumable pack costing £150 per patient (1500 patients)Alcon managed contract

9.1.3 Outsourcing Arrangements

In addition to the insourcing arrangements the capacity across the region can be further increased by utilising the local opportunities for outsourcing. Outsourcing can relieve some of the management and back office administrative time associated with working through

the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Outsourcing arrangements and costs include patient travel.

- Option 2 Outsourcing @ 2,000 cases per year

9.1.4 Booking and scheduling For Option 2 (Maximising the use of NHH and POWH):
In one year the team will need to book 6,700 outpatient appointments across both the North and South Hubs and schedule 6,700 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 15,400 patient bookings per year

A team of 16 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5. A POWH Eye Unit Manager and NHH Eye Unit Manager is also required to manage the unit on evenings and weekends as much of the activity is happening outside of usually office hours and to ensure capacity levels are maximised.

Staff Required:

- 8 WTE Patient Schedulers Band 3
- 8 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7
- 1 WTE POWH Eye Unit Manager Band 7
- 1 WTE NHH Unit Manager Band 7

Non Staff Costs

- Facilities costs for 22 members of staff, IT costs and office space have been estimated at £90,000

9.1.5 Option 2 Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through

- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

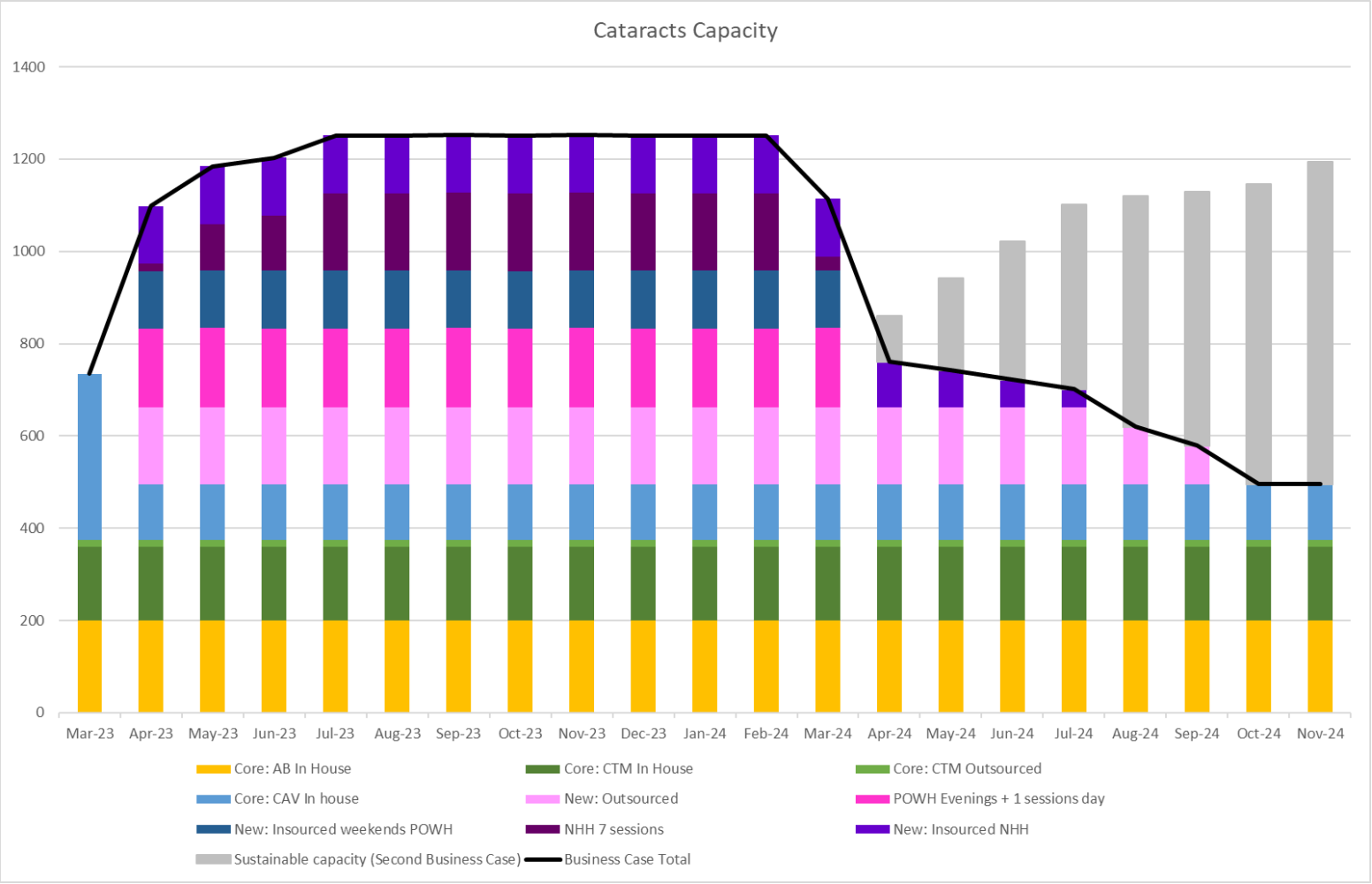
9.2 Option 2 – Option Appraisal

9.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Regional	**Total**	Average Demand	Difference
AB	2400	36%	3121	**5521**	4080	1441
CAV	1440	15%	1300	**2740**	1800	940
CTM	2100	49%	4247	**6347**	4080	2267
Regional Total	5940		8668	**14608**	9960	4648

9.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: POWH	New: NHH	**Business Case Total**
2023/24	2400	1920	180	1440	2000	3558	3110	**14608**
2024/25	1200	960	90	720	875	0	280	**4125**

9.2.3 Regional Delivery by Site

This chart indicates the volumes that will be delivered on each site, for outpatients and for day case/inpatients

For Outpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: POWH	New: NHH	Business Case Total
23/24	2400	1920	180	1440	2000	3628	3120	14688
24/25	1200	960	90	720	875	0	280	4125

For Inpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: POWH	New: NHH	Business Case Total
23/24	2400	1920	180	1440	2000	3558	3110	14608
24/25	1200	960	90	720	875	0	280	4125

9.2.4 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
2023/24	2400	3121	5521
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
2023/24	1920	180	4247	6347
2024/25	960	90	566	1616

CAV Patients (estimated)

	Core: CAV In house	CAV 15%	CAV Total from this business case
2023/24	1440	1300	2740
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	5521	2740	6347	14608
2024/25	1616	893	1616	4125

9.2.5 Option 2 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Recruiting additional NHS workforce for NHH
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the POWH Eye Unit 7 days per week
- Enables a greater reduction in the backlog
- No additional capital required
- Reduces the backlog by 4,648 patients waiting

9.2.6 Option 2 Risks

The specific risks associated with option 2 are:

- High volumes of surgery through POWH Eye Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

9.2.7 Option 2 Patient Considerations

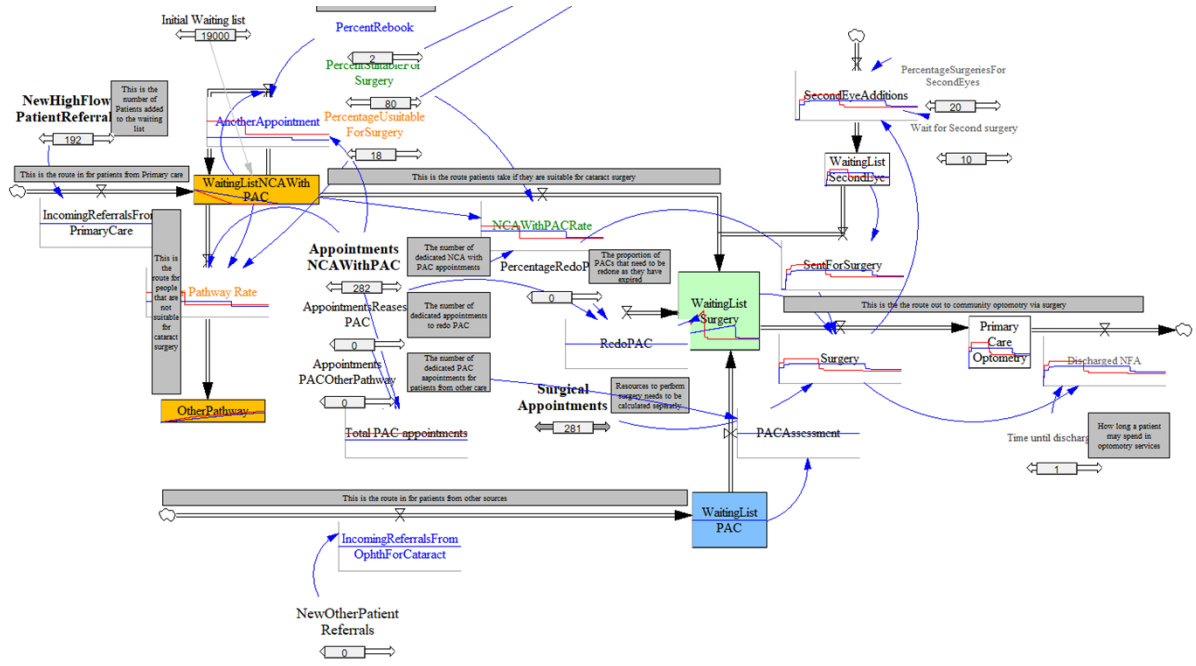
Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

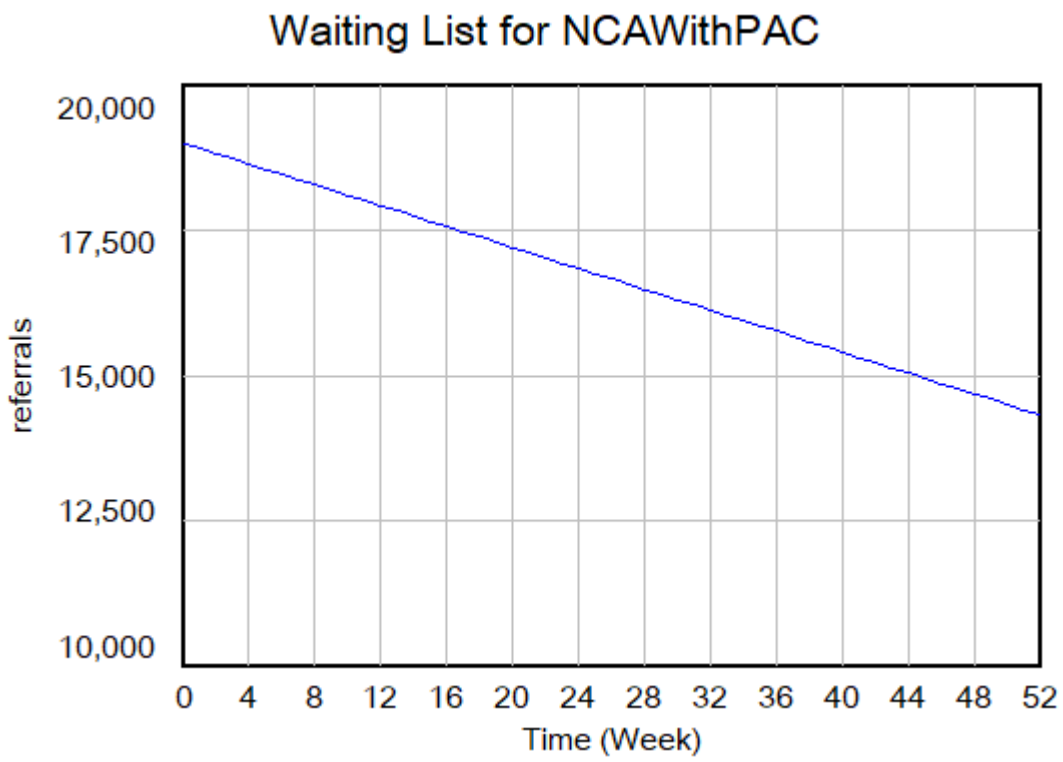
This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

9.2.9 Option 2 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 14,608 cataracts procedures per year (281 per week, 1217 per month)
- 14,608 outpatients per year (282 per week, 1224 per month)





After 52 weeks of the total capacity of 14,608 per year the waiting list is reduced from 19,000 across the region to 14,352

Appendix Five: Option 3a Details

Option 3a –Vanguard and NHH

Option 3a is an insourcing and outsourcing option involving a two-hub model of NHH in the North and a combination of POWH for outpatients and Vanguard for Inpatients in the South, along with outsourcing in the following volumes over a 12 month period:

- South Hub: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 6,120
- **Plus 7,700 additional**
- **Total capacity 13,820 per year**
- Waiting list reduction 3,814 (from 19,000 to 15,186)
- Total costs 23/24:
- Cost per patient:

10.1 Option 3a - Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

10.1.1 Maximising the Use of the Vanguard Unit in UHW

The Vanguard Unit in UHW is a mobile twin theatre alongside modular units for consulting, patient waiting and recovery. It is currently contracted for use for cataract surgery by CAV on a 5 day per week basis Monday to Friday with this arrangement running until 8th January 2023. As a short-term solution and to maximise the options available for this business case, the unit will be extended until 31st March 2023 and the capacity during this extension period will be divided between the three health boards in the region.

If extended, then the new contract for the Vanguard Unit will be for 7 days per week to maximise the use of the unit for the regional extension of the cataracts service. The Vanguard Unit requires capital funding.

The benefits of retaining the Vanguard Unit include the stability of staff and retaining this well trained and experienced staffing group, the ability to treat more complex patients than the insourcing and outsourcing will enable, increasing the training opportunities available across the region and providing a solid foundation for the second sustainable phase of the cataracts expansion to be based.

10.1.2 Clinical Service Model North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny.

Outpatient Stage

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 125 outpatient appointments per month (30 per week, 1,500 per year) the sessions will be a 'one stop shop' model, held on a Saturday in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area.

Assuming that the required clinical staff including Consultants, PAC nurse and biometry staff will be provided by the Insourcing provider, the following additional staff will also be required to run weekly Saturday OP clinics for 1 year:

- 0.5 WTE Receptionist Band 2 £15,780
- 0.5 WTE Health Records Clinical Notes Band 2 £15,780
- 0.5 WTE Governance Nurse band 6 £29,372

Other non staff requirements for the OP sessions are

- Cleaning (Saturday) £7500

Lenses will be also ordered at this point if the patient is suitable for surgery. Costs of lenses will be included in the Inpatient section.

Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies

- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage

Patients accessing the additional capacity for insourcing in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub arrangements in NHH.

In order to undertake 30 procedures per week (125 per month, 1,500 per year) the procedures will be undertaken in Main Theatres at NHH every Saturday and Sunday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6 WTE Governance Nurse band 6 £35,246

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities - £47,883
- HSDU costs (Including transport) - £30,000
- Purchase of additional surgical trays and equipment - £38,284
- Stellaris Handpieces- £87,500
- Pharmacy costs, Lens and consumables - £224,310
- Additional lens costs £7,716.

10.1.3 Clinical Service Model South Hub Weekends (Option 1 UHW)

Through Option 1 The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from University Hospital of Wales on weekends via an insourcing company

Outpatients Stage (Weekend Insourcing in UHW)

The UHW site has two pre-assessment rooms which can be used concurrently during weekends during 2023/24. Each room would house one pre-assessment nurse each, and both could be serviced with one doctor in clinic. All the clinical staff would be provided through the insourcing company. In one session using two PAC nurses concurrently, 10 patients could be assessed.

In addition the staffing costs for running outpatient clinics evenings and weekends would be:

- 0.5 WTE B2 Receptionist
- 0.5 WTE B3 Booking
- 0.5 WTE B6 Governance Nurse

Non- staffing costs are

- Cleaning

Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage (Weekend Insourcing in Vanguard Unit UHW)

Patients accessing the additional capacity for insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their Outpatient assessment through the South hub insourcing arrangements in UHW.

In the Vanguard theatres the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen in a

morning. By running the two theatres for AM and PM on Saturdays and AM on Sundays 42 patients can be seen in a weekend (total 6 sessions). This model can run for 36 weeks to treat the 1,500 patients through the insourcing.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.33WTE Receptionist Band 2 £TBC
- 0.33WTE Health Records Clinical Notes Band 2 £TBC
- 0.33WTE Governance Nurse band 6 £TBC
- 1 wte Manager 8b (included in section 8.1.5)

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities
- HSDU costs - £TBC
- Purchase of 45 additional surgical trays and handpieces - £239,682
- Pharmacy costs, Lens and consumables - £225,000 - This is based on a consumable pack costing £150 per patient (1500 patients)Alcon managed contract

10.1.4 Additional Vanguard Capacity for the Region

This option includes the additional Vanguard capacity for the region. The Vanguard Unit surgical capacity and the associated outpatient capacity required to run the service would continue to operate as it has since January 2022, retaining the same staff, maintaining the same list size, training opportunities and job plans as are currently in place and operational Monday to Friday for 20 sessions per week across the twin theatre arrangement. Through this option this existing service model would be retained until March 2024.

7.5 sessions out of 20 per week (37.5%) of the capacity would be for Cardiff and Vale core capacity funded by Cardiff and Vale and the other 12.5 sesions ourt of 20 (62.5%) would be available to the regional patients and funded by this regional business case.

As it is currently set up, the Vanguard Unit treats more complex patients that the outsourcing and insourcing capacity can. The unit will continue to treat the same complexity

of patient and clinical criteria will need to be developed to determine the referral criteria for the regional proportion of the Unit.

Under this model, patients treated in the Vanguard unit will have their outpatient assessment on the UHW site on a weekday and this will continue to run as it currently is with the Cardiff and Vale staff and estates.

10.1.5 Outsourcing Arrangements

In addition to the insourcing arrangements the capacity across the region can be further increased by utilising the local opportunities for outsourcing. Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Outsourcing arrangements and costs include patient travel.

- Outsourcing @ 2,000 cases per year

10.1.6 Booking and scheduling For Option 3a (Vanguard Capacity and North Hub NHH Weekends):

In one year the team will need to book 5,900 outpatient appointments across both the North and South Hubs and schedule 5,900 inpatient procedures and facilitate 2,000 outsourced patients.

A team of 14 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5. A Vanguard Unit Manager and NHH Eye Unit Manager are also required to manage the unit and to ensure capacity levels are maximised.

Staff Required:

- 7 WTE Patient Schedulers Band 3
- 7 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7
- 1 WTE Vanguard Unit Manager Band 8b
- 1 WTE NHH Eye Unit Manager Band 7

Non Staff Costs

- Facilities costs for 20 members of staff, IT costs and office space have been estimated at £90,000

10.1.7 Option 3a Assumptions

- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters
- 52 weeks waiters numbers under monthly review and capacity adjusted accordingly
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes

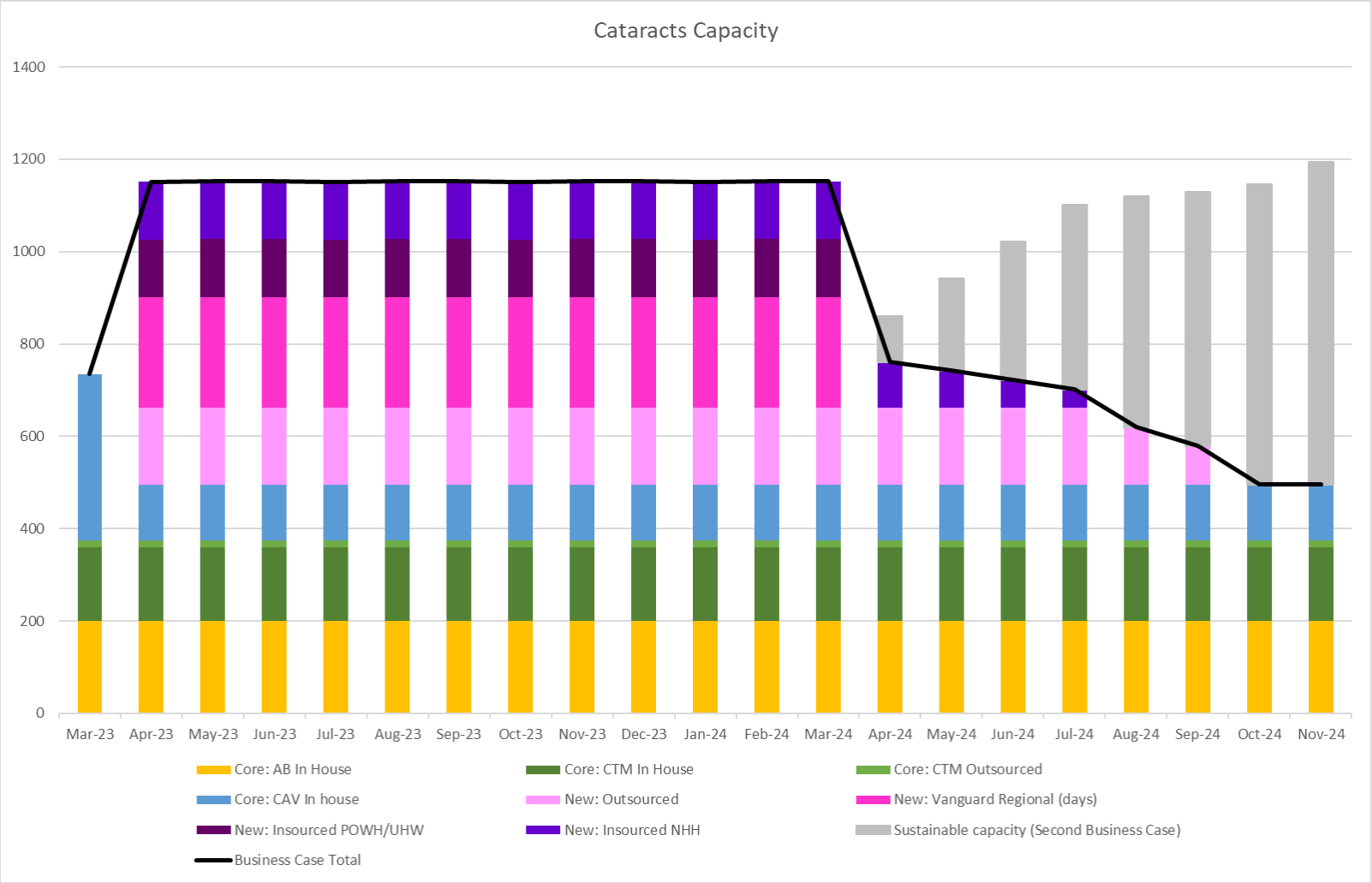
10.2 Option 3a – Option Appraisal

10.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Vanguard	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	1037	1800	**5237**	4080	1157
CAV	1440	15%	432	750	**2622**	1800	822
CTM	2100	49%	1411	2450	**5961**	4080	1881
Regional Total	5940		2880	5000	**13820**	9960	3860

10.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Vanguard Regional (days)	New: Insourced POWH/UHW	New: Insourced NHH	**Business Case Total**
2023/24	2400	1920	180	1440	2000	2880	1500	1500	**13820**
2024/25	1200	960	90	720	875	0	0	280	**4125**

10.2.3 Regional Delivery by Site

This chart indicates the volumes that will be delivered on each site, for outpatients and for day case/inpatients

For Outpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Vanguard Regional (days)	New: Insourced POWH	New: Insourced NHH	Business Case Total
23/24	2400	1920	180	1440	2000	2880	1500	1500	13820
24/25	1200	960	90	720	875	0	0	280	4125

For Inpatients

	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Vanguard Regional (days)CAV Surgery	New: Insourced UHW	New: Insourced NHH	Business Case Total
23/24	2400	1920	180	1440	2000	2880	1500	1500	13820
24/25	1200	960	90	720	875	0	0	280	4125

10.2.4 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
2023/24	2400	2837	5237
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
2023/24	1920	180	3861	5961
2024/25	960	90	566	1616

CAV Patients (estimated)

	Core: CAV In house	CAV 15%	CAV Total from this business case
2023/24	1440	1182	2622
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	5237	2622	5961	13820
2024/25	1616	893	1616	4125

10.2.5 Option 3a Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[9]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[10]
- Provides a solid base to develop the sustainable regional solution

[9] Insourcing and Outsourcing will take the less complex patients

[10] Vanguard offers the opportunity for more training lists that are shorter in size

- Fully utilised the Vanguard unit 7 days per week
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 3,814 patients waiting

10.2.6 Option 3a Risks

The specific risks associated with option 1 are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

10.2.7 Option 3a Patient Considerations

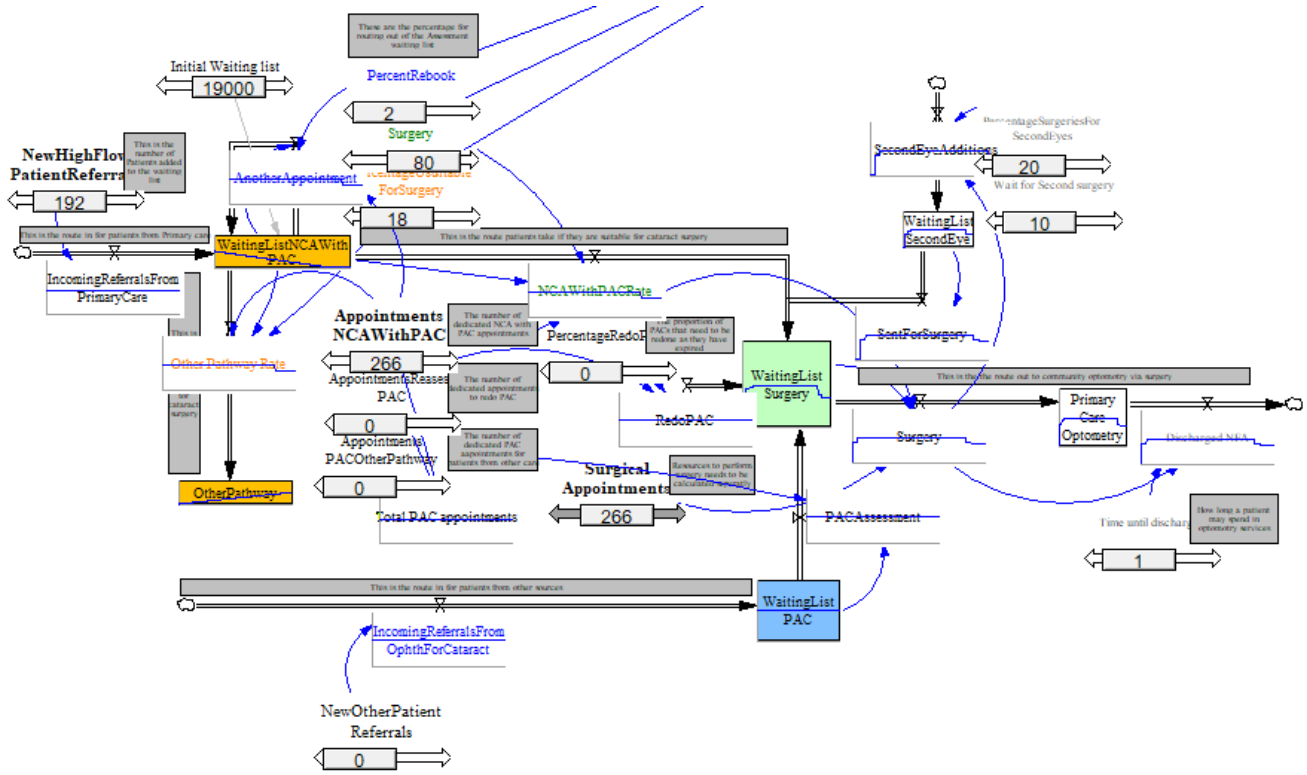
Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

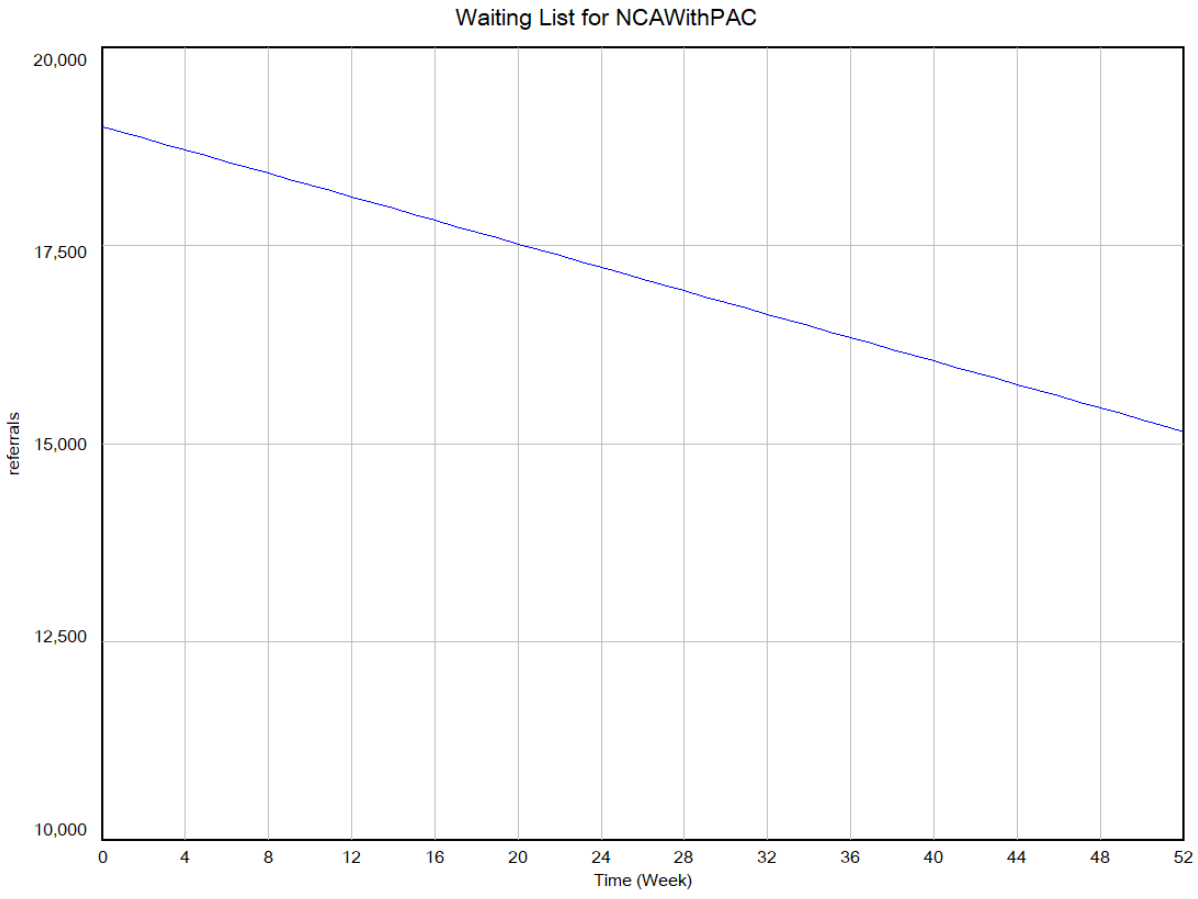
This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

10.2.9 Option 3a Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 13,820 cataracts procedures per year (266 per week, 1152 per month)
- 13,820 outpatients per year (266 per week, 1152 per month)


Initial Waiting list
19000
PercentRebook
2
Surgery
80
AnotherAppointment
ForSurgery
18
192
WaitingListNCAWithPAC
IncomingReferralsFromPrimaryCare
NCAWithPACRate
Appointments NCAWithPAC
266
AppointmentsReasesPAC
0
PercentageRedoPAC
RedoPAC
WaitingList Surgery
SentForSurgery
Surgery
Primary Care Optometry
SecondEyeAdditions
20
Wait for Second surgery
WaitingList SecondEye
10
Other Pathway Rate
OtherPathway
Appointments PACOtherPathway
0
Total PAC appointments
Surgical Appointments
266
PACAssessment
1
WaitingList PAC
IncomingReferralsFromOphthForCataract
NewOtherPatient Referrals
0


Waiting List for NCAWithPAC
20,000
17,500
15,000
12,500
10,000
referrals
0
4
8
12
16
20
24
28
32
36
40
44
48
52
Time (Week)

After 52 weeks of the total capacity of 13,820 per year the waiting list is reduced from 19,000 across the region to 15,186

Appendix Six: Option 3b Details

Option 3b –Vanguard and maximising NHH

This is the preferred option

As the preferred option this option has been developed in more detail than the other options.

Realistic assumptions have been made about the feasibility of delivery and the model has been designed to be distributed over 14 months split across 23/24 and 24/25.

Option 3b

As option 3a but with the addition of 7 weekday NHS sessions in NHH

Option 3b is an insourcing and outsourcing option involving a two-hub model of NHH in the North and the Vanguard Unit in the South with the following volumes over a 14 month period:

- South Hub Weekdays: Retaining the weekday 20 sessions in vanguard and using 7.5 sessions for CAV core capacity (1620 patients per year, funded by CAV) and 12.5 sessions for regional capacity (2700 patients per year, regionally funded, provided by NHS staff)
- South Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in Vanguard (UHW)
- North Hub Weekdays: 1610 outpatient assessment and inpatient procedures carried out in weekdays in NHH using NHS staffing
- North Hub Weekends: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- An additional 2,000 outsourced outpatient and inpatient procedures
- One theatre in NHH and twin theatres in Vanguard
- Total core 7,140 for 14 months (6,120 annual)
- **Plus 9,310 additional**
- **Total capacity 16,450 per year**
- Waiting list reduction 4,832 (from 19,000 to 14,168)
- Total costs: £15.3m
- Cost per patient: £1,640

11.1 Clinical and Service Model

11.1.1 Clinical Service Model North Hub (NHH) Additional for Option 3b

The North hub would primarily provide outpatient and inpatient provision to patients primarily in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny as the regional geography suits.

Weekdays: Outpatients Stage (NHS Staff)

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 135 outpatient appointments per month (38 per week, 1,620 per year) the sessions will be a 'one stop shop' model, held on weekdays in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area. This weekday activity will be staffed through recruitment of NHS staff for all of the clinical and not clinical staff required.

Outpatients Clinical Model

These patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Weekdays; Inpatient Stage (NHS Staff)

Patients attending the weekday regional capacity for cataract surgery in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub weekday arrangements in NHH with NHS staff.

In order to undertake 38 procedures per week (135 per month, 1,610 per year) the procedures will be undertaken in Main Theatres at NHH on weekdays, Mondays and Wednesday to Friday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional

Non-Staff Requirements

Other non-staff requirements for the Inpatient sessions are:

Weekends
Cleaning / Waste / Facilities - £47,883 HSDU costs (Including transport) - £30,000 Purchase of additional surgical trays and equipment - £38,284 Stellaris Handpieces- £87,500 Pharmacy costs, Lens and consumables - £224,310 Additional lens costs £7,716

11.1.2 Booking and scheduling For Option 3b (Vanguard and Maximising NHH):
In one year the team will need to book 7,500 outpatient appointments across both the North and South Hubs and schedule 7,500 inpatient procedures and facilitate 2,000 outsourced patients. Totalling 17,000 patient bookings per year

A team of 18 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5. A Vanguard Unit Manager and NHH Eye Unit Manager are also required to manage the unit and to ensure capacity levels are maximised.

Staff Required:

- 9 WTE Patient Schedulers Band 3
- 9 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7
- 1 WTE Vanguard Unit Manager Band 8b
- 1 WTE Eye Unit Manager NHH band 7

Non Staff Costs

- Facilities costs for 24 members of staff, IT costs and office space have been estimated at £100,000

11.1.3 Option 3b Assumptions

- NHH Workforce can be fully recruited
- Shared PTL across the region
- Share of regional capacity based on percentage split of over 52 week waiters

- 52 weeks waiters numbers under monthly review
- Regional booking team may not all be based in one place
- IT solutions will need to be worked through
- Insourcing and Outsourcing contracting will be done at a National level
- That insourcing and outsourcing capacity will be available in the market through contracting arrangements
- Insourcing numbers on a list to be determined by the insourcing company with annual numbers included in the contracting arrangement
- Effective clinical governance arrangements
- Vanguard workforce can continue into 23/24
- CTM continue with their current levels of outsourcing (15 per month)
- NHH Workforce can be fully recruited
- Patients receive pre-assessment and surgery through the same element of provision (e.g. weekend pre-assessment and weekend surgery)
- Patient eligibility criteria are to be developed and agreed
- 80% conversion rate from outpatients to surgery
- 20% of patients require a second eye
- Patients requiring second eye have one pre assessment to cover both eyes
- NHH Workforce can be fully recruited

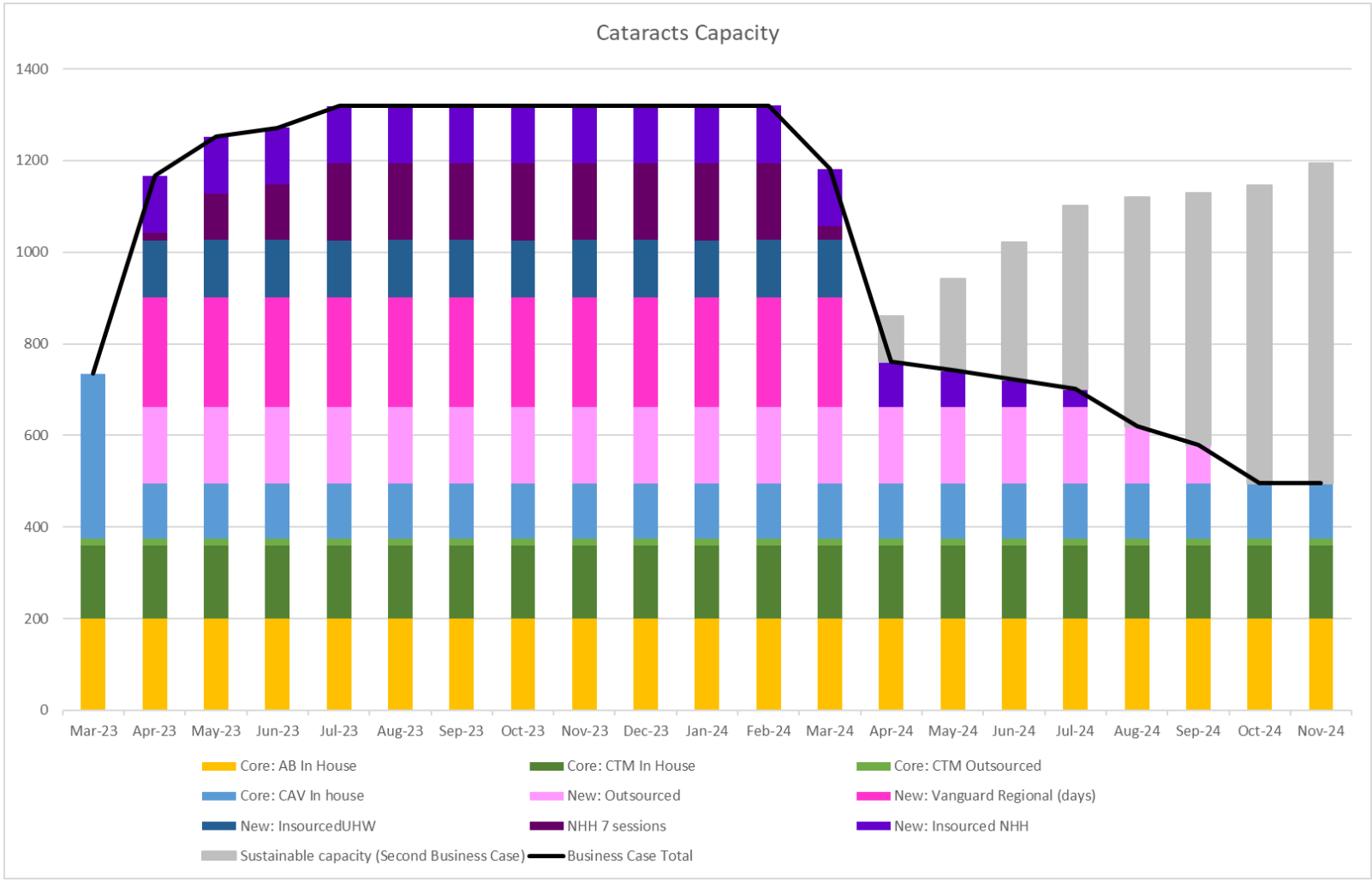
11.2 Option 3b – Option Appraisal

11.2.1 Additional Regional Capacity

Capacity	Core 14 months	Additional Capacity %	Additional Regional	**Total**	14 months demand	Difference
AB	2800	36%	3352	**6152**	4760	1392
CAV	1890	15%	1397	**3287**	2100	1187
CTM	2440	49%	4562	**7002**	4760	2242
Regional Total	7140		9310	**16450**	11620	4830

11.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a ‘tail’ of 6 months to enable the sustainable capacity (second business case) to build up.


Cataracts Capacity
1400
1200
1000
800
600
400
200
0
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Core: AB In House
Core: CTM In House
Core: CTM Outsourced
Core: CAV In house
New: Outsourced
New: Vanguard Regional (days)
New: InsourcedUHW
NHH 7 sessions
New: Insourced NHH
Sustainable capacity (Second Business Case)
Business Case Total

11.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages.

Delivery is split over 2 financial years as follows:

- 9 months of 23/24 from 1st July 2023 to 31st March 2024
- 5 months of 24/25 from 1st April 2024 to 31st August 2024

AB Patients

	Core: AB In House	AB 39%	AB Total from this business case
1st July 2023 to 31st March 2024	1800	2313	4113
1st April 2024 to 31st August 2024	1000	1039	2039
Total Allocation	2800	3352	6152

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
1st July 2023 to 31st March 2024	1215	964	2179
1st April 2024 to 31st August 2024	675	433	1108
Total Allocation	1890	1397	3287

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
1st July 2023 to 31st March 2024	1440	135	3148	4723
1st April 2024 to 31st August 2024	800	75	1414	2289
Total Allocation	2240	210	4562	7012

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
1st July 2023 to 31st March 2024	4113	2179	4723	11014
1st April 2024 to 31st August 2024	2039	1108	2289	5436
Total Allocation	6152	3287	7012	**16450**

11.2.4 Option 3b Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Retaining a well trained and experienced staff within the Vanguard unit
- Ability to treat more complex patients are part of the regional capacity[11]
- Continuity and stability of employment for Vanguard staff
- Increased opportunities for staff training learning and development[12]
- Provides a solid base to develop the sustainable regional solution
- Fully utilised the Vanguard unit 7 days per week
- Greater proportion of cataracts surgery undertaken by NHS staff
- Enables a greater reduction in the backlog
- Stabilises the short term regional arrangement (Jan-March 2023)
- Reduces the backlog by 4,832 patients waiting

11.2.5 Option 3b Risks

The specific risks associated with this option are:

- High volumes of surgery through Vanguard Unit may put a strain on equipment readiness levels (low risk following mitigation actions)
- Clinical risks and patient harm risks associated with outsourcing and insourcing capacity (low risk following mitigation actions)

11.2.6 Option 3b Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will start to reduce. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

[11] Insourcing and Outsourcing will take the less complex patients

[12] Vanguard offers the opportunity for more training lists that are shorter in size

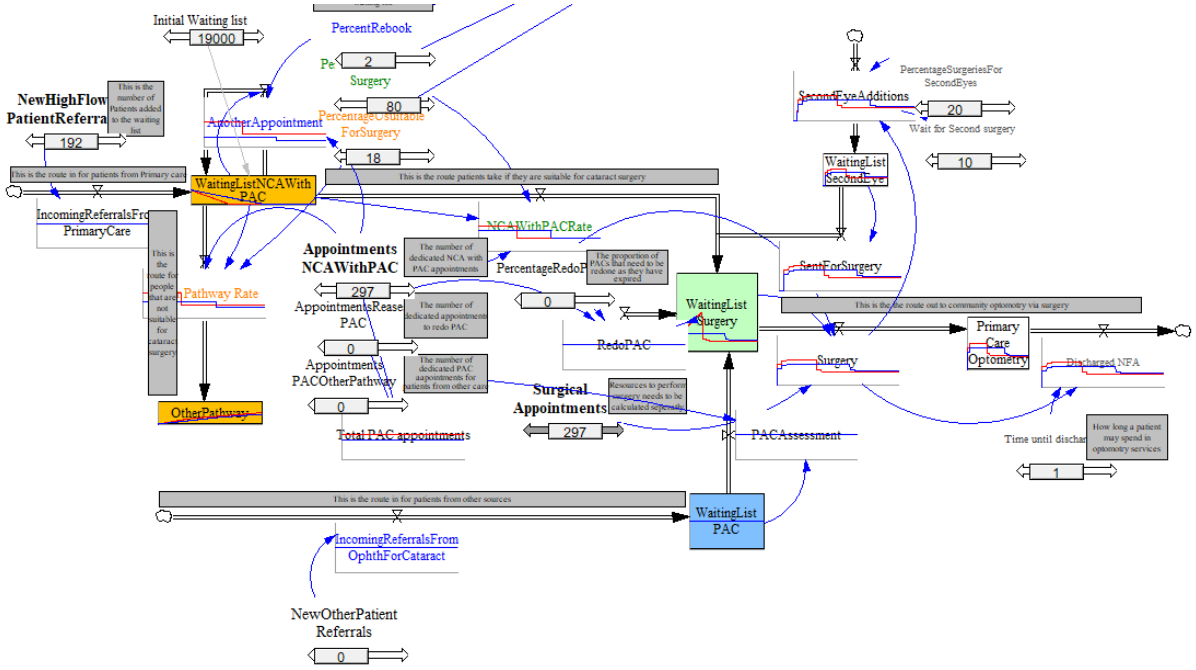
11.2.8 Option 3b Activity Modelling

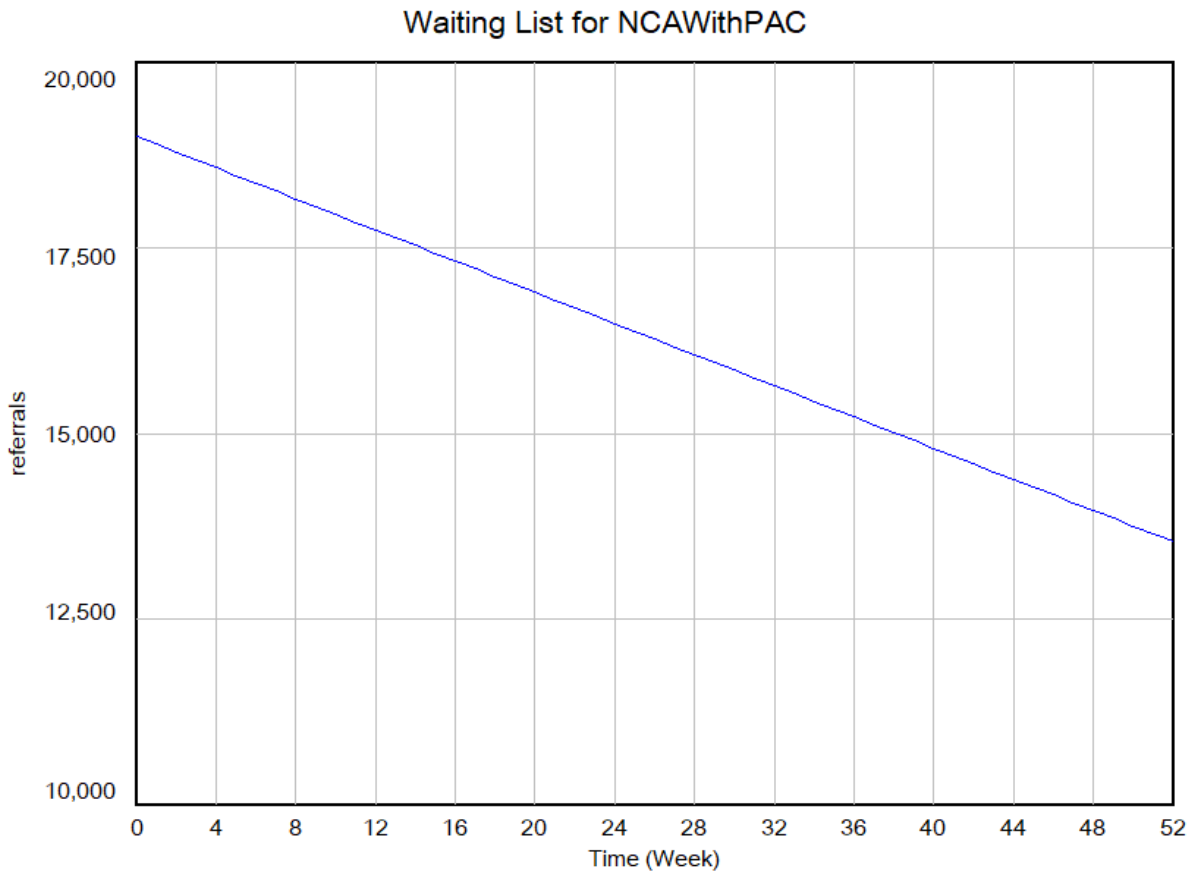
This scenario is based on the following assumptions:

- 9,960 referrals per year (192 per week, 830 per month)
- 15,430 cataracts procedures per year (297 per week, 1286 per month)
- 15,430 outpatients per year (297 per week, 1286 per month)

Over 14 months this would be:

- 11,620 referrals per year
- 16,450 cataracts procedures per year
- 16,450 outpatients per year





This scenario is based on the following assumptions:

- 9,960 referrals per year (192 per week, 830 per month)
- 15,430 cataracts procedures per year (297 per week, 1286 per month)
- 15,430 outpatients per year (297 per week, 1286 per month)

Over 14 months this would be:

- 11,620 referrals per year
- 16,450 cataracts procedures per year
- 16,450 outpatients per year

After 14 months the total capacity of 16,450 per year the waiting list is reduced from 19,000 across the region to 14,168

Appendix Seven: Option 4 Details

Option 4 – Weekend Insourcing and Outsourcing Only

The Insourcing and outsourcing option involves a two hub model of NHH in the North and the use of POWH in the south for outpatients and Inpatients, along with outsourcing in the following volumes over a 12 month period:

- North Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in NHH
- South Hub: 1,500 outpatient assessment and inpatient procedures carried out by an insourcing company in POWH
- An additional 2,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**
- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £7,193,028
- Cost per patient: £1,439

12.1 Option 4 – Clinical and Service Model

The Clinical Model includes an outpatient stage and inpatient stage.

At the outpatient stage the clinical teams review the patients, determine their suitability for surgery and conduct pre-operative assessments. Through the proposed model this will be carried out during a single patient visit.

At the inpatient stage patient receive their cataract surgery. Following surgery patients are discharged to Primary Care. Primary Care advisors have confirmed that no additional resource is required in primary care at present for the additional capacity as it will be adequately dispersed amongst optometric practices across the region.

12.1.1 North Hub

The North hub would primarily provide outpatient and inpatient provision to patients in North CTM and North AB from Nevill Hall Hospital (NHH) in Abergavenny.

Outpatient Stage

Patients will be booked into the additional capacity for outpatients in NHH via the regional booking and scheduling team (see section 5.4)

In order to undertake 125 outpatient appointments per month (30 per week, 1,500 per year) the sessions will be a ‘one stop shop’ model, held on a Saturday in the OP dept in NHH. 4 consulting rooms will be required plus a waiting area.

Assuming that the required clinical staff including Consultants, PAC nurse and biometry staff will be provided by the Insourcing provider, the following additional staff will also be required to run weekly Saturday OP clinics for 1 year:

- 0.5 WTE Receptionist Band 2 £15,780
- 0.5 WTE Health Records Clinical Notes Band 2 £15,780
- 0.5 WTE Governance Nurse band 6 £29,372

Other non staff requirements for the OP sessions are

- Cleaning (Saturday) £7500

Lenses will be also ordered at this point if the patient is suitable for surgery. Costs of lenses will be included in the Inpatient section.

Patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage

Patients accessing the additional capacity for insourcing in the North Hub will be booked through the regional booking team (see section 6.4). They will also have had their OP assessment through the North hub arrangements in NHH.

In order to undertake 30 procedures per week (125 per month, 1,500 per year) the procedures will be undertaken in Main Theatres at NHH every Saturday and Sunday.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6 WTE Governance Nurse band 6 £35,246

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities - £47,883
- HSDU costs (Including transport) - £30,000
- Purchase of additional surgical trays and equipment - £38,284
- Stellaris Handpieces- £87,500
- Pharmacy costs, Lens and consumables - £224,310
- Additional lens costs £7,716.

12.1.2 South Hub

Through Option 2 The South Hub would provide outpatient and inpatient provision for patients in the south of the region. The outpatient and inpatient provision will be delivered from Princess of Wales Hospital in Bridgend on weekends via an insourcing company

Outpatients Stage (Weekend Insourcing in POWH)

The POWH site has two pre-assessment rooms which can be used concurrently during weekends during 2023/24. Each room would house one pre-assessment nurse each, and both could be serviced with one doctor in clinic. All the clinical staff would be provided through the insourcing company. In one session using two PAC nurses concurrently, 10 patients could be assessed.

In addition the staffing costs for running outpatient clinics evenings and weekends would be:

- 0.5 WTE B2 Receptionist
- 0.5 WTE B3 Booking
- 0.5 WTE B6 Governance Nurse

Non- staffing costs are

- Cleaning

Patients are taken from new or stage 1 waiting list. During the one-stop session, patients are:

- Ophthalmic history/general medical history/medication/family history/allergies
- Vision
- Anterior segment examination
- Biometry +/- corneal topography
- Pupil dilatation
- Posterior segment examination by ophthalmologist
- Choose intraocular lens/refractive plan
- Cataract care pathway checklist completed
- Consented for surgery

Inpatient Stage *(Weekend insourcing at POWH)*

Patients accessing the additional capacity for insourcing in the South Hub will be booked through the regional booking team (see section 5.4). They will also have had their OP assessment through the South hub arrangements in POWH.

POWH has a twin theatre set up and the flow enables a maximum of 7 patients on a list for high flow low complexity patients. Running the twin theatres enables 14 patients to be seen in a morning. By running the two theatres on Saturdays all day and Sunday mornings, 42 patients can be seen in a weekend (total 6 sessions). This model can run for 36 weeks to treat the 1,500 patients through the insourcing.

As this is additional volume and there is a strong requirement to protect the core capacity additional trays and handpieces will need to be purchased to support this additional capacity

Assuming that all of the clinical staff required for the surgery and recovery are provided by the insourcing company (Consultants, Nurses, HCSW's) then the following additional staff are required to support the service model:

- 0.6 WTE Receptionist Band 2 £18,936
- 0.6 WTE Health Records Clinical Notes Band 2 £18,936
- 0.6WTE Governance Nurse band 6 £35,246

Other non-staff requirements for the Inpatient sessions are:

- Cleaning / Waste / Facilities - £47,883
- HSDU costs (Including transport) - £30,000
- Purchase of 45 additional surgical trays and handpieces - £239,682
- Pharmacy costs, Lens and consumables - £225,000 - This is based on a consumable pack costing £150 per patient (1500 patients)Alcon managed contract

12.1.3 Outsourcing Arrangements

In addition to the insourcing arrangements the capacity across the region can be further increased by utilising the local opportunities for outsourcing. Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Option 4 will deliver an additional 2,000 cases per year. Outsourcing arrangements and costs include patient travel.

12.1.4 Booking and scheduling for Option 4 (Weekend Insourcing and Outsourcing)

In one year the team will need to book 3,000 outpatient appointments across both the North and South Hubs and schedule 3,000 inpatient procedures in addition to facilitating 2,000 outsourced patients. There is also a requirement to confirm which patients are suitable for the additional capacity and which need to be treated as part of core capacity as they are more complex cases.

A team of 8 booking and scheduling staff on Band 3 are required to support the regional arrangements along with a band 7 team leader and 3 waiting list managers band 5.

Staff Required:

- 4 WTE Patient Schedulers Band 3
- 4 WTE Booking Clerks Band 3
- 3 WTE Waiting list managers Band 5
- 1 WTE Team Leader Band 7

Non Staff Costs

- Facilities costs for 14 members of staff, IT costs and office space have been estimated at £30,000

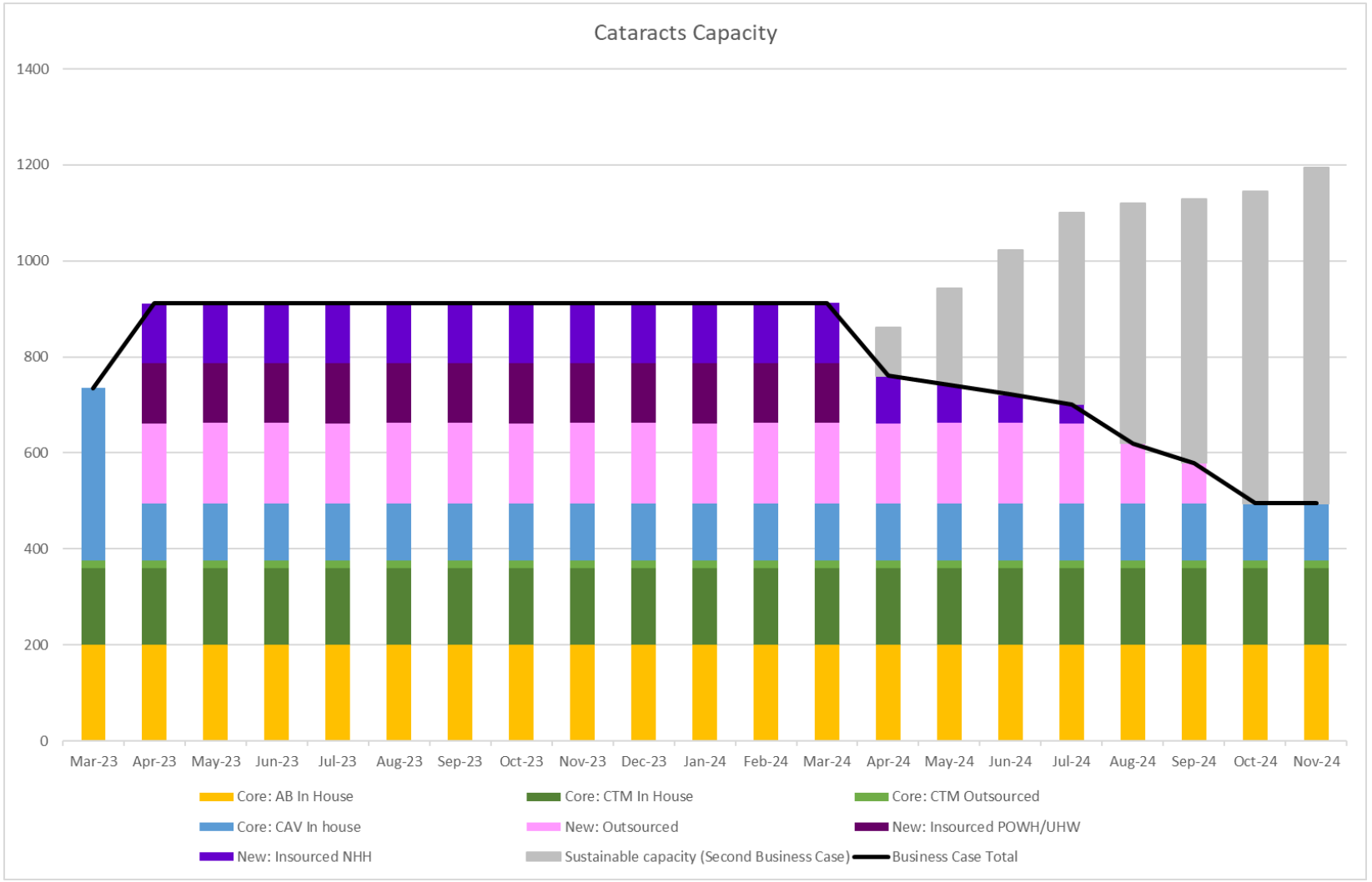
12.2 Option 4 – Option Appraisal

12.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

12.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Insourced POWH	New: Insourced NHH	**Business Case Total**
2023/24	2400	1920	180	1440	2000	1500	1500	**10940**
2024/25	1200	960	90	720	875	0	280	**4125**

12.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list, 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
2023/24	2400	1800	4200
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
2023/24	1920	180	2450	4550
2024/25	960	90	566	1616

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
2023/24	1440	750	2190
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	4200	2190	4550	10940

2024/25	1616	893	1616	4125

12.2.4 Option 4 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Reduces the backlog by 517 patients waiting

If the Vanguard theatres are not taken forward after March 2023 there will be additional staff from UHW that could be utilised at one of the other hub areas.

12.2.5 Option 4 Risks

The specific risks associated with this option are:

- Loss of experienced and well trained staff at the Vanguard Unit (low risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)

12.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels. This option includes a North and South Hub where patients who meet the criteria for this additional capacity would be directed to their closest hub for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and additional capacity provision.

This option also includes outsourcing where the costing includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity, insourcing, and NHS sessions do not include patient travel contributions.

12.2.7 Option 4 Costs

Option 4 costs are shown here

Option 2: Use of NHH and POWH and not retaining Vanguard

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale						
Aneurin Bevan	Insource	1,500	£246,182	1,500	£1,711,811	£1,957,993
Cwm Taf	Insource	1,500	£246,182	1,500	£1,711,811	£1,957,993
External	Outsource	2,000	£316,000	2,000	£2,379,333	£2,695,333
Regional Operational Team						£581,709
TOTAL		**5,000**	**£808,364**	**5,000**	**£5,802,955**	**£7,193,028**

Indicative Cost per Patient £1,439

2024/25

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
Cardiff and Vale	Insource					
Aneurin Bevan	Insource	280	£45,954	280	£319,538	£365,492
Cwm Taf	Insource	280	£45,954	280	£319,538	£365,492
External	Outsource	875	£138,250	875	£1,040,958	£1,179,208
Regional Operational Team						£229,441
TOTAL		**1,435**	**£230,158**	**1,435**	**£1,680,034**	**£2,139,633**

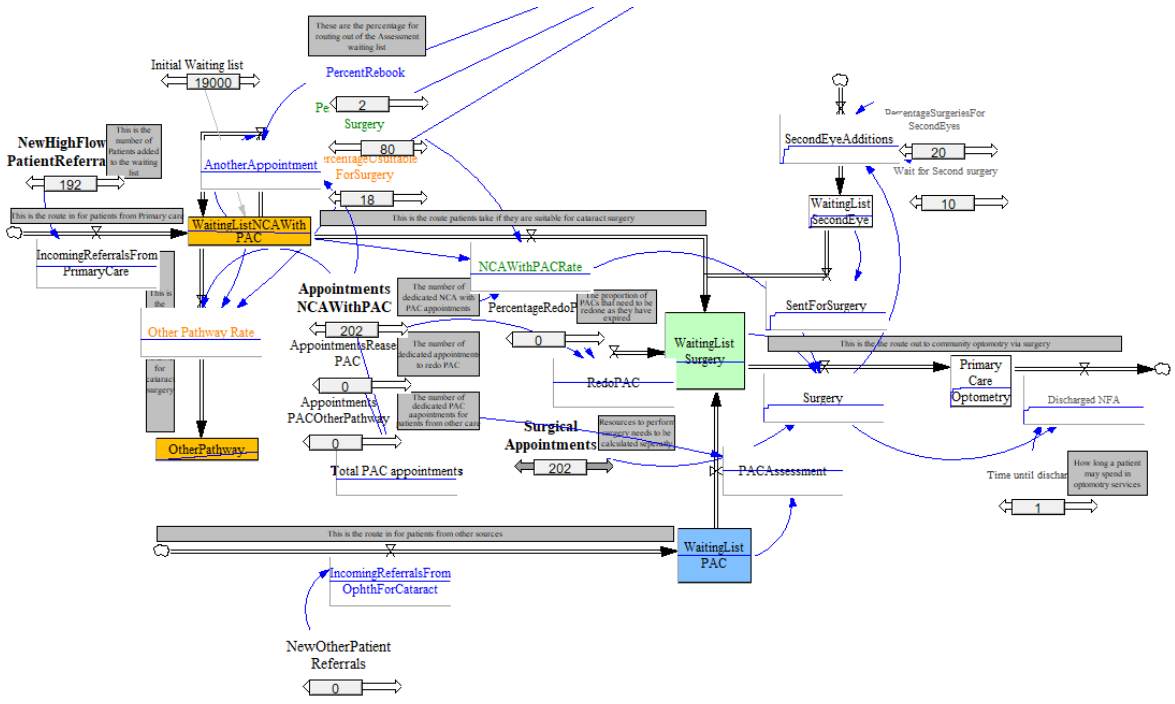
Assumptions-

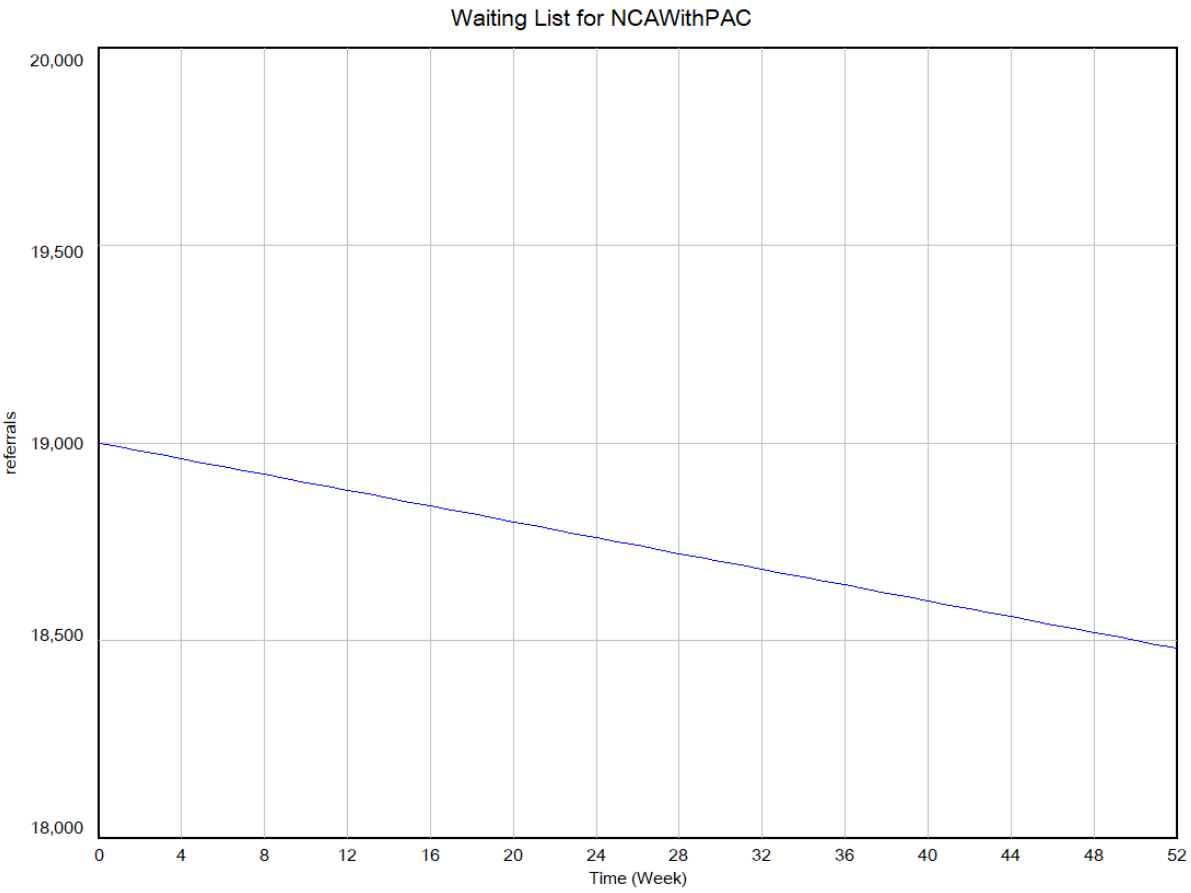
- Cost assumptions are based on locally provided figures
- Insource cost estimates are based on Framework expectation of PbR plus 10% but will depend on casemix and provider
- Outsourcing estimates are based on PbR with an element for transport but dependent on casemix and provider

12.2.8 Option 4 Activity Modelling

This scenario is based on the following assumptions for year 1:

- 9,960 referrals per year (192 per week, 830 per month)
- 10,940 cataracts procedures per year (202 per week, 874 per month)
- 10,940 outpatients per year (202 per week, 874 per month)





After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Appendix Eight: Option 5 Details

Option 5 – Outsourcing

The option involves outsourcing the whole additional capacity and not insourcing or using the Vanguard Unit for capacity. By using outsourcing only, the demands on the regional booking and scheduling team also reduce. It is likely that one supplier would not be able to fulfil the whole 5,000 procedures per year and so it would be split across different providers with the following volumes over a 12 month period:

- An additional 5,000 outsourced outpatient and inpatient procedures
- Total core 5,940
- **Plus 5,000 additional**

- **Total capacity 10,940 per year**
- Waiting list reduction 517 (from 19,000 to 18,483)
- Total costs 23/24: £6,978,436
- Cost per patient: £1,396

13.1 Option 5 – Clinical and Service Model

13.1.1 Outsourcing Arrangements

Outsourcing can relieve some of the management and back office administrative time associated with working through the backlog as the booking and scheduling, record keeping, outpatient and inpatient activity are all supplied as part of the contract. In this way the outsourcing opportunities also represent value for money and free up valuable resources for allocation towards the management of the core capacity and the insourcing arrangements. Through this option 5,000 cases are outsourced. Outsourcing arrangements and costs include patient travel.

Patients are reviewed by a non-clinical administrator for their suitability for outsourcing and then referred on to the outsourcing company for assessment and treatment. Communication with the patient about booking and scheduling and locations are conducted by the outsourcing company. Follow ups post-surgery are conducted in primary care. Hospital patient records are updated.

13.1.2 Booking and scheduling For Option 5 (Outsourcing)

In one year the team would need to facilitate 5,000 outsourced patients and ensure records are kept up to date and that these patients are suitable for the outsourcing route.

A team of 4 patient liaison, 1 waiting list manager and a team leader are required to support the outsourcing

Staff Required:

- 4 WTE Patient Liaison Band 3
- 1 WTE Waiting List Manager Band 5
- 1 WTE Team Leader Band 7

Non Staff Costs

- Facilities costs for 6 members of staff, IT costs and office space have been estimated at £15,000

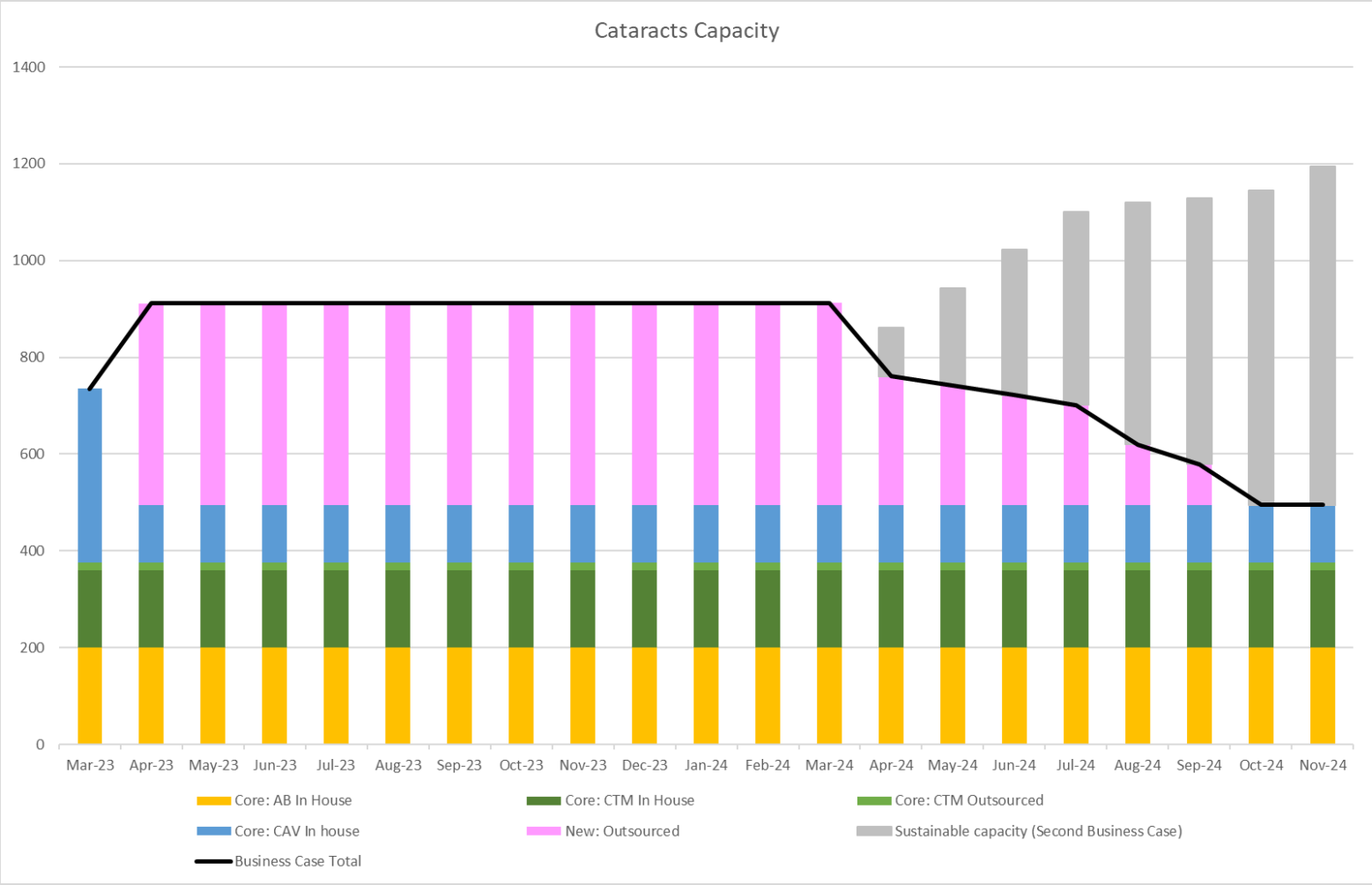
13.2 Option 5 – Option Appraisal

13.2.1 Additional Regional Capacity

Capacity	Core Annual	Additional Capacity %	Additional Capacity (outsourced)	**Total**	Average Demand	Difference
AB	2400	36%	1800	**4200**	4080	120
CAV	1440	15%	750	**2190**	1800	390
CTM	2100	49%	2450	**4550**	4080	470
Regional Total	5940		5000	**10940**	9960	980

13.2.2 Regional Capacity Plan

The chart below shows how the regional capacity will be delivered during 2023 and 2024. The business case will run for 12 months with a 'tail' of 6 months to enable the sustainable capacity (second business case) to build up.



	Core: AB In House	Core: CTM In House	Core: CTM Outsourced	Core: CAV In house	New: Outsourced	New: Insourced POWH	New: Insourced NHH	**Business Case Total**
2023/24	2400	1920	180	1440	5000	0	0	**10940**
2024/25	1200	960	90	720	1155	0	0	**4125**

13.2.3 Regional Capacity by expected patients treated

Reviewing the end of the list 49% of the long waiters are from CTM, 36% from AB and 15% from CAV. Projections of the use of the regional capacity are based on these percentages, however as the waiting list progresses, the percentages will change over time

AB Patients

	Core: AB In House	AB 36%	AB Total
2023/24	2400	1800	4200
2024/25	1200	416	1616

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total
2023/24	1920	180	2450	4550
2024/25	960	90	566	1616

CAV Patients

	Core: CAV In House	CAV 15%	CAV Total
2023/24	1440	750	2190
2024/25	720	173	893

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
2023/24	4200	2190	4550	10940

2024/25	1616	893	1616	4125

13.2.4 Option 5 Benefits

In addition to the high level benefits identified above, the additional benefits of this option include

- Outpatient assessments and inpatients treatments are performed on the same site
- Additional capacity delivered at reduced costs from insourcing
- Reduces the backlog by 517 patients waiting

13.2.5 Option 5 Risks

The specific risks associated with option 2 are:

- Loss of experienced and well trained staff at the Vanguard Unit (medium risk following mitigation actions)
- Reduction in training capacity across the region (medium risk following mitigation actions)
- Reduced capacity to treat more complex patients (medium risk following mitigation actions)
- Increased number of patients required to travel further for treatment

13.2.6 Option 4 Patient Considerations

Through this option there would be additional capacity for patients across the region for cataract assessment and surgery and patient waiting time will remain at current levels.

This option is for outsourcing activity where patients who meet the criteria for this additional capacity would be directed to outsourcing for assessment and treatment. Patients unable or unwilling to travel will be treated within their own health board as part of the core capacity. Waiting times may vary between core and outsourcing capacity provision. This option also includes patient travel as this may be outside of the boundary of the region (dependent on the contracting). The core capacity does not include patient travel contributions.

13.2.7 Option 5 Costs

Option 3: Outsourcing

Revenue Costs **2023/24**

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	5,000	£790,000	5,000	£5,948,333	£6,738,333
Regional Operational Team						£240,103
TOTAL		**5,000**	**£790,000**	**5,000**	**£5,948,333**	**£6,978,436**

Indicative Cost per Patient £1,396

2024/25

Host Health Board	Delivery	Outpatients	Outpatients	Surgical Procedures	Surgical Procedures	Total Estimated Costs
		Activity	Cost	Activity	Cost	
External	Outsource	875	£138,250	875	£1,040,958	£1,179,208
Regional Operational Team						£120,052
TOTAL		**875**	**£138,250**	**875**	**£1,040,958**	**£1,299,260**

13.2.8 Option 5 Activity Modelling

The assumptions used in this option are the same as in option 4, as the capacity stays the same but the mode of delivery changes.

After 52 weeks of the total capacity of 10,940 per year the waiting list is reduced from 19,000 across the region to 18,483

Appendix Nine: Split of Preferred Option By Health Board

Delivery is split over 2 financial years as follows:

- 9 months of 23/24 from 1st July 2023 to 31st March 2024
- 5 months of 24/25 from 1st April 2024 to 31st August 2024

AB Patients

	Core: AB In House	AB 36%	AB Total from this business case
1st July 2023 to 31st March 2024	1800	2313	4113
1st April 2024 to 31st August 2024	1000	1039	2039
Total Allocation	2800	3352	6152

CAV Patients

	Core: CAV In house	CAV 15%	CAV Total from this business case
1st July 2023 to 31st March 2024	1215	964	2179
1st April 2024 to 31st August 2024	675	433	1108
Total Allocation	1890	1397	3287

CTM Patients

	Core: CTM In House	Core: CTM Outsourced	CTM 49%	CTM Total from this business case
1st July 2023 to 31st March 2024	1440	135	3148	4723
1st April 2024 to 31st August 2024	800	75	1414	2289
Total Allocation	2240	210	4562	7012

Regional Total

	AB Total	CAV Total	CTM Total	Regional Total
1st July 2023 to 31st March 2024	4113	2179	4723	11014
1st April 2024 to 31st August 2024	2039	1108	2289	5436
Total Allocation	6152	3287	7012	**16450**

Appendix Ten: Full Patient Travel Survey

Patient Travel Survey

January 2023

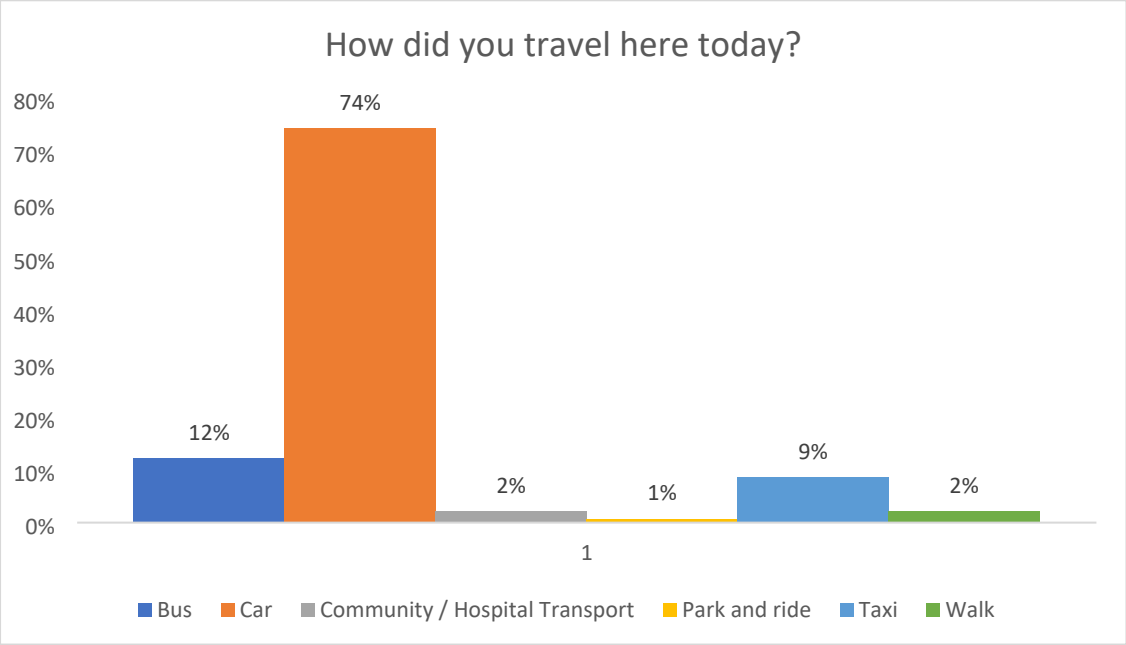
Offthalmoleg Ardal De-ddwyrain Cymru
South East Wales Regional Ophthalmology

A patients travel questionnaire was undertaken in Princess of Wales Hospital on 5th January, Royal Gwent Hospital on 11th January, and University of Wales Hospital on 12th January. 140 patients attending appointments on those day were asked questions about their travel to hospital and their willingness to travel to another hospital for treatment. All respondents were anonymous. This report show the total responses from each location and will form part of the supporting information for the Regional Cataracts business case.

Question 1. Which Hospital are you attending today?

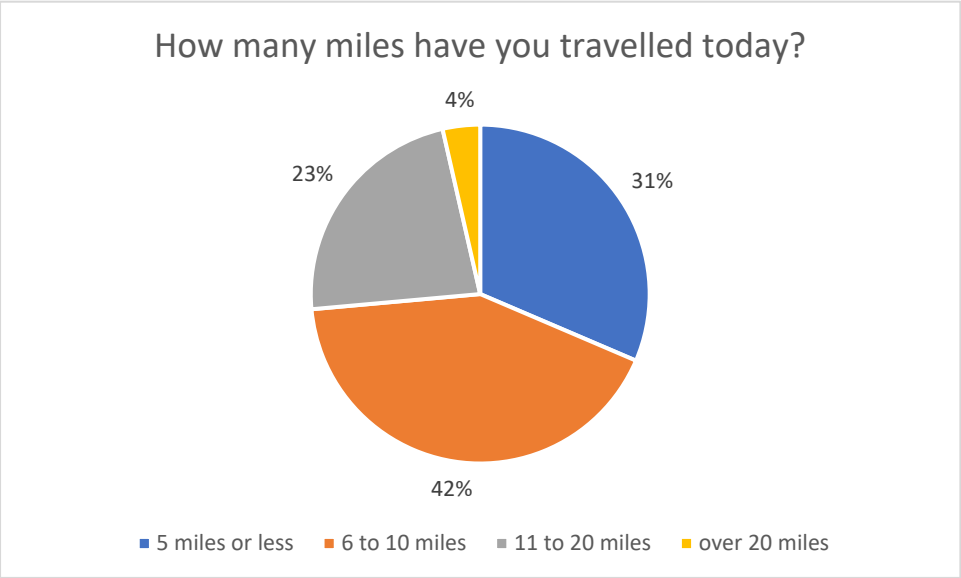
Princess of Wales	35 patients	25%
Royal Gwent	35 patients	25%
University Hospital of Wales	70 patients	50%
Total	140 patients	100%

Question 2. How did you travel here today?



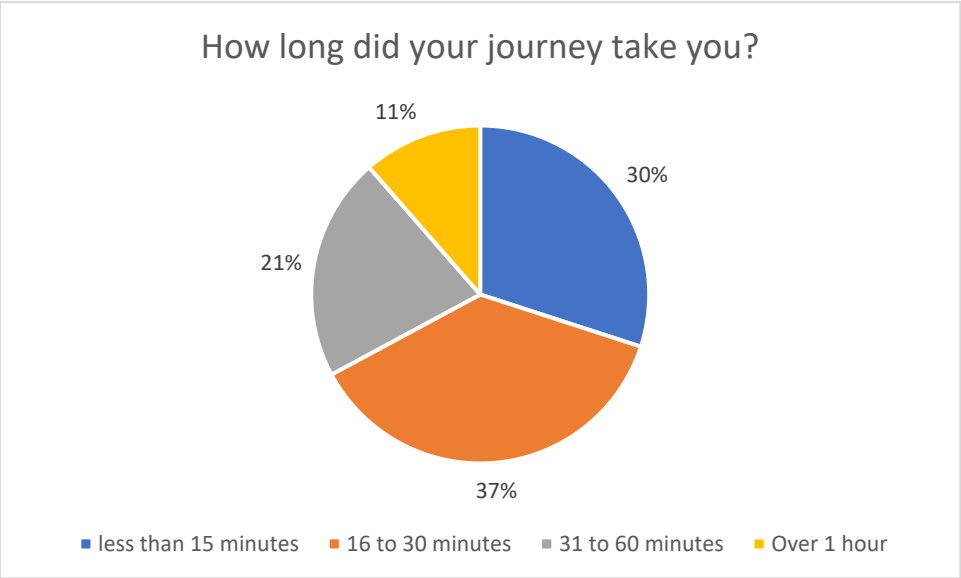
How did you travel here today?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Bus	6	1	10	17
Car	28	29	47	104
Community / Hospital Transport			3	3
Park and ride			1	1
Taxi		4	8	12
Walk	1	1	1	3
Grand Total	**35**	**35**	**70**	**140**

Question 3. How many miles Have you travelled today?



How many miles have you travelled today?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
5 miles or less	17	7	20	44
6 to 10 miles	16	15	28	59
11 to 20 miles	2	13	17	32
over 20 miles			5	5
Grand Total	**35**	**35**	**70**	**140**

Question 4. How long did your journey take you?

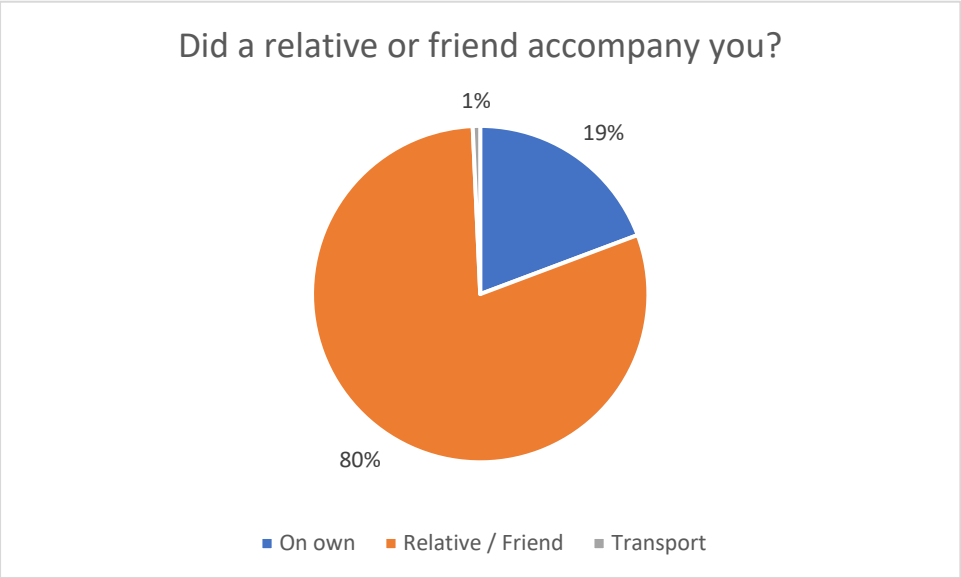


How long did your journey take you?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
less than 15 minutes	16	6	20	42
16 to 30 minutes	16	18	18	52
31 to 60 minutes	3	10	17	30
Over 1 hour		1	15	16
Grand Total	**35**	**35**	**70**	**140**

*on the day of the survey in UHW there was sever weather, flooding and an accident on the A470 resulting in journeys that were longer than the patients were expecting.

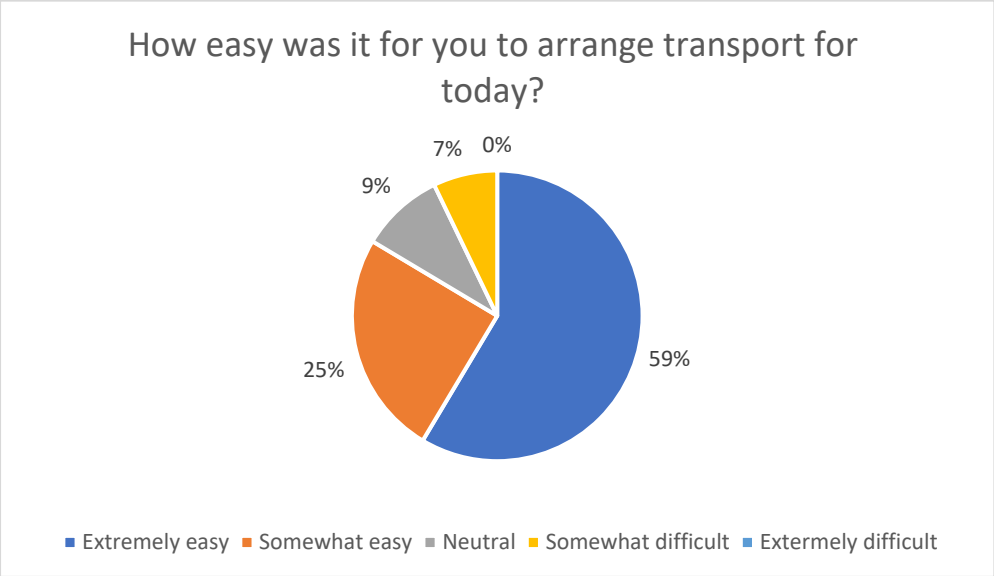
Question 5 asked patients where they travelled from

Question 6. Did a Relative or friend accompany you?



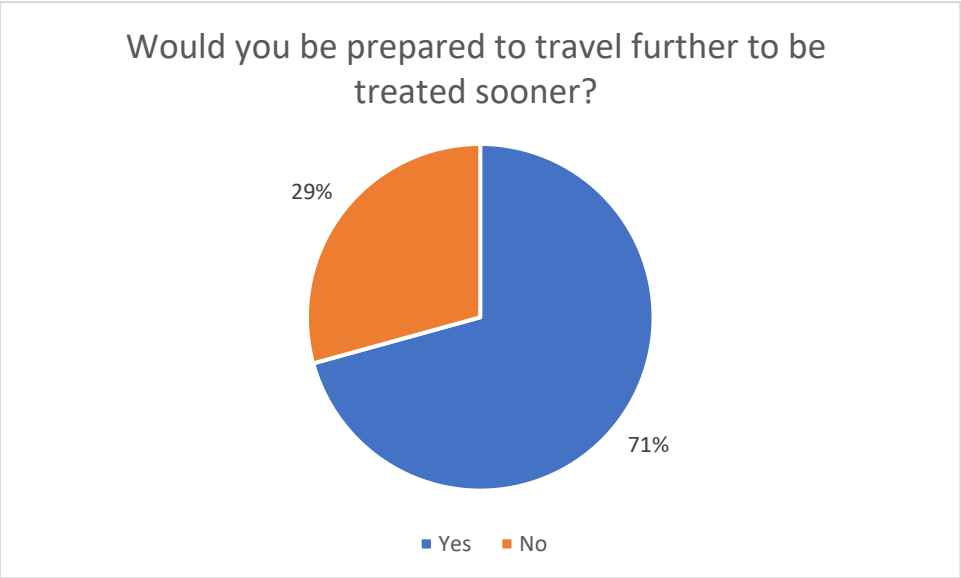
Did a relative or friend accompany you?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
On own	5	3	19	27
Relative / Friend	30	32	50	112
Transport			1	1
Grand Total	**35**	**35**	**70**	**140**

Question 7. How easy has it been for you to arrange transport today?



How easy was it for you to arrange transport for today?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Extremely easy	24	23	35	82
Somewhat easy	6	9	20	35
Neutral	4	1	8	13
Somewhat difficult	1	2	7	10
Extremely difficult				0
Grand Total	**35**	**35**	**70**	**140**

Question 8. Would you be prepared to travel further if you could have been treated sooner?



Would you be prepared to travel further to the treated sooner?	Princess of Wales Hospital	Royal Gwent Hospital	University Hospital of Wales	Grand Total
Yes	25 (71%)	27 (77%)	47 (67%)	99 (71%)
No	10 (29%)	8 (23%)	23 (33%)	41 (29%)
Grand Total	**35**	**35**	**70**	**140**

Question 9. Where would you travel to?

- From Princess of Wales Hospital in Bridgend, of the 25 patients willing to travel 25 would go to Cardiff and 19 to Swansea
- From Royal Gwent Hospital in Newport, of the 27 patients willing to travel 19 would be willing to travel to Cardiff and 25 to Abergavenny
- From University Hospital of Wales in Cardiff, of the 47 patients willing to travel 38 would be willing to travel to Bridgend and 41 to Newport

Where would you travel to?	From Princess of Wales Hospital	From Royal Gwent Hospital	From University Hospital of Wales
Bridgend / POWH		7	38
Cardiff / UHW	25	19	
Newport / RGH	11		41
Abergavenny / NHH	5	25	30
Bristol	5	6	10
Swansea	19	3	10
Further in the UK	5	3	4
Grand Total	**70**	**63**	**133**

**patients could provide multiple answers to this question*

AGENDA ITEM
6.1

PLANNING, PERFORMANCE & FINANCE COMMITTEE
FINANCE UPDATE – MONTH 12 MOVEMENTS FROM FORECAST IN 2022/23

Date of meeting	27/06/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Mark Thomas, Deputy Director of Finance
Presented by	Sally May, Director of Finance & Procurement
Approving Executive Sponsor	Executive Director of Finance & Procurement
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**

FINANCE UPDATE – MONTH 12 MOVEMENTS FROM FORECAST

1. SITUATION/BACKGROUND

The M12 Finance Performance report reported to the Executive Leadership Group (ELG) and the Performance, Planning and Finance Committee (PPFC) in April highlighted that the M12 Delegated overspend was £3.2m worse than the forecasts that had been submitted in the M11 finance packs (i.e. the forecasts were showing a £1.7m underspend for M12 but the actual position was a £1.5m overspend).

Further work has now been undertaken to understand the key reasons for this significant unexpected movement from forecast and also any associated learning for the Finance teams and budget holders within the Care Groups and directorates. The purpose of this report is to feedback the results of this work to ELG and PPFC.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

A summary of the movements in the M12 Delegated position is provided in the table below.

Care Group or Directorate	Net difference between M12 Actual and M12 Forecast		Recurrent	NR	TBC
	£k		£k	£k	£k
Unscheduled care	1006		701	56	249
C&F	439		194	215	30
Planned care	690		0	614	76
Mental health	349		239	110	0
Primary care & community	209		112	97	0
DT&S:					
Medicines Mgt	580		580	0	0
Therapies	-67		0	-67	0
Pathology and Radiology	441		256	185	0
Total -Care Groups	**3647**		**2082**	**1210**	**355**
Facilities Hub	-28		0	71	-99
Facilities Non Hub	130		0	130	0
Public Health	-113		0	-113	0
PC&S	29		0	29	0
Planning & partnerships	-405		0	-405	0
Estates	-180		0	251	-431
Estates - Energy	-450		0	-450	0
WOD	-131		0	-131	0
NIAD	-62		0	-62	0
Contracting & Commissioning	-234		0	-234	0
Planned care recovery	1029		0	1029	0
Total - Outside Care Groups	**-415**		**0**	**115**	**-530**
GRAND TOTAL	**3232**		**2082**	**1325**	**-175**

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

A detailed breakdown of the key individual movements behind the £3.2m movement is provided at Annex A. This analysis shows:

- The key reasons for the movement between forecast and actual:
- Whether the impact is assessed to be recurring or non-recurring, or to be confirmed(TBC);
- The areas where there are learning points for the finance teams and budget holders.

The key action is for the Finance leads for the Care Groups and directorates to:

- Discuss the key learning points with their Finance teams and with budget holders in order to reduce the differences between the monthly forecast and actual positions in 23/24.
- Take account of any recurrent movements in their financial plans and forecasts for 23/24.

The Finance Department will also consider where there are themes and areas where there are cross CTM actions which could improve monthly reporting and forecasting.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
Equality Impact Assessment (EIA) completed - Please note EIAs are required for all new, changed or withdrawn policies and services.	
	Not Required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	The paper is directly relevant to the allocation and utilisation of resources.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

The Planning, Performance & Finance Committee is asked to **DISCUSS** the contents of this report.

Service Division

	Difference between M12 Actual and M12 Forecast	Recurrent	NR	TBC	No learning as movement due to random events or demand driven etc.	Learning points: Budget holder engagement and communication	Learning points: Communication between Finance teams	Learning points: Forecasting issues within Finance	Learning points: Impact of new system / service / data	Comments
	£k	£k	£k	£k						
Mental Health										
CHC	170	170					X	X	X	Net 6 new packages - largely in Bridgend - Need for better understanding of the CHC position and information/data sharing. Meeting to discuss with CHC team has been arranged.
Bridgend Rates adjustment	69	69					X			No recharges from Corporate team until M12 and not identified until post M11.
Various non pay movements - esp. establishment expenses-training cots, legal fees, furniture & minor works	60		60			X				Spread across a number categories but largely within Camhs so not sure why this wasn't mentioned to Finance but will raise with the service going forward.
LD funding not received	50		50				X			Confusion around receiving funding - 2x LD funding available but only one intended for MH and the other was RiF related
Sub total	**349**	**239**	**110**	**0**						
PC & Community										
PC-GMS-Enhanced services slippage	-133	-133				X				Largely Des Warfin/DOACs - opening forecast incorrect - not updated via service
PC-Dental Income	-98		-98		X					Income better than forecast - impossible to predict to this level
PC-CDS	59		59			X				£25k re cone beam recharge from C&V unexpected and higher M&SE spend
PC-Other PC	54		54				X			Largely due to Home oxygen over accrual for 12 months - However £82k was adjusted post day 4 following a review of all variances
Agreement of Post Day 4 reduction of (£82k)										Adjusted post day 4 following a review of all variances
PC-RiF	-21		-21		X					Minor movements across a few lines
CHC/FNC	245	245					X	X	X	Need for better understanding of the CHC position and information/data sharing. Meeting to discuss with CHC team has been arranged.
VBHC adjustment	136		136				X			£136k Lymphodema VBHC funding reduction not forecast in M11 - budget had been previously profiled in 12th's throughout the year, which wasn't clear during handover, therefore large hit in M12 not expected
Nurse agency - ward 21 BRG	-60		-60				X	X		Nurse agency accrual over estimated in m11 based on working file. Change of assumptions and knowledge in m12 re-calculated the outstanding accrual which was materially lower than previously.
M&SE/non pay items	27		27			X				Various one-off purchases including disabled living aids, cushions etc. (£12k was known about but not until after the m11 forecast had been submitted.)
Sub total	**209**	**112**	**97**	**0**						
Pathology										
Immunology SLA over performance	34	34			X					The over-performance element for Immunology relates to the C&V SLA. See point below.
Cardiff Lab SLA over performance	30	30			X					Monitoring reports received quarterly in arrears and used as a basis for accruing any under or over-performance. The Q3 report suggested a small under performance, however when the YE AoB exercise was done, the HB was invoiced for over-performance based on Q4 information. The reason for the change in activity and cost is being investigated with the service and potentially C&V to provide earlier indications going forward.
PHW SLA over performance	74	74			X					There are newly set up meetings with PHW to review the SLA as well as quarterly detailed activity information. The unexpected over-performance is due to this process becoming established and the invoicing becoming more timely and accurate from PHW avoiding late adjustments.
PHW SLA missed accrual in M11 so catch up	100		100					X		
NSO-largely Lab costs	70	70						X		Mostly NHS England
Various M&SE and Lab consumables	65		65		X					Fluctuates up and down according to timing of orders
Agreement of Post Day 4 reduction of (£80k)										Further reduction Post day 4 of £80k as Roche confirmed in writing that 21/22 overperformance was lower than previously accrued.
Sub total	**373**	**208**	**165**	**0**						
Radiology										
PCR funding shortfall re Everlight outsourcing	20		20				X	X		shortfall not identified at M10
Price increase on Omnipaque	12	12			X					
C&V SLA unexpected over performance in Q4	36	36			X					
Sub total	**68**	**48**	**20**	**0**						
USC										
Medical Agency, predominantly ED at 3 sites	300	114		186	X	X				Multiple issues, some demand driven re. sickness. Some linked to study leave x 3 trainees, service could have communicated sooner. Analysis identified a number of Patchwork commitments with 'open shifts' at the default 70hrs per week, if these had been closed to reflect actual hours, in month cost would have been lower. Being followed up with CSGs for more timely Patchwork updates.
Medical pay pressures, non agency, including WLIs, ADH and locum spend	111			111	X	X			X	Learning re. forecasting issue re. WLI funding.
Medical Job plan arrears	87	87				X				Presume given arrears this could have been highlighted by the CSG and captured in the forecast earlier.

	Difference between M12 Actual and M12 Forecast	Recurrent	NR	TBC	No learning as movement due to random events or demand driven etc.	Budget holder engagement and communication	Communication between Finance teams	Forecasting issues within Finance	Impact of new system / service / data	Comments
	£k	£k	£k	£k						
RN agency, predominantly ED across 3 sites	286	164		122	X	X	X	X		Increase in cover to manage higher A/L taken - learning opportunity if there is a way to get an update on A/L still to be taken earlier in the year to inform the forecast. Have established some A/L reporting within USC, will help understand movements, unclear if this will help to inform forecasting, but should inform better roster management. Some of this is likely linked to people having carried forward more A/L into 22/23 so a bigger issue than normal at the year end? Therefore an element should be one off. Learning opportunity - catch up of M11 costs, anomaly could have been spotted in M11 reporting within Finance team and the catch up forecast for M12. Likely not helped by Finance team being new to looking after some budgets and not being familiar with 'normal' run rate etc.
RN overtime actual Vs trend	123		123		X	X				As noted above, an increase in cover to manage higher A/L taken - learning opportunity if there is a way to get an update on A/L still to be taken earlier in the year to inform the forecast. Some of this liekly linked to people having carried forward more A/L into 22/23 so a bigger issue that normal at the year end?
Payment of A/L days (AJ estimate)	51		51		X					
POW AMU clarity on agency rate - standard not specialist rate	-200			-200		X			X	Better information rates as a result of eBilling process, incorrect information previously provided by CSG. TBC if on off benefit or some recurrent opportunity, ebilling process enabling more timely charges/payments so scale of accrual reduced.
HCA spend better than forecast, includng agency reduction	-161			-161	X					Range of factors driving this, ultimately demand reduced, likely linked to improved controls. Possibly improved RN fill rate also. Hopefully this will develop to a sustained trend.
POW Admin agency catch up	35		35			X			X	New information led to a change in accrual approach. Learning opportunity - discuss any changes to accrual approach within finance team ahead of transacting it.
Agreement of balance dialogue re. Swansea Bay recharge for POW Endoscopy Maintenance historic charges	-132		-132		X		X			Was resolved late in the day, learning - if Finance team had escalated earlier, may have clarified sooner. Though equally the lateness may have helped SB agree to forgo the income?!
Stocktakes	85			85	X		X			Stock take numbers communicated with finance/transacted at M12, but in most cases stock takes completed in M11. Could there be some earlier communication so that queries can be worked through sooner to avoid trying to resolve issues during WD2/3/4 M12.
Pacing RGH	217	217							X	New information led to a change in accrual approach and catch up on costs. Learning opportunity - discuss any changes to accrual approach within finance team ahead of transacting it.
Pacing POW	112	80	32		X	X				Activity up 18% M11 and M12, catch up on M11 as activity data received late.
POW M11 double funding Gastro - NICE and Parc Prison	102		102		X				X	
POW Drug funding catch up, funding for full year re. specific cardiology drug	-110			-110		X				Unclear why a delay in funding, presumably more prompt Meds Mgt processes could have reduced the delay.
RGH Drugs - NICE funding % reduction, plus FP10 increase in Q4	156			156	X	X				NICE funding issue possibly linked to delay in Homecare funding - more timely reporting of NICE status could avoid a time lag in cost vs funding. Spike in latest FP10 data compounded by accrual.
WAST invoices - Deputy COO decision for USC to pay, new cost and no funding	60			60	X					
Income	-155		-155		X	X			X	Income recovery not highlighted in some cases e.g. secondment income. Some demand driven - commissioning numbers reviewed at year end.
Endoscopy maintenance extension	57	57								
CRES adjustment	-18	-18								
Sub total	**1006**	**701**	**56**	**249**						
C&F										
RN overtime above trend, B6 and B7, Paeds ward, SCU, Acute midwifery	72	38		34						In part, an increase in cover to manage higher A/L taken - learning opportunity if there is a way to get an update on A/L still to be taken earlier in the year to inform the forecast. Some of this liekly linked to people having carried forward more A/L into 22/23 so a bigger issue that normal at the year end? Therefore an element should be one off.
RN overtime actual Vs trend	54			54						
Nursing	-58			-58						
Medical ND funding for WLIs	-69	-69						X		
Medical O&G POW Agency, ADH rates	24	-13	37		X	X				
Admin - overtime and agency	25	9	16		X	X				
Stocktakes	33	33			X					
M&SE spend	43	43			X					
Drugs, HIV and maternity, particularly FP10s	67	67			X					
LAC invoices, particularly Hywel Dda	66		66		X					Charge errors, to be resolved with Hywel Dda
CHC CAMHS patient 2:1 care	43		43		X	X				Improved reporting of patient status, dependent on feedback from different Care Group
Insulin pumps	40	40				X				Service establishing a plan for diabetic pumps so spend is more predictable
Legal fees	28		28		X					
Lease car, anomaly costs	12		12				X	X		Post M12 advised that coding error, charges should have gone against balance sheet, to be adjusted M01. Also portion of costs linked to 'out of time' VAT charges. Learning is external to DSA team.
Neonatal SLA, charges backdated to May 22	13	13				X				
Halcyon costs	13		13					X		
Nurse recruitment, incl income offset	50	50								
Income updates	-17	-17								
Sub total	**439**	**194**	**215**	**30**						

	Difference between M12 Actual and M12 Forecast	Recurrent	NR	TBC	No learning as movement due to random events or demand driven etc.	Budget holder engagement and communication	Communication between Finance teams	Forecasting issues within Finance	Impact of new system / service / data	Comments
	£k	£k	£k	£k						
Other USC Comments										Other comments from team: If new information surfaces, discuss amongst team ahead of changing approaches which would result in a material change Agreement of balance issues, ensure anything that is TBC whether income or spend in highlighted within team ahead of M12 Procurement cut off 3 weeks before year end, does this drive a behaviour to over stock at year end. Is it still necessary to have such an early cut off? Budget reconciliations, ensure these are happening for all areas each month. Inclusing checks to specific funding streams e.g. PCR budget v forecast reporting. Also recurrent CRES template vs ledger. Ensure adequate review of run rates, especially for unexpected increases or decreases - don't assume a reduction is correct (as much as it may be what we want to see).
Planned Care										
Strike overpayment	100		100		X					Unexpected payment following system change, accrued out centrally
Additional ADH accrual	150		150				X			Extended timeframe for calculation of ADH accrual
Unexpected increase in Medical agency	135		135			X				Primarily in RGH general surgery and urology could be linked to increased annual leave
Increase in nurse overtime costs	153		77	76		X				Significant increase across wards, theatres and ITU - likely linked to year-end annual leave booking
Other	-2		-2		X					
Stock take adjustment	78		78		X					unplanned stock take adjustment
increased spend in theatres	81		81			X				significant increase in activity in m12
other	-5		-5		X					
Sub total	**690**	**0**	**614**	**76**						
Medicines Management										
PAR	800	800						X		Higher than anticipated growth (price related not volume)
Income	-269	-269						X		higher than antedated funding for OATs from commissioning
other	49	49			X					
Sub total	**580**	**580**	**0**	**0**						
Therapies										
lower than projected non pay spend	-78		-78			X				Predominantly in weight management (new service)
other	11		11		X					
Sub total	**-67**	**0**	**-67**	**0**						
Facilities Hub										
WAST invoice less than anticipated	-99			-99	x					Information from WAST not provided regularly to assess usage of vehicles
Laundry	71		71				x	x		21/22 accrual issues hit in 22/23 NWSSP would not accept recharge this year. Sould have been highlighted as a risk
Sub total	**-28**	**0**	**71**	**-99**						
Facilities non hub										
Agency Spike in M10 not factored into the forecast	79		79				x	x		Impact lost in handover process
Removal Expenses	21		21			x				
Other	30		30							Various small upd and downs across all the areas
Sub total	**130**	**0**	**130**	**0**						
PC&S										
Other	29		29		x					Multiple small movements
Sub total	**29**	**0**	**29**	**0**						
Public Health										
Recovery of CVC funding	193		193				x			Forecast did not account for funding reclaim as not advised it was happeneing
Underspend on COVID programes above forecast	-306		-306					x		Forecast for LA costs overstated
Sub total	**-113**	**0**	**-113**	**0**						
National Imaging Academy										
CTM share of underspend	-41		-41					x		Value was not carried forward from m10 forecast to m11
Further slippage over plan agreed with service	-21		-21			x				
Sub total	**-62**	**0**	**-62**	**0**						
Planning & partnerships										
Catch up on secondment income	-81		-81			x				Not aware it needed to be billed
Slippage on SW@H2	-111		-111				x	x		Anticipaded staff transfers not actioned but forecast should also have higlighted this earlier

	Difference between M12 Actual and M12 Forecast	Recurrent	NR	TBC	No learning as movement due to random events or demand driven etc.	Budget holder engagement and communication	Communication between Finance teams	Forecasting issues within Finance	Impact of new system / service / data	Comments
	£k	£k	£k	£k						
Budget phasing into M12	-160		-160					x		Budget phased into M12 was not accounted for in forecast
RCT invoices not received.	-48		-48			x		x		Service ceased / historic budget not reallocated
HCF WeG allocation recovery	0		0			x	x			Anticipated underspend £499k recognised in forecast. Not notified to WeG by regional team in a timely fashion. Confusion over income / allocation issue not disucussecd across teams as a result
Other	-5		-5							
Sub total	**-405**	**0**	**-405**	**0**						
Estates										
SB Income above forecast	-250		-250			x				
Budget phasing into M12	-431			-431				x		Budget phased into M12 was not accounted for in forecast
PCH Rates recovery	471		471		x					Uncertainty surrounding timing of recovery
Energy	-450		-450				x	x		Various movements from forecast due to complications associated with energy costs being reported in Estates and also Care Groups
Other	30		30							Various movements from forecast
Sub total	**-630**	**0**	**-199**	**-431**						
W&OD										
Budget phasing issues	-131		-131					x		Budget phased into M12 was not accounted for in forecast
Sub total	**-131**	**0**	**-131**	**0**						
Contracting & Commissioning	**-234**		**-234**				x			Bowel screening budget not issued to CSGs £120k, Private patient and non LTA income improvements in M12.
Planned care recovery	**1029**		**1029**					x		Increased outsourcing activity and ensuring the accounting treatment captured all 'pathway costs' .
TOTAL	**3232**	**2082**	**1325**	**-175**						

(Agenda Item) 6.2	27 June 2023	Planning , Performance & Finance Committee	M2 Finance Report

Report Details:	
FOI Status:	Open (Public)
If closed please indicate reason:	N/A
Prepared By:	Mark Thomas, Deputy Director of Finance
Presented By:	Sally May, Director of Finance & Procurement
Approving Executive Sponsor:	Sally May, Director of Finance & Procurement
Report Purpose	For Discussion
Engagement undertaken to date:	N/A

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	There are no specific quality or safety implications related to the activity outlined in this report.
Related Health and Care Standard	Governance, Leadership & Accountability
Has an EQIA been undertaken?	Not required
Are there any Legal Implications /Impact.	There are no specific legal implications related to the activity outlined in this report.
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes. The paper is directly relevant to the allocation and utilisation of resources.
Link to Strategic Goals	Sustaining Our Future.

2023-24 Finance Report

Month 2

Summary

Situation	Background
Our draft financial plan for 23/24 was submitted to Welsh Government (WG) on 31 March 2024. The draft plan identified a forecast deficit of £79.6m and WG confirmed that the plan was not supportable. The Health Board submitted a supplementary paper to WG at the end of May outlining the further work undertaken and the impact on the plan assumptions. However, the forecast deficit of £79.6m is unchanged. We are awaiting feedback on the 31 May submission. The draft plan includes a £27.3m savings target which will require a significant step up in savings delivery compared to recent years. The failure to submit a financially balanced plan is a breach of our statutory duty under the Finance (Wales) Act 2014. This report outlines our financial performance against the draft plan for Month 2 (i.e. the period to 31st May 2023. A separate Finance Performance report has been prepared which sets out the financial performance of the individual Care Groups and directorates as at M2 (i.e. the Delegated budget position).This financial performance report is discussed at the Planning, Performance & Finance Committee (PPFC) and the Executive Leadership Group (ELG) meetings.	Our financial performance for 2022-23 was a deficit of £24.5m. This meant that we did not achieve our break even financial duty against the Revenue Resource Limit over the 3 year period 2020-21 to 2022-23. Our underlying position also deteriorated during 2022-23 with a forecast B'fwd financial challenge from 2022-23 of £79.6m. This includes : • Core plan recurrent deficit = £60.9m • Ongoing Covid response costs at the end of 22/23 = £10.0m • Ongoing exceptional energy costs = £8.7m We planned to achieve recurrent savings of £17.3m in 2022-23 but only £9.2m was delivered recurrently. Our recurrent savings shortfall in 2022-23 was therefore £8.1m.

Summary

Assessment

Overall Revenue position:

- The M2 in month position reported a £6.8m deficit (M1: £6.6m).
- The M2 YTD position is reporting a £13.4m deficit against the Revenue Resource Limit. This represents a £0.1m adverse variance compared to 2/12th of the forecast £79.6m deficit in the financial plan (£13.3m).
- The year end forecast remains at £79.6m which is consistent with the draft plan. Significant risks have been highlighted on page 18 (Risks and opportunities) which total £13.0m.
- This forecast assumes that we will receive £11m of funding for ongoing Covid programme costs.

Savings position:

- Actual savings to M2 YTD was £2.2m which is £2.3m below the M2 savings target of £4.6m.
- The M2 forecast In year savings is £19.9m. This is £7.4m below the annual savings target of £27.3m.The M2 forecast Recurrent savings of £20.7m is £6.6m below the £27.3m target.
- Forecast savings have increased by £10.9m from M1 (primarily from increased Non Delegated savings) but the latest plans are still £7.4m below the target for 23/24.Urgent work is needed to develop robust plans to close the forecast gap of £7.4m In year and £6.6m recurrently.

Cash position:

- The forecast Cash Flow position to year end shows a projected deficit of £79.6m. This reflects the forecast deficit in the draft plan and will require future strategic cash support. Without cash support there will be a cash shortfall in the latter months of the financial year.

Recommendation

The PPFC is asked to **DISCUSS** and **NOTE** the financial performance of the Health Board for the period to 31st May 2023.

Contents

Executive Summary

Overall Revenue Position

- The M2 in month position reported a £6.8m deficit (M1: £6.6m).
- The M2 YTD position is reporting a £13.4m deficit against the Revenue Resource Limit. This represents a £0.1m adverse variance compared to 2/12ths of the forecast £79.6m deficit in the financial plan (£13.3m).
- The year end forecast remains at £79.6m which is consistent with the draft plan. Significant risks totalling £13.0m have been highlighted on page 18 (Risks and opportunities).

Savings

- Actual savings to M2 YTD was £2.2m which is £2.3m below the M2 savings target of £4.6m.
- The M2 forecast In year savings is £19.9m. This is £7.4m below the annual savings target of £27.3m.The M2 forecast Recurrent savings of £20.7m is £6.6m below the £27.3m target.
- Forecast savings have increased by £10.9m from M1 (primarily from increased Non Delegated savings) but the latest plans are still £7.4m below the target for 23/24.Urgent work is needed to develop robust plans to close the forecast gap of £7.4m In year and £6.6m recurrently.

Cash

- The closing cash balance at 31st May 2023 was £5.4m.
- The forecast Cash Flow position to year end shows a projected deficit of £79.6m. This reflects the forecast deficit in the draft plan and will require strategic cash support. Without cash support there will be a cash shortfall in the latter months of the financial year.

Capital

- The Capital Resource Limit for 2023-24 is currently £64.5m, this is supplemented by £0.1m of donated funds and £0.2m of assets disposed of in this financial year giving an overall programme of £64.8m.
- Expenditure to M2 was £10.9m.
- The forecast outturn capital position is breakeven to the CRL target.

Year to Date Performance and Forecast

	M2 Actual	M2 YTD	M2 Forecast	Financial Plan
	£m	£m	£m	
Core plan deficit	**6.1**	**11.9**	**70.9**	**70.9**
Exceptional Energy costs	0.7	1.5	8.7	8.7
Covid programme costs:				
Health Protection	0.4	0.9	9.1	9.1
PPE	0.0	0.1	0.3	1.0
Adferiad	0.0	0.1	1.0	1.0
Nosocomial	0.0	0.1	0.6	0.6
Anticipated funding	(0.5)	(1.1)	(11.0)	(11.7)
Total	**0.0**	**0.0**	**0.0**	**0.0**
Grand total	**6.8**	**13.4**	**79.6**	**79.6**

Key Points:

- The M2 in month position reported a £6.8m deficit (M1: £6.6m).
- The M2 YTD position is reporting a £13.4m deficit against the Revenue Resource Limit. This represents a £0.1m adverse variance compared to 2/12th of the forecast £79.6m deficit in the financial plan (£13.3m).
- The M2 YTD Core plan position was a deficit of £11.9m.
- The M2 YTD Exceptional energy cost pressure was £1.5m, and remains in line with the plan.
- The M2 YTD COVID costs was £1.1m with anticipated WG funding of £1.1m to match.

Year to Date Performance

	Annual Budget (£m)	Cur Month Variance (£m)	YTD Variance (£m)	Page reference
Pay	627.6	1.0	1.6	8
Non Pay	863.9	(0.5)	(1.0)	12
Income	(143.0)	(0.4)	(0.5)	15
Allocations	(1,238.1)	0.0	0.0	
Forecast deficit in draft plan (£79.6m)	(79.6)	6.6	13.3	
Grand Total	**0.0**	**6.8**	**13.4**	

Key Points:

- The Annual Plan includes a savings target of £27.3m. As at M2 only £2.2m of savings has been achieved against a savings target of £4.5m, leaving a savings shortfall at M2 of £2.3m.
- The £13.4m deficit noted above is £0.1m worse than 2/12th of the forecast deficit of £79.6m. This includes the £2.3m savings shortfall which is offset by other favourable operating variances of £2.2m.

Pay Expenditure

Staff Group	Plan £'m	YTD Actual £'m	YTD Variance £'m
Administrative & Clerical	14.8	14.8	.0
Medical And Dental	25.7	27.7	2.0
Nursing And Midwifery Registered	34.9	33.7	-1.3
Add Prof Scientific And Technical	3.4	3.0	-0.4
Additional Clinical Services	13.1	14.3	1.2
Allied Health Professionals	6.8	6.6	-0.2
Healthcare Scientists	2.2	2.2	0.0
Estates And Ancilliary	6.0	6.3	0.2
Students	0.0	0.0	0.0
Pay Budget Adjustments	-0.1	0.0	0.1
Grand Total	**106.9**	**108.5**	**1.6**

Key Points:

- The M2 YTD pay expenditure is £108.5m . This represents a £1.6m adverse variance compared to the M2 plan of £106.9m.
- The £2.0m adverse variance in Medical & Dental is mainly due to increased ADH payments and Agency costs. The Care Groups will need to review and understand the drivers for this overspend and take actions to reduce.
- The £1.2m adverse variance in Additional Clinical Services includes additional cover provided to manage registered nursing vacancies.
- The £1.3m favourable variance in Nursing & Midwifery Registered is mainly the result of vacancies.

Pay Expenditure Trends

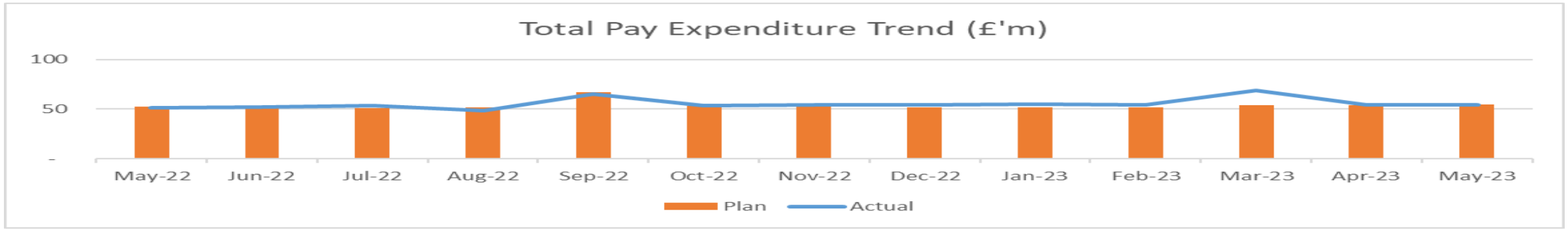
Staff Group	Dec-22 £'m	Jan-23 £'m	Feb-23 £'m	Mar-23 £'m	Apr-23 £'m	May-23 £'m
Administrative & Clerical	7.2	7.3	7.1	8.5	7.5	7.3
Medical And Dental	14.2	14.1	13.8	17.7	13.5	14.2
Nursing And Midwifery Registered	17.1	16.3	17.1	22.2	17.1	16.6
Add Prof Scientific And Technical	1.5	1.5	1.5	1.6	1.5	1.5
Additional Clinical Services	6.9	8.1	7.3	9.2	7.2	7.1
Allied Health Professionals	3.3	3.3	3.3	4.4	3.2	3.4
Healthcare Scientists	1.1	1.1	1.1	1.4	1.1	1.1
Estates And Ancillary	3.0	3.1	3.0	4.1	3.0	3.3
Students	.2	.1	.1	.1	.0	.0
Grand Total	**54.4**	**54.9**	**54.2**	**69.1**	**54.1**	**54.4**

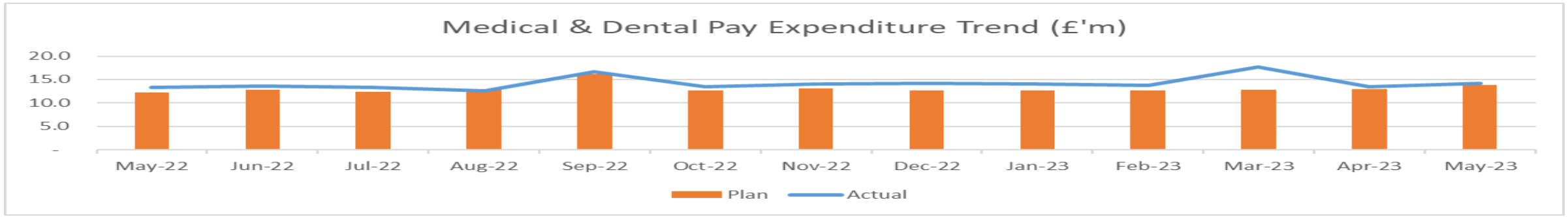
Spend category	Dec-22 £'m	Jan-23 £'m	Feb-23 £'m	Mar-23 £'m	Apr-23 £'m	May-23 £'m
Core	45.2	45.0	45.4	58.0	46.2	46.1
Agency	5.6	5.4	4.8	5.5	4.3	4.5
Overtime	1.2	2.0	1.7	2.4	1.3	1.3
ADH	1.3	1.2	1.1	1.5	1.1	1.2
Bank	0.8	1.1	1.0	1.3	1.1	1.0
WLI	0.3	0.1	0.2	0.4	0.1	0.3
Grand Total	**54.4**	**54.9**	**54.2**	**69.1**	**54.1**	**54.4**

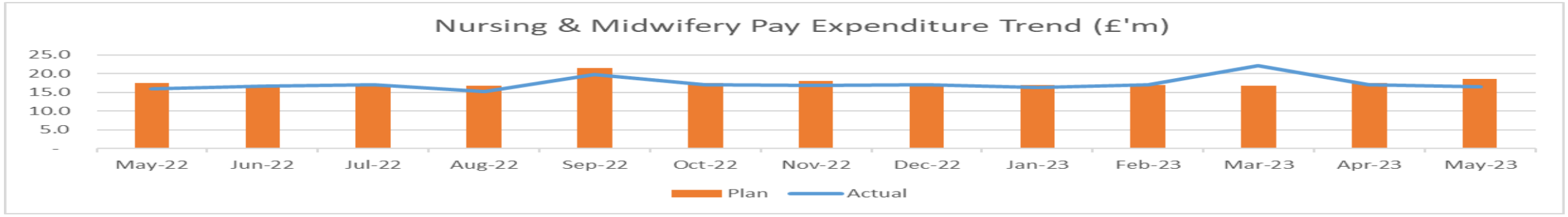
Key Points:

- The M12 expenditure of £69.1m included a number of one off items. The net position after excluding these one off items was £57.5m.
- Total spend in M2 increased slightly compared to M1 which reflects the Easter Bank Holidays. The main movements were the £0.7m increase in Medical & Dental spend mainly related to agency expenditure, offset by a £0.5m reduction in Nursing & Midwifery Registered costs .
- Individual spend categories are broadly consistent with M1.
- The £0.2m increase in agency costs in M2 includes a £0.5m increase in Medical agency and a £0.5m reduction in Nursing agency.

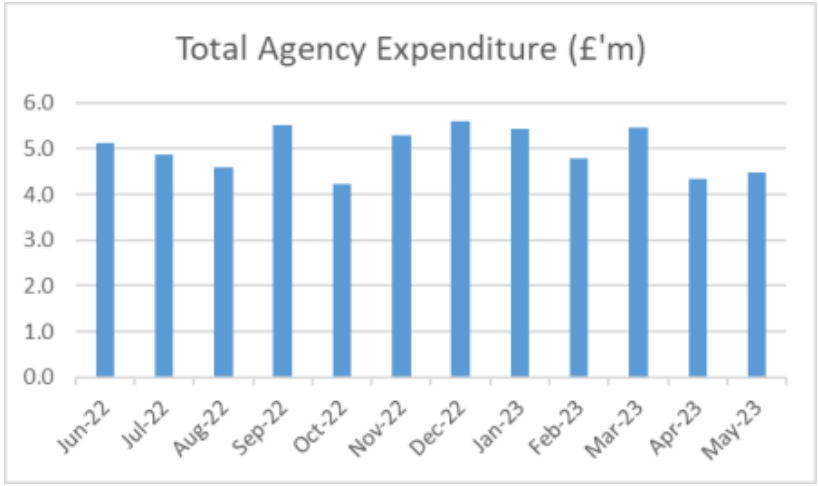
Pay Expenditure Trends

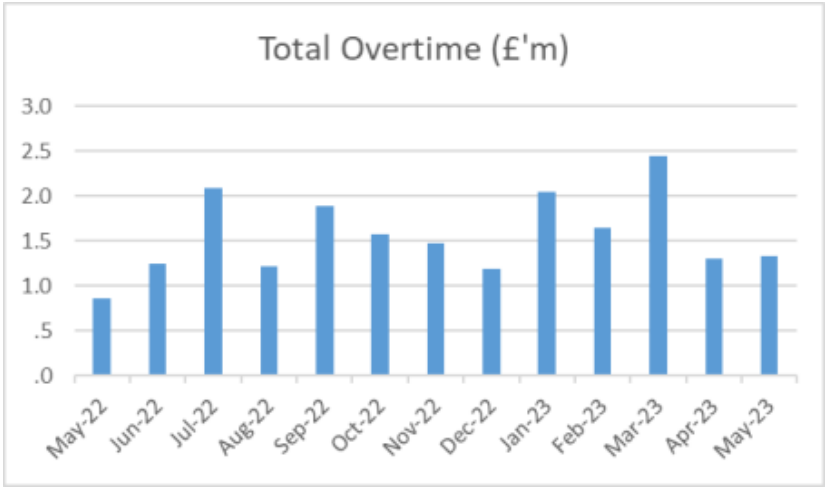


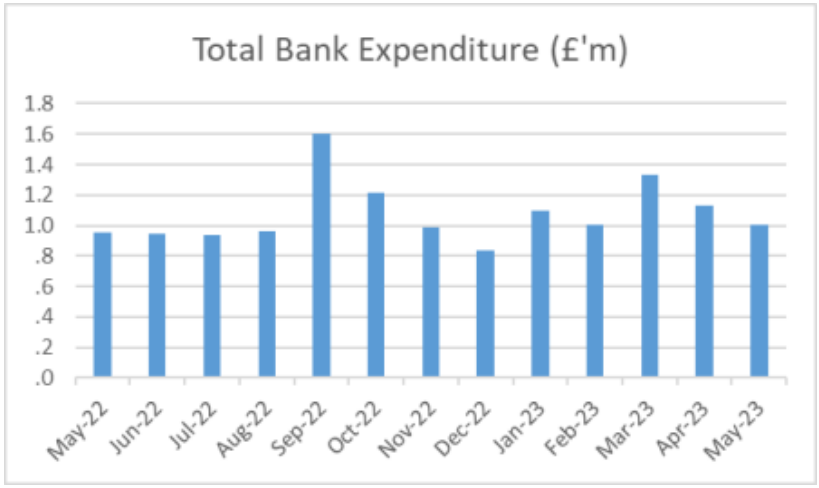


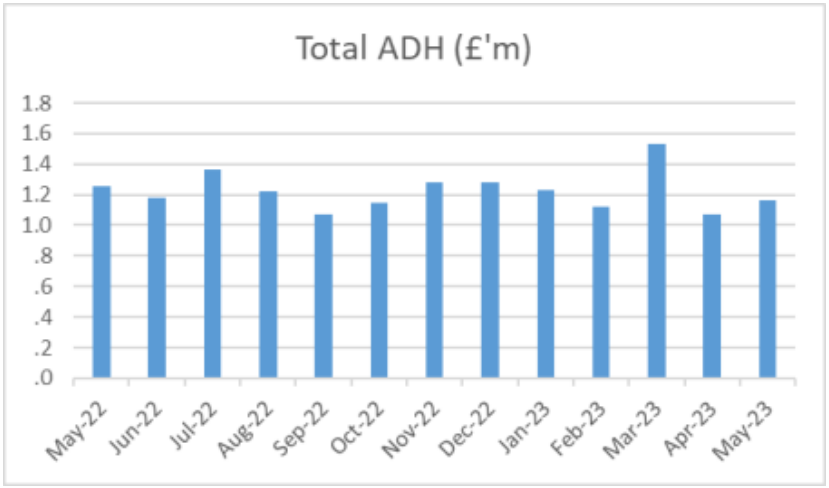


Variable Pay Expenditure Trends







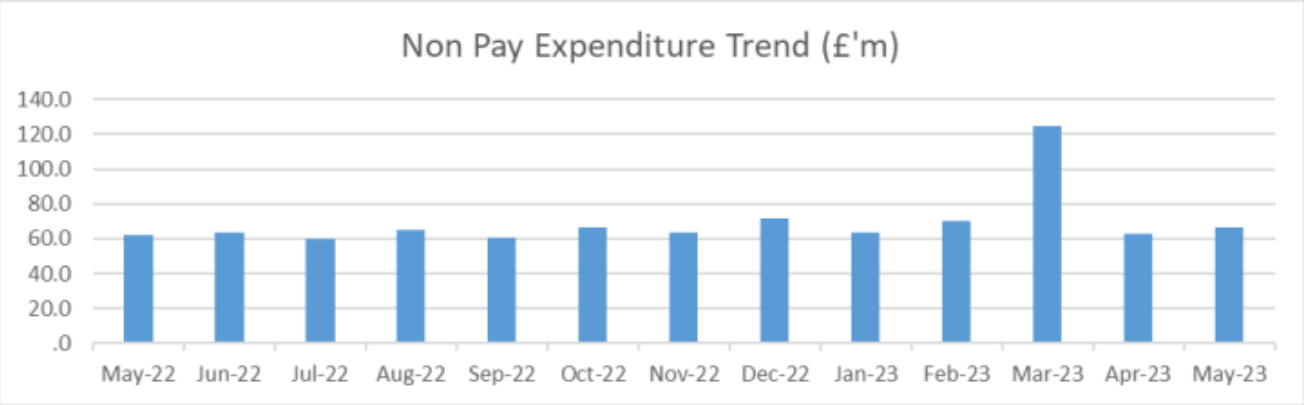


Key Points :

- M2 Total agency expenditure increased by £0.2m compared to M1.
- M2 Overtime costs remain consistent with M1.
- M2 Bank Expenditure decreased by £0.1m compared to M1.
- M2 ADH expenditure increased by £0.2m compared to M1.
- Variable pay expenditure remains volatile with no consistent reductions in trend.

Non Pay Expenditure

Staff Group	Plan £'m	YTD Actual £'m	YTD Variance £'m
Primary Care Contractors	23.0	22.5	(0.5)
Primary Care Drugs	16.7	18.1	1.3
Provider Non Pay	25.4	27.2	1.8
Commissioned Activity	56.5	56.6	0.1
Capital Charges	5.5	5.5	0.0
Other Non Pay	3.5	(0.4)	(3.9)
Total Expenditure	**130.6**	**129.4**	**(1.1)**



Key Points:

- The M2 YTD non pay position is reporting a £1.1m underspend.
- The main overspending area relates to Primary Care Drugs which is reporting a £1.3m adverse variance. This is high level estimate pending receipt of the M1 prescribing data which will not be received until M3 (i.e. 2m in arrears). The increases in M11 and M12 have been reflected in the financial plan plus an estimate for growth and price inflation.
- The underspend of £3.9m in Other Non pay includes a release of non delegated reserves and non delegated savings of £2.6m.
- The Provider Non Pay overspend of £1.8m is mainly £0.8m NICE Drugs, £0.8m clinical supplies & services.
- The increase in M12 expenditure was mainly attributed to Capital charges of circa £46m together with Planned care recovery £2.5m and £4.5m in Planning and Partnerships as a result of increased spend on the Regional Integration Fund (RIF) RIF at year end. M2 expenditure is broadly consistent with M1 and also M10 & M11 of 22/23.

COVID Expenditure

	M02 Actual	M02 YTD	M02 Forecast	Financial Plan	Change
Programme costs	**£m**	**£m**	**£m**	**£m**	**£m**
Public Health Response - TTP	0.1	0.2	2.7	2.7	0.0
Public Health Response - Mass Vaccination	0.3	0.7	6.4	6.4	0.0
PPE	0.0	0.1	0.3	1.0	(0.7)
Adferiad (Long COVID)	0.0	0.1	1.0	1.0	0.0
Nosocomial Investigation	0.0	0.1	0.6	0.6	0.0
Confirmed funding	**(0.5)**	**(1.1)**	**(11.0)**	**(11.7)**	**(0.7)**
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Key Points:

- The M2 spend of £0.5m was consistent with M1.
- The M2 forecast is £0.7m lower than the Financial Plan due to reduced PPE costs.

Savings

	Month 2			Month 1		
	M2 YTD	23/24	Rec	M1 YTD	23/24	Rec
	£m	£m	£m	£m	£m	£m
Savings target as at M2	4.6	27.3	27.3	2.3	27.3	27.3
Actual and Forecast Savings	(2.2)	(19.9)	(20.7)	(0.3)	(9.0)	(9.3)
Total	2.3	7.4	6.6	2.0	18.3	18.0

Key Points:

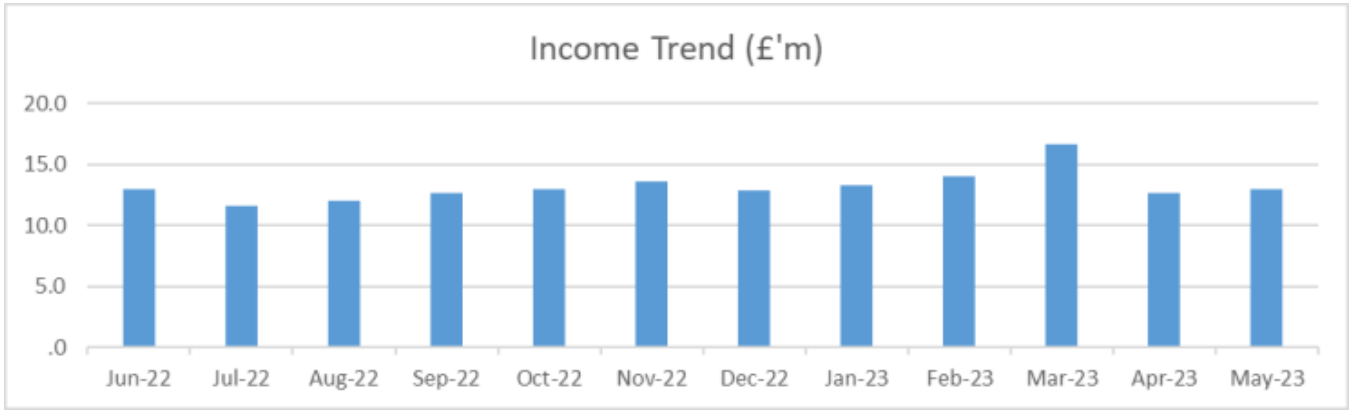
- The actual savings to M2 was £2.2m which is £2.3m below the M2 savings target of £4.6m.
- The M2 forecast In year savings is £18.9m. This is £7.4m below the annual savings target of £27.3m.
- The M2 forecast Recurrent savings of £19.7m is £6.6m below the £27.3m target.
- Forecast savings have increased by £10.9m from M1 (primarily from increased Non Delegated savings) but the latest plans are still £7.4m below the target for 23/24.
- Urgent work is needed to develop robust plans to close the forecast gap of £7.4m In year and £6.6m recurrently.
- The financial plan for 2023/24 also includes anticipated accountancy gains of £3.0m

Income

Income Group	M02 YTD Plan £'m	M02 YTD Actual £'m	M02 YTD Variance £'m
Health Organisations Income	15.5	16.0	(0.6)
Local Authorities Income	2.6	2.5	0.0
Catering Income	0.5	0.5	0.1
Private Patients	0.1	0.0	0.0
Other Income	6.4	6.5	(0.1)
Total	**25.0**	**25.5**	**(0.5)**

Key Points:

- The M2 year to date income position is reporting a £0.5m favourable variance.
- Further details of the NHS income assumptions are included on page 17 together with a specific income risk with Aneurin Bevan Health Board.



Income Assumptions WG

	REVENUE RESOURCE LIMIT				Resource Limit £'m
	HCHS £'m	Pharmacy £'m	Dental £'m	GMS £'m	
Confirmed Welsh Government Allocations	1,053.2	28.5	23.5	83.3	1,188.5
Anticipated Allocations:					
RLW Social Care Workers	4.8				4.8
Substance Misuse	3.9				3.9
COVID Programme costs	10.4				10.4
1.5% Consolidate NHS Pay Award 22/23	8.9				8.9
Regional PCR Cataracts	3.8				3.8
Mental Health Investment Funding	3.3				3.3
Six Goals and Same Day Emergency Care (SDEC)	3				3
Regional PCR Mobile Endoscopy	2.9				2.9
23/24 Pay award	tbc				tbc
Other	4.9				4.9
Total Allocations	**1,099.1**	**28.5**	**23.5**	**83.3**	**1,234.4**

Key Points:

- As at M2 the confirmed Revenue Resource allocation was £1,188.5m.
- The forecast position assumes a further £45.9m of Anticipated allocations to give a Total allocation of £1,234.4m.
- We are also anticipating that the 23/24 pay award will be fully funded.
- Until formally confirmed by WG, there are a number of risks associated with some of the these anticipated allocations. These are included in the Risk table on Page 18.

Income Assumptions - NHS

	Contracted Income	Non Contracted Income	Total Income
	£'m	£'m	£'m
Swansea Bay University	31.7	0.9	32.5
Aneurin Bevan University	21.1	1.3	22.4
Betsi Cadwaladr University	0.0	0.2	0.2
Cardiff & Vale University	16.3	1.5	17.8
Cwm Taf Morgannwg University	0.0	0.0	0.0
Hywel Dda University	0.5	0.3	0.8
Powys	4.8	0.5	5.3
Public Health Wales	3.3	0.8	4.1
Velindre	0.0	10.2	10.2
NWSSP	0.0	0.0	0.0
DHCW	1.3	0.0	1.3
Wales Ambulance Services	0.0	0.1	0.1
WHSSC	12.0	1.1	13.1
EASC	0.0	0.0	0.0
HEIW	0.0	13.3	13.3
NHS Wales Executive	0.0	0.0	0.0
Total	**91.0**	**30.2**	**121.2**

Key Points :

- The Health Board is assuming that LTA arrangements for 23/24 will follow the recommendation accepted by the majority view at the Directors of Finance meeting on the 17th March 2023.
- The Health Board has received a letter from ABUHB indicating that they do not accept this position. The risk to our draft plan is £3.1m and this has been included in our Risk table on Page 18.
- If the dispute between AB and CTM is not resolved, the WG guidance states that an arbitration case must be submitted by both parties by the 30th June. Discussions to attempt to resolve the dispute between DoFs in the first instance and then CEOs will need to have taken place prior to the arbitration case being submitted.

Risk Management Risks and Opportunities

	Month 2 £m	May submission £m	Comment
Savings delivery risks:			
Shortfall against planned savings delivery of £27.3m.	7.4	8.6	The latest forecast shortfall at M2 is £7.4m.
Forecast recurrent overspends in Care Groups not recognised in the plan. Risk of not delivering the £7.0m of NR benefits in 22/23 again in 23/24.	0.0	0.0	
Funding risks:			
Assumed WG funding for dental – 30% abatement of the dental income target	0.0	0.0	WG have confirmed that Health Board's should not assume funding for Dental patient charges shortfalls in 23/24.
Assumed funding for the impact of RLW in 23/24	1.2	1.2	Further clarification needed on funding assumptions for 23/24.
Assumed funding for Regional Planned care Recovery solutions	3.8	3.8	Further clarification needed on funding assumptions for 23/24. In the meantime, the potential risk has been estimated at 50% of the assumed Regional allocation.
Risk of the 23/24 pay award not being fully funded given the £1.9m recurrent shortfall in 22/23	1.0	1.0	Further clarification needed on funding assumptions for 23/24.
Risk of the additional costs for the extra bank holiday in 23/24 not being fully funded	0.0	0.0	Funding risk removed following confirmation of the WG funding position.
Cost pressure risks:			
Return to pre Covid Cost & Volume LTA arrangements in 23/24	1.0	1.0	
Contracting risks with other Health Boards	3.1	3.1	See Page 17 re specific risk re ABUHB.
Primary care prescribing – inflation and volume growth different to plan assumptions	Tbc	Tbc	Prescribing data is 2m in arrears and we will not have Q1 data until August 2023.
Significant uncertainty surrounding the expected energy cost pressure	Tbc	Tbc	
NICE costs exceed planned growth of £3.0m	Tbc	Tbc	
Non-Pay Inflation exceeds the £4.9m provision made in the plan (4.9%)	0.0	0.0	
Pension changes – Increased pension costs if staff opt back in following changes to the 1995 scheme	0.8	0.8	
Winter plans – All schemes funded non recurrently in 22/23 need to stop by 31 March	0.8	0.8	
Total Risks	**19.0**	**20.2**	

Key Points :

- The draft plan highlighted several significant risks and opportunities.
- As at M2 we are reporting total risks of £19.0m offset by total opportunities of £6m (next page) to give a net position of £13.0m.
- The most significant risk is the savings plan position, where the latest plans are currently £7.4m short of the £27.3m savings target.
- There are also significant risks associated with the WG funding assumptions for 23/24. The risk table includes £6.0m of funding risks where further clarification is needed on the assumptions for 23/24.
- There is also a £3.1m risk with ABUHB which is explained on Page 17.

Risk Management Risks and Opportunities

	Month 2 £m	May submission £m	Comment
Contingencies / Opportunities			
Further balance sheet review within 22/23	(2.5)	(2.5)	
Retrospective vat recoveries – Primary care and Microsoft contract	(0.5)	(0.5)	
Provision for an adverse movement in discount rates in 23/24 (following a positive movement in 22/23) not required	(1.0)	(1.0)	
Potential opportunity if the HB can reduce expenditure for TTP/vaccination below the notified allocation amount – and be allowed to retain any slippage.	(2.0)	(2.0)	Further clarification needed on funding assumptions for 23/24.
Total Opportunities	**(6.0)**	**(6.0)**	
Total	**13.0**	**14.2**	

Key Points :

- No issues to note at M2.

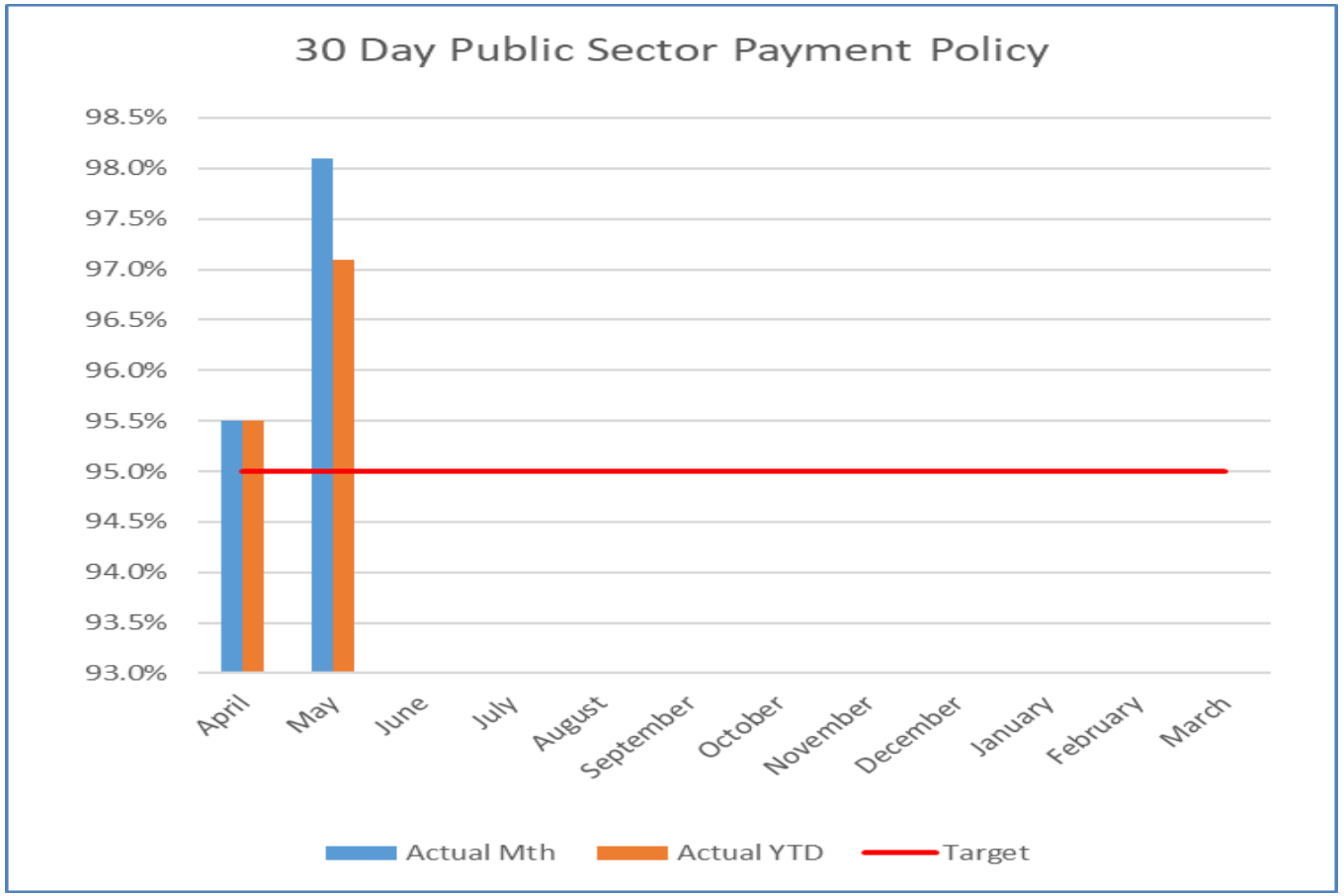
Cash Flow Forecast

Cashflow	Actual/Forecast												
	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Total £'000
Receipts													
WG Revenue Funding	113,271	100,294	104,500	105,000	103,500	117,000	94,500	107,500	120,000	97,000	112,000	37,039	1,211,604
WG Capital Funding	0	10,000	5,500	6,500	6,500	5,500	5,000	4,500	4,000	5,200	7,000	7,206	66,906
Sale of Assets	0	249	0	0	0	0	0	0	0	0	0	0	249
Welsh NHS Org'ns	12,193	12,612	10,900	10,600	10,900	10,900	10,900	10,900	10,900	10,900	10,900	10,900	133,505
Other	5,917	7,290	4,000	3,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	4,000	52,207
Total Receipts	**131,381**	**130,445**	**124,900**	**125,100**	**124,900**	**137,400**	**114,400**	**126,900**	**138,900**	**117,100**	**133,900**	**59,145**	**1,464,471**
Payments													
Primary Care Services	28,974	7,530	29,960	7,715	17,180	28,530	7,435	19,080	33,335	8,665	19,430	19,015	226,849
Salaries and Wages	50,003	69,212	44,000	56,500	53,300	53,200	53,000	53,300	53,200	53,300	53,000	53,500	645,515
Non Pay Expenditure	43,561	46,456	50,000	51,500	49,000	50,000	49,000	50,000	49,000	50,000	54,000	62,035	604,552
Capital Payments	5,502	6,527	5,788	6,136	6,336	5,608	5,057	4,551	3,851	5,116	6,861	7,048	68,381
Other	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Payments	**128,040**	**129,725**	**129,748**	**121,851**	**125,816**	**137,338**	**114,492**	**126,931**	**139,386**	**117,081**	**133,291**	**141,598**	**1,545,297**
Net Cash In/Out	3,341	720	(4,848)	3,249	(916)	62	(92)	(31)	(486)	19	609	(82,453)	
Balance B/F	1,348	4,689	5,409	561	3,810	2,894	2,956	2,864	2,833	2,347	2,366	2,975	
Balance C/F	4,689	5,409	561	3,810	2,894	2,956	2,864	2,833	2,347	2,366	2,975	(79,478)	

Key Points within the Cash Flow Forecast :

- The closing cash balance at 31st May 2023 was £5.4m.
- The forecast Cash Flow position to year end shows a projected deficit of £79.6m. This reflects the forecast deficit in the draft plan and will require future strategic cash support. Without cash support there will be a cash shortfall in the latter months of the financial year.

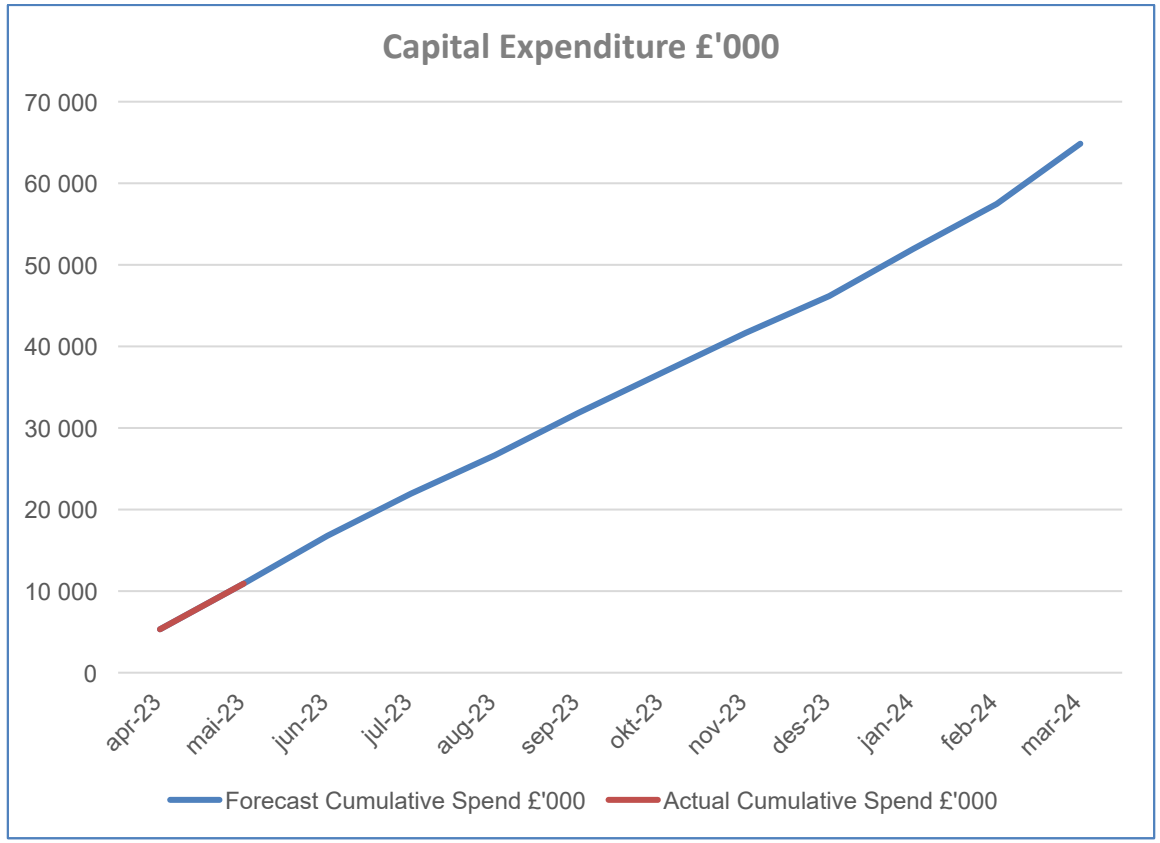
Public Sector Payment Policy



Key Points in the Public Sector Payment Policy :

- The percentage for the number of non-NHS invoices paid within the 30 day target in February was 98.1%.
- The cumulative percentage year to date is 97.1%. The PSPP target is therefore currently being achieved up to M2 of 2023-24.

Capital Expenditure



Key Points in Capital Expenditure:

- The Capital Resource Limit for 2023-24 of £64.5m was issued on the 25th May 2023.
- This is supplemented by £0.1m of donated funds and £0.2m of assets disposed of in this financial year giving an overall programme of £64.8m.
- Expenditure to M2 was £10.9m.
- The forecast outturn capital position is breakeven to the CRL target.

(Agenda Item) 6.3 | 27 June 2023 | Planning , Performance & Finance Committee | M2 Finance Performance Report

FOI Status:	Open (Public)
If closed please indicate reason:	N/A
Prepared By:	Mark Thomas, Deputy Director of Finance
Presented By:	Sally May, Director of Finance & Procurement
Approving Executive Sponsor:	Sally May, Director of Finance & Procurement
Report Purpose	For Discussion
Engagement undertaken to date:	N/A

Impact Assessment:	
Indicate the Quality / Safety / Patient Experience Implications:	There are no specific quality or safety implications related to the activity outlined in this report.
Related Health and Care Standard	Governance, Leadership & Accountability
Has an EQIA been undertaken?	Not required
Are there any Legal Implications /Impact.	There are no specific legal implications related to the activity outlined in this report.
Are there any resource (capital/Revenue/Workforce Implications / Impact?	Yes. The paper is directly relevant to the allocation and utilisation of resources.
Link to Strategic Goals	Sustaining Our Future.

2023-24 Finance Performance Report

Month 2

Summary

Situation

Our draft financial plan for 23/24 was submitted to Welsh Government (WG) on 31 March 2024. The draft plan identified a forecast deficit of £79.6m and WG confirmed that the plan was not supportable. The Health Board submitted a supplementary paper to WG at the end of May outlining the further work undertaken and the impact on the plan assumptions. However, the forecast deficit of £79.6m is unchanged. We are awaiting feedback on the 31 May submission.

The purpose of this report is focus on the financial performance of the individual Care Groups and directorates as at M2 (i.e. the **Delegated** budget position). This financial performance report is discussed at the PPFC and ELG meetings .

Where required, PPFC may request further information or a 'deep dive' on the financial performance of individual ILGs and directorates.

A separate Finance report has been prepared which sets out the overall financial position of the Health Board as at M2.The overall financial position report is discussed at the Full Board, the Planning, Performance & Finance Committee (PPFC) and also the Executive Leadership Group (ELG).

Background

The financial plan for 23/24 is based on a 'Control Total' approach which requires the Care Groups and Directorates to deliver a maximum allowable overspend of £23.8m.
To meet the Control Total Care Groups and Directorates will need to deliver a £28.3m Savings target from their M11 forecast out-turn positions for 22/23. In addition, since their forecast recurrent positions were greater than the In year positions, the Care Groups and Directorates will also need to deliver £11.7m of savings to cover the Non Recurrent benefits reported in 22/23.In summary:

	Delegated	Non Delegated	Comment
	£m	£m	£m
Control Total	23.8	-23.8	0
Savings Targets 23/24	-28.3	1.0	-27.3
Savings required to cover the NR benefits reported in 22/23	-11.7	4.8	-6.9

Any reported overspends against the Delegated Control Total will therefore be due to.:

- Shortfalls in savings to meet the £28.3m target for 23/24
- Shortfalls in savings to cover the £11.7m of NR benefits reported in 22/23
- Other operating variances

Savings plans are only reported against the 23/24 Savings target once the NR benefits reported in 22/23 have been covered.

Summary

Assessment	Recommendation
The M2 year to date **Delegated** overspend was £6.5m, which is an adverse variance of £2.5m compared to the M2 Delegated Control Total of £4m. This Control Total variance includes: • A £3.7m shortfall against the new £27.3m savings targets for 23/24 • £1.2m of other favourable operating variances. The main reason for the M2 **Delegated** overspends is therefore shortfalls in savings delivery. Forecast **Delegated** savings is only £12.6m, which is £15.7m below the Annual target. The largest savings shortfalls are in: • Unscheduled Care £2.6m, • Medicines Management £2.9m • Mental Health & LD £1.7m • Primary Care & Community £2.5m • Corporate Executives £1.9m Forecast **Delegated** Recurrent savings is only £13.4m , which is £14.9m below target. The largest recurrent savings gaps are in • Medicines Management £3.1m, • Unscheduled Care £2.3m, • Planned Care £2.2m	The PPFC is asked to **DISCUSS** and **NOTE** the financial performance of individual Care Groups and directorates for the period to 31st May 2023.

Contents

Executive Summary

Current Month Analysis

- The M2 position is reporting an adverse variance against the Control Total for **Delegated** budgets of £2.5m. The M2 **Delegated** overspend of £2.5m includes a shortfall against the M2 **Delegated** 23/24 savings target of £2.1m.

Year to Date Analysis

- The M2 YTD position is reporting an adverse variance against the Control Total for **Delegated** budgets of £2.6m.
- The M2 Delegated overspend of £2.6m includes:
  - A shortfall against the M2 YTD Delegated 23/24 savings target of £3.7m.
  - Other favourable Operating Variances of £1.2m which have not yet been recognised as savings.

Forecast Position

- A simple extrapolation of the M2 YTD position would indicate a forecast **Delegated** overspend against the £23.9m Control Total of circa £15m.
- Bottom of forecasts from the Care Groups and directorates will be provided from M3 onwards.

M2 Summary Performance – Variance against Control totals

	Annual Budget	Control Total	M2 Variance against Control Total	YTD Variance against Control Total
	£m	£m	£m	£m
Delegated Budgets				
Planned Care	158.1	3.8	0.3	0.3
Unscheduled Care	147.9	12.8	0.4	0.7
Primary & Community Care	190.7	0	(0.3)	(0.4)
Mental Health & Learning Disabilities	110.9	0	0.1	0.2
Children & Families	74.5	0	0.3	0.2
Diagnostics, Therapies & Specialties (Med Mgt)	154.3	5.2	0.8	0.8
Diagnostics, Therapies & Specialties (Therapies)	26.6	0	0.0	0.0
Diagnostics, Therapies & Specialties (CSS)	52.1	0.2	0.3	0.4
Facilities (Non Hub)	29.0	1.7	0.2	0.1
Corporate directorates	130.6	0.2	0.2	(0.1)
Contracting & Commissioning	143.7	0	0.3	0.4
Total Delegated Budgets	**1,218.4**	**23.9**	**2.5**	**2.6**
Non Delegated Budgets				
Total Non Delegated Budgets	**(1218.4)**	**(23.9)**	**(2.4)**	**(2.5)**
Grand total	**0**	**0**	**0.1**	**0.1**

Key Points :

- The M2 YTD position is reporting an adverse variance against the Control Total of £2.6m for **Delegated** budgets. This gives a total M2 overspend of £0.1m.
- A breakdown of the £2.6m **Delegated** overspend against the Control Total is provided on the next page. This includes:
  - A shortfall against the M2 YTD Delegated 23/24 savings target of £3.7m.
  - A shortfall against the M2 YTD Delegated B/Fwd savings target of £34k.
  - Other favourable Operating Variances of £1.2m which have not yet been recognised as savings.

M2 Summary Performance – Variance against Control totals

DELEGATED BUDGETS	Year to Date Variance (M02-24) 23/24 Savings £'000	B/Fwd Savings £'000	Other Operating Variances £'000	Variance from Control Total £'000
Women & Children	215	(12)	20	223
Mental Health & LD	411	86	(319)	177
Planned Care	471	(175)	18	313
Diagnostics, Therapies & Specialties (CSS)	208	(47)	274	435
Diagnostics, Therapies & Specialties (Med Mgt)	876	263	(302)	837
Diagnostics, Therapies & Specialties (Therapies)	(2)	0	(18)	(20)
Unscheduled Care	425	(119)	388	694
Primary Care & Community	355	(95)	(672)	(411)
Facilities (Non Hub)	192	40	(179)	53
Corporate directorates	409	94	(599)	(96)
Contracting & Commissioning	167	0	184	351
TOTAL DELEGATED BUDGETS	**3,728**	**34**	**(1,204)**	**2,557**
Non Delegated Budgets	**(1,391)**	**0**	**(1,049)**	**(2,440)**
GRAND TOTAL	**2,337**	**34**	**(2,253)**	**117**

Key Points :

- The main overspending areas are as follows:
  - DT&S Meds Mgt - £837k.
  - Unscheduled Care - £694k
  - DT&S CSS - £435k
  - Planned Care - £313k
- The main reasons for these overspends are shortfalls in savings delivery. Further information on the savings shortfalls (23/24 Savings and B'fwd savings) is provided at Annex A.
- Other Operating variances – The main adverse operating variances are for:
  - Unscheduled Care - £388k - predominantly driven by medical staffing spend which is circa £400k above forecast
  - DT&S CSS - £274k – Primarily the result of agency premium (£110k) & Pathology SLA's (£110k)
  - Contracting & Commissioning £184k – Lower than expected Injury cost recovery scheme income.
- A breakdown of the Corporate directorates is provided later in this report.

M2 Summary Performance Against Control Totals – Corporate directorates

Corporate Directorates	Annual Budget	Annual Control Total	M2 Variance against Control Total	M2 YTD Variance against Control Total
	£k	£k	£k	£k
Patient Care & Safety	13,965	0	48	105
Corporate Development	581	0	(15)	(32)
Chief Executive	3,463	0	(16)	(37)
Finance	4,620	0	14	(3)
Public Health	3,386	0	1	(102)
Digital	20,821	0	(6)	(6)
Medical Director	605	0	(1)	(0)
National Imaging Academy	1,593	0	3	(0)
Value Based Healthcare	2,227	0	(7)	0
Planning & Partnership	20,705	0	(2)	(34)
Research & Development	939	0	4	7
Estates	25,473	0	118	20
Therapies & Healthcare Sciences	197	0	(3)	(4)
Workforce & Organisational Development	10,121	0	(46)	(75)
COO Management	5,704	107	(7)	(44)
Facilities Hub	15,231	101	82	95
COVID Response	0	0	9	15
Total	**129,631**	**208**	**175**	**(96)**

Key Points for Year to Date Performance:

- The M2 YTD position is reporting a favourable variance against the Control Total of £96k.
- A breakdown of the £96k favourable variance between the following areas is provided on the next page.
  - Shortfalls in savings to meet the £28.3m savings targets for 23/24
  - Shortfalls in savings to cover the £11.7m of NR benefits reported in 22/23
  - Other operating variances

M2 Summary Performance Against Control Totals – Corporate directorates

Corporate directorates	Year to Date Variance (M02-24) 23/24 Savings £'000	B/Fwd Savings £'000	Other Operating Variances £'000	Variance from Control Total £'000
Patient Care & Safety	61	20	24	105
Corporate Development	1	6	(39)	(32)
Chief Executive	9	(3)	(44)	(37)
Finance	17	0	(20)	(3)
Public Health	9	7	(119)	(102)
Digital	87	56	(148)	(6)
Medical Director	0	0	(0)	(0)
National Imaging Academy	0	0	(0)	(0)
Value Based Healthcare	0	0	0	0
Planning & Partnership	22	0	(56)	(34)
Research & Development	0	0	7	7
Estates	91	0	(71)	20
Therapies & Healthcare Sciences	0	0	(4)	(4)
Workforce & OD	35	2	(111)	(75)
COO Management	17	(12)	(49)	(44)
Facilities Hub	61	17	17	95
Planned Care Recovery	0	0	0	0
COVID Response	0	0	15	15
TOTAL	**409**	**94**	**(599)**	**(96)**

Key Points for Savings:

- The M2 £96k favourable variance includes:
  - A shortfall against the M2 YTD Delegated 23/24 savings target of £409k.
  - A shortfall against the M2 YTD Delegated B/Fwd savings target of £94k.
  - Other favourable Operating Variances of £599k which have not yet been recognised as savings.
- The main overspending areas are as follows:
  - Patient Care & Safety - £105k.
  - Facilities Hub - £95k
- Other Operating variances- there are no significant adverse variances at M2. Further work is needed to convert the significant favourable variances to savings.

Corporate directorates M2 23/24 Savings - Forecast

Corporate Directorates	23/24 Welsh Government Savings Target				
	WG Savings Target £'000	F/Cast Achievement £'000	F/Cast Variance £'000	Rec F/Cast Achievement £'000	Rec F/Cast Variance £'000
Patient Care & Safety	364	158	207	0	364
Corporate Development	13	6	7	6	7
Chief Executive	78	22	56	22	56
Finance	104	0	104	0	104
Public Health	52	38	14	38	14
Digital	520	278	242	100	420
Medical Director	16	16	0	16	0
Planning & Partnership	130	0	130	0	130
Estates	546	383	163	303	243
Workforce & OD	208	0	208	0	208
COO Management	104	0	104	0	104
Facilities Hub	364	180	184	0	364
TOTAL DELEGATED BUDGETS	**2,499**	**1,080**	**1,419**	**485**	**2,014**

Key Points for Savings:

- The forecast 23/24 WG Savings achievement is £1.1m compared to the £2.5m savings target giving an adverse variance of £1.4m for Corporate directorates.
- As at M2, the forecast recurrent delegated savings achievement is only £0.5m compared to the recurrent target of £2.5m, giving a recurrent adverse variance of £2.0m.
- Only 43% of the savings target has been identified in plans, with the recurrent plans being 19%.
- The areas with the greatest proportion of savings plans compared to target are :
  - Estates **70%** forecast achievement
  - Digital **53%** forecast achievement
  - Facilities Hub **49%** forecast achievement.
- The areas with the lowest proportion of savings plans compared to target are:
  - Finance **0%** forecast achievement
  - Planning & Partnership **0%** forecast achievement
  - Workforce & OD **0%** forecast achievement
  - COO Management **0%** forecast achievement

Annex A
Savings Performance Report

Month 2

Background

The financial plan for 23/24 is based on a 'Control Total' approach which requires the Care Groups and Directorates to deliver a maximum allowable overspend of £23.8m.

To meet the Control Total Care Groups and Directorates will need to deliver a £28.3m Savings target from their M11 forecast out-turn positions for 22/23. In addition, since their forecast recurrent positions were greater than the In year positions, the Care Groups and Directorates will also need to deliver £11.7m of savings to cover the Non Recurrent benefits reported in 22/23.

In summary:

	Delegated £m	Non Delegated £m	Total £m
Assessed Underlying Position	63.8	-29.6	34.2
Savings required to cover the NR Benefits from 22/23 assumed to be delivered in 23/24 plan	-11.7	4.8	-6.9
New 23/24 Savings Target	-28.3	1.0	-27.3
Control Total	**23.8**	**-23.8**	**0.0**

Any reported overspends against the Delegated Control Total will therefore be due to.:

- Shortfalls in savings to meet the £28.3m target for 23/24
- Shortfalls in savings to cover the £11.7m of NR benefits reported in 22/23
- Other operating variances

Savings plans are only reported against the 23/24 Savings target once the NR benefits reported in 22/23 have been covered.

Executive Summary- Month 2

Year to Date

- The M2 YTD position is reporting an adverse variance against the Control Total for delegated budgets of £2,557k. This is offset by a £2,440k favourable variance for Non Delegated budgets to give a £117k adverse position against the M2 Control Total. The M2 Delegated overspend of £2,557k includes:
  - A shortfall against the M2 YTD Delegated 23/24 savings target of £3.7m.
  - A shortfall against the M2 YTD Delegated B/Fwd savings target of £0.03m.
  - Other favourable Operating Variances of £1.2m which have not yet been recognised as savings.
- The M2 Delegated savings shortfall of £3.7m is offset by a £1.4m favourable variance on Non delegated savings to give a M2 total savings shortfall of £2.3m.

23/24 Savings Forecast

- The forecast delegated 23/24 WG Savings achievement is £12.6m compared to the £28.3m savings target ,giving an adverse variance of £15.7m for delegated budgets.
- The M2 savings plans are reporting an improvement of £3.6m compared to the month 1 reported position of £9m.
- The forecast recurrent delegated savings achievement is £13.4m compared to the recurrent target of £28.3m, giving a recurrent adverse variance of £14.9m.
- Only 44% of the savings target has been identified in plans, with the recurrent plans being 44%.
- The forecast delegated savings shortfalls of £15.7m and £14.9m are offset by a £8.3m favourable variance on Non delegated savings to give a total forecast savings shortfall of £7.4m In year and £6.6m Recurrent.

Brought Forward Savings Forecast

- The forecast delegated brought forward savings achievement is £10.8m compared to the £11.7m savings target, giving an adverse variance of £0.9m for delegated budgets.
- The forecast recurrent delegated savings achievement is £2.6m compared to the recurrent target of £11.7m, giving a recurrent adverse variance of £9.0m.
- Circa 70% of the current year savings target has been identified in plans, with the recurrent plans being only 22%.

Year to Date Performance – Month 2

DELEGATED BUDGETS	Year to Date Variance – Month 2 23/24 Savings £'000	B/Fwd Savings £'000	Other Operating Variances £'000	Variance from Control Total £'000
Women & Children	215	(12)	20	223
Mental Health & LD	411	86	(319)	177
Planned Care	471	(175)	18	313
Diagnostics, Therapies & Specialties (CSS)	208	(47)	274	435
Diagnostics, Therapies & Specialties (Med Mgt)	876	263	(302)	837
Diagnostics, Therapies & Specialties (Therapies)	(2)	0	(18)	(20)
Unscheduled Care	425	(119)	388	694
Primary Care & Community	355	(95)	(672)	(411)
Facilities (Non Hub)	192	40	(179)	53
Corporate Executives	409	94	(599)	(96)
Contracting & Commissioning	167	0	184	351
TOTAL DELEGATED BUDGETS	**3,728**	**34**	**(1,204)**	**2,557**
NON DELEGATED BUDGETS	**(1,391)**	**0**	**(1,049)**	**(2,440)**
TOTAL	**2,337**	**34**	**(2,253)**	**117**

Key Points :

- The M2 YTD position is reporting an adverse variance against the Delegated Control Total of £2,557k. This is offset by a £2,440k favourable variance for Non Delegated budgets to give a total M2 adverse variance of £117k.
- The M2 Delegated overspend of £2,557k includes:
  - A shortfall against the M2 YTD Delegated 23/24 savings target of £3.7m.
  - A shortfall against the M1 YTD Delegated B/Fwd savings target of £0.03m.
  - Other favourable Operating Variances of £1.2m which have not yet been recognised as savings.
- The M2 Delegated savings shortfall of £3.7m is offset by a £1.4m favourable variance on Non delegated savings to give a M2 total savings shortfall of £2.3m.

23/24 WG Savings Forecast- Month 2

DELEGATED BUDGETS	23/24 Welsh Government Savings Target				
	WG Savings Target £'000	F/Cast Achievement £'000	F/Cast Variance £'000	Rec F/Cast Achievement £'000	Rec F/Cast Variance £'000
Women & Children	1,904	1,011	893	1,276	628
Mental Health & LD	2,808	1,136	1,672	1,050	1,758
Planned Care	4,588	2,074	2,514	2,375	2,213
Diagnostics, Therapies & Specialties (CSS)	1,248	72	1,176	113	1,135
Diagnostics, Therapies & Specialties (Med Mgt)	5,256	2,338	2,918	2,146	3,110
Diagnostics, Therapies & Specialties (Therapies)	624	464	160	160	464
Unscheduled Care	5,076	2,441	2,635	2,761	2,315
Primary Care & Community	2,132	463	1,669	1,050	1,082
Facilities (Non Hub)	1,152	1,000	152	1,000	152
Corporate Executives	2,499	565	1,934	485	2,014
Contracting & Commissioning	1,000	1,000	0	1,000	0
TOTAL DELEGATED BUDGETS	**28,287**	**12,564**	**15,723**	**13,416**	**14,871**
NON DELEGATED BUDGETS	(1,000)	7,300	(8,300)	7,300	(8,300)
TOTAL	**27,287**	**19,864**	**7,423**	**20,716**	**6,571**

Key Points :

- The forecast delegated Savings achievement is £12.6m compared to the £28.3m savings target, giving an adverse variance of £15.7m for delegated budgets.
- The M2 plans are reporting an improvement of £3.6m compared to the M1 forecast achievement (£9m).
- The forecast recurrent delegated savings achievement is £13.4m compared to the recurrent target of £28.3m, giving a recurrent adverse variance of £14.9m.
- Only 44% of the £28.3m Delegated savings target has been identified in plans, with the recurrent plans being 47%.
- The areas with the greatest proportion of savings plans compared to target are:
  - Contracting & Commissioning **100%** forecast achievement
  - Facilities (non Hub) **87%** forecast Achievement
  - DT&S - Therapies **74%** forecast achievement
- The areas with the lowest proportion of savings plans compared to target are:
  - Clinical Support Services **6%** forecast achievement
  - Primary Care & Community **22%** forecast achievement
  - Corporate Executives **23%** forecast achievement
- The forecast delegated savings shortfalls of £15.7m and £14.9m are offset by a £8.3m favourable variance on Non delegated savings to give a total forecast savings shortfall of £7.4m In year and £6.6m Recurrent.

23/24 WG Savings Forecast- Month 2

DELEGATED BUDGETS	23/24 Welsh Government Savings Target										
	WG Savings Target £'000	Green £'000	Amber £'000	RED (Excluded from WG Return) £'000	F/Cast Achievement (Excluding Red schemes) £'000	F/Cast Variance (Excluding Red schemes) £'000	Green £'000	Amber £'000	RED (Excluded from WG Return) £'001	Rec F/Cast Achievement (Excluding Red schemes) £'002	Rec F/Cast Variance (Excluding Red schemes) £'003
Women & Children	1,904	707	303	0	1,011	893	769	507	0	1,276	628
Mental Health & LD	2,808	875	262	0	1,136	1,672	742	308	0	1,050	1,758
Planned Care	4,588	1,945	129	17	2,074	2,514	2,159	216	100	2,375	2,213
Diagnostics, Therapies & Specialties (CSS)	1,248	13	60	0	72	1,176	15	98	0	113	1,135
Diagnostics, Therapies & Specialties (Med Mgt)	5,256	1,694	643	0	2,338	2,918	1,502	643	0	2,146	3,110
Diagnostics, Therapies & Specialties (Therapies)	624	324	140	0	464	160	20	140	0	160	464
Unscheduled Care	5,076	2,297	144	300	2,441	2,635	2,571	190	500	2,761	2,315
Primary Care & Community	2,132	390	73	0	463	1,669	542	508	0	1,050	1,082
Facilities (Non Hub)	1,152	0	1,000	0	1,000	152	0	1,000	0	1,000	152
Corporate Executives	2,499	116	449	44	565	1,934	116	369	44	485	2,014
Contracting & Commissioning	1,000	0	1,000	0	1,000	0	0	1,000	0	1,000	0
TOTAL DELEGATED BUDGETS	**28,287**	**8,361**	**4,203**	**361**	**12,564**	**15,723**	**8,436**	**4,979**	**644**	**13,416**	**14,871**
NON DELEGATED BUDGETS	(1,000)	7,300	0	0	7,300	(8,300)	7,300	0	0	7,300	(8,300)
TOTAL	**27,287**	**15,661**	**4,203**	**361**	**19,864**	**7,423**	**15,736**	**4,979**	**644**	**20,716**	**6,571**

Key Points :

- As at M2, the forecast delegated 23/24 WG Savings achievement is reporting £8.4m of Green schemes with £4.2m of amber and £0.4m of Red. It is important to note that Red schemes cannot be reported as part of the WG savings plans so will remain as unidentified schemes until such time as their assessment is changed to Amber or Green.
- The risk assessment shows that only 30% of the delegated savings target has been identified as Green (High confidence of achievement), the remaining identified Amber and Red schemes have a significant element risk to the forecast delivery.

B/Fwd Savings Forecast- Month 2

DELEGATED BUDGETS	Brought Forward Savings Target				
	B/f Savings Target £'000	F/Cast Achievement £'000	F/Cast Variance £'000	Rec F/Cast Achievement £'000	Rec F/Cast Variance £'000
Women & Children	1,590	1,691	(101)	315	1,275
Mental Health & LD	2,693	2,693	(0)	467	2,226
Planned Care	3,088	2,932	156	1,093	1,995
Diagnostics, Therapies & Specialties (CSS)	129	326	(197)	214	(85)
Diagnostics, Therapies & Specialties (Med Mgt)	1,579	0	1,579	0	1,579
Diagnostics, Therapies & Specialties (Therapies)	431	431	0	0	431
Unscheduled Care	137	803	(666)	0	137
Primary Care & Community	938	1,416	(478)	113	825
Facilities (Non Hub)	241	120	121	50	191
Corporate Executives	868	365	503	365	503
Contracting & Commissioning	0	0	0	0	0
TOTAL DELEGATED BUDGETS	**11,695**	**10,777**	**918**	**2,618**	**9,077**
NON DELEGATED BUDGETS	(4,843)	0	(4,843)	0	(4,843)
TOTAL	**6,852**	**10,777**	**(3,925)**	**2,618**	**4,234**

Key Points :

- The forecast delegated brought forward savings achievement is £10.8m compared to the £11.7m savings target, giving an adverse variance of £0.9m for delegated budgets.
- The forecast recurrent delegated savings achievement is £2.6m compared to the recurrent target of £11.7m, giving a recurrent adverse variance of £9.0m.
- Only 22% of the recurrent savings target has been identified in plans.
- Most of the areas are reporting full forecast achievement of the brought forward target, the 4 exceptions being:
  - Medicines Management **0%** forecast achievement
  - Corporate Directorates **42%** forecast achievement
  - Facilities **50%** forecast achievement

B/Fwd Savings Forecast- Month 2

	Brought Forward Savings Target										
DELEGATED BUDGETS	B/F Savings Target £'000	Green £'000	Amber £'000	RED £'000	F/Cast Achievement £'000	F/Cast Variance £'000	Green £'000	Amber £'000	RED £'001	Rec F/Cast Achievement £'002	Rec F/Cast Variance £'003
Women & Children	1,590	1,464	227	0	1,691	(101)	0	315	0	315	1,275
Mental Health & LD	2,693	2,693	0	0	2,693	(0)	467	0	0	467	2,226
Planned Care	3,088	2,274	658	0	2,932	156	1,093	0	0	1,093	1,995
Diagnostics, Therapies & Specialties (CSS)	129	326	0	0	326	(197)	214	0	0	214	(85)
Diagnostics, Therapies & Specialties (Med Mgt)	1,579	0	0	0	0	1,579	0	0	0	0	1,579
Diagnostics, Therapies & Specialties (Therapies)	431	302	129	0	431	0	0	0	0	0	431
Unscheduled Care	137	480	323	0	803	(666)	0	0	0	0	137
Primary Care & Community	938	1,130	263	23	1,416	(478)	73	0	40	113	825
Facilities (Non Hub)	241	50	70	0	120	121	50	0	0	50	191
Corporate Executives	868	312	53	0	365	503	275	90	0	365	503
Contracting & Commissioning	0	0	0	0	0	0	0	0	0	0	0
TOTAL DELEGATED BUDGETS	**11,695**	**9,031**	**1,722**	**23**	**10,777**	**918**	**2,173**	**405**	**40**	**2,618**	**9,077**
NON DELEGATED BUDGETS	(4,843)	0	0	0	0	(4,843)	0	0	0	0	(4,843)
TOTAL	**6,852**	**9,031**	**1,722**	**23**	**10,777**	**(3,925)**	**2,173**	**405**	**40**	**2,618**	**4,234**

Key Points :

- As at M2, the forecast delegated Brought Forward Savings achievement is reporting £9.0m of Green schemes and £1.7m of amber. The recurrent forecast savings achievement is reporting only £2.6m against the delegated £11.7m target.

AGENDA ITEM
6.4

PLANNING, PERFORMANCE & FINANCE COMMITTEE

REINFORCED AUTOCLAVED AERATED CONCRETE PLANKS (RAAC)

Date of meeting	(27/06/2023)
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	Tim Burns, Assistant Director – Capital and Estates
Presented by	Tim Burns, Assistant Director- Capital and Estates
Approving Executive Sponsor	Executive Director of Finance
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
RAAC	Reinforced autoclaved aerated concrete
SESN	Specialist Estates Services Notification
CTMUHB	Cwm Taf Morgannwg University Health Board

1. SITUATION/BACKGROUND

1.1 Reinforced autoclaved aerated concrete (RAAC) is a relatively weak product and has been used in lightweight masonry blocks and

structural units such as roof planks and wall and floor units in the construction of various buildings built between 1960 and 1995. RAAC was not used in the construction of buildings outside of this date range. In recent years there have been a number of failures which have included the partial collapse of roof structures in schools. This led to the publication of a structural safety alert by the Institution of Structural Engineers, Standing Committee on structural safety which noted the failures and risks of RAAC in buildings.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 In November 2019, NHS Wales Specialist Estates Services issued an estates notification (SESN 19/11) requesting that Health Boards in Wales determine whether any RAAC planks were present on buildings in roofs , walls and floors constructed between 1960- 1990. The conclusion of this work confirmed that the buildings owned by Cwm Taf Morgannwg University Health Board or buildings where CTMUHB hold the head lease did not have RAAC present. This was reported to NHS Wales Specialist Estates Services in December 2019.

2.2 In January 2022, NHS Wales Specialist Estates Services issued a follow up estates notification (SESN 22/02) requesting Health Boards to:-

1. Provide a schedule of all Health Board properties which were constructed between 1960 -1990.
2. A record of actions taken to determine the presence of RAAC.
3. A condition survey and management plan concerning each location where the presence of RAAC had been identified.
4. An extract of the Board's risk log showing the risks and associated management plans.

2.3 As with the previous submission the work concluded that the buildings owned by CTMUHB or buildings where CTMUHB hold the head lease did not have RAAC present, consequently points 3 and 4 above are non – applicable. This was also reported to NHS Wales Specialist Estates Services at the time.

2.4 In February 2023 the Deputy Director of NHS Wales Specialist Estates Services emailed all Health Boards in Wales and noted-

"*Following receipt of responses from organisations in NHS Wales to SESN 22/02 we have reviewed each submission with our appointed specialists (Curtins Structural engineers) and concluded that a further*

iteration of investigation is urgently required to provide health organisations and Welsh Government with a Board level assurance that this matter is fully understood and that appropriate measures are in place to manage the issue in the short and longer term."

And instructed Health Boards to:-

Ensure that properties and / or extensions constructed within the period 1960-1995, (date range previously requested was 1960 – 1990) are identified for examination of building records and visual inspection. For the avoidance of doubt, each property identified must have a completed appraisal to determine RAAC presence.

3. HEALTH BOARD ASSURANCE

3.1 To provide additional assurance on the position previously reported to Specialist Estates Services and Welsh Government the Health Board appointed James and Nicholas Consulting Structural engineers to survey, inspect and report upon all Health Board properties for the presence of RAAC (excluding Prince Charles hospital) built between 1960-1995.

3.2 Following the surveys James and Nicholas concluded that there was no evidence of the presence of RAAC planks in any of the properties that they inspected. The summary of inspections / findings is included at **Appendix A.**

3.3 Prince Charles Hospital is undergoing a significant capital project consequently for this site WSP the Consulting Structural Engineers working on the scheme were requested to report on the RAAC position. Following a review they confirmed that **"***it is our opinion that the slab units at Prince Charles Hospital are not formed from RAAC"*

3.4 The properties within CTMUHB portfolio that were not inspected as they were constructed outside of the date range are included at **Appendix B.**

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Choose an item. If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Sustaining Our Future

5. RECOMMENDATION

5.1 The Planning, Performance and Finance committee are asked to**:**

- **NOTE** that following inspections from James and Nicholas and WSP Consulting Structural Engineers no RAAC has been identified in buildings owned by CTMUHB or in buildings where CTMUHB hold the head lease that were constructed between 1960 and 1995.

STRUCTURAL INSPECTION, PRESENCE OF RAAC PLANKS

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

APPENDIX A - SUMMARY OF INSPECTIONS

Item No.	Property Name	Location	Inspection Date	Date Constructed	Record Drawings Available?	Brief Description of Construction	Any evidence of RAAC Planks (Roof Planks/Floor/Wall Planks)?	Photo No. (ref. Appendix B)
1	Dewi Sant Hospital - Main Hospital Block	CF37 1LB	17/03/2023	Circa 1968	Some/limited	Four-storey with flat roof. Dense in-situ concrete frame including roof slab and floors. Part single-storey (Physiotherapy) with flat roof (timber-framed roof on load-bearing walls)	No	1
2	Dewi Sant Hospital - Admin Block	CF37 1LB	17/03/2023	Circa 1968	None	Four-storey with flat roof. Dense in-situ concrete frame including roof slab and floors	No	2
3	Dewi Sant Hospital - Estates Block	CF37 1LB	17/03/2023	Circa 1968	Some/limited	Single/Part Two-storey with flat roof. Dense in-situ concrete frame roof slab and floors	No	3
4	East Glamorgan Site - Plant Rooms	CF38 1UR	16/03/2023	Circa 1964 - 1995	None	Various single-storey with flat roofs. Wood wool slab on steel frame. In-situ concrete slab on steel-frame and profile steel cladding on steel-frame.	No	4
5	East Glamorgan Site - Production/Laundry Area	CF38 1UR	16/03/2023	Circa 1964 - 1995	None	Single-storey with flat roofs. Wood wool slab on steel frame or profile steel cladding on steel-frame.	No	5
6	East Glamorgan Site - Store	CF38 1UR	16/03/2023	Circa 1964 - 1995	None	Single-storey (part basement) with pitched roof. Timber purlins and rafters on steel framing. Basement comprises dense in-situ concrete slab and frame.	No	6
7	East Glamorgan Site - Uniform Stores and Office	CF38 1UR	16/03/2023	Circa 1964 - 1995	None	Single-storey with pitched timber roof of traditional construction on load-bearing masonry walls.	No	7
8	East Glamorgan Site - Document Store	CF38 1UR	16/03/2023	Circa 1964 - 1995	None	Single-storey with pitched roof. Timber rafters and purlins supported on steel-trusses and load-bearing masonry walls.	No	8
9	Ysbyty George Thomas	CF42 6YG	16/03/2023	Circa 1990	Some/Limited	Single-storey with pitched roof. Timber rafters on steel frame. Two-storey Plant Room of similar construction	No	9
10	Princess of Wales Hospital - Main Hospital Buildi	CF31 1SQ	28/03/2023	Circa 1984	Some/Limited	Two/three-storey with pitched roof. Steel-framed roof on dense in-situ concrete frame.	No	10
11	Princess of Wales Hospital - Diabetic Clinic	CF31 1SQ	31/03/2023	Circa 1992	None	Two-storey with pitched roof. Traditional construction. Trussed rafters on load-bearing masonry walls.	No	11
12	Princess of Wales Hospital - Coity Clinic	CF31 1SQ	31/03/2023	Circa 1994	None	Part single/two/three-storey with pitched roofs. Tiles on metal cladding system on steel-frame with dense precast concrete planks to suspended floors.	No	12
13	Princess of Wales Hospital - Theatres 5 & 6	CF31 1SQ	31/03/2023	Circa 1995	None	Two-storey with pitched roof. Timber rafters on steel frame. Suspended floors, concrete-filled metal deck.	No	13
14	Aberfan Health Centre	CF48 4QU	17/03/2023	Circa 1990	None	Single-storey with pitched roof. Traditional construction. Timber-trussed rafters on load-bearing masonry walls.	No	14
15	Aberdare Health Centre	CF44 7DD	06/04/2023	Circa 1980s	None	Single-storey, part two-storey, steel frame structure with flat metal-deck roof. Upper floor comprises dense pre-cast concrete floor planks.	No	15
16	Pontypridd Health Centre	CF37 4PF	17/03/2023	Circa 1974	None	Three-storey with flat roof. Metal deck roof on load-bearing masonry walls and in-situ reinforced concrete frame.	No	16
17	Talbot Green Health Centre	CF72 8AJ	16/03/2023	Circa 1989	None	Single storey with pitched timber-trussed rafter roof on load bearing-masonry.	No	17
18	Tonypandy Health Centre	CF40 2LE	16/03/2023	Circa 1970	Yes	Single-storey flat roof. Hybrid construction primarily metal roof deck on steel or timber beams, columns and load-bearing walls. Dense precast concrete planks used over Plant Room.	No	18
19	Tylorstown Clinic	CF43 3HB	16/03/2023	Circa 1989	None	Single-storey with pitched roof. Traditional construction. Timber rafters on load-bearing masonry walls.	No	19
20	Bryncethin Clinic	CF32 9NY	16/03/2023	Circa 1966	None	Single-storey with flat roof. Timber-frame construction.	No	20
21	Bryntirion Clinic	CF31 4EA	28/03/2023	Circa 1980	None	Single-storey with flat roof. Timber-frame construction.	No	21
22	North Cornelly Clinic	CF33 4HS	28/02/2023	Circa 1980	None	Single-storey pitched roofs and flat roof of traditional construction. Timber roof structure on load-bearing masonry walls	No	22
23	Central Stores, Princess of Wales Hospital	CF31 1RQ	28/03/2023	Circa 1986	None	Single-storey unit, part two-storey within. Steel-clad, steel-framed portal type unit. Dense concrete floor to first floor offices.	No	23
24	Old THQ, Quarella Road	CF31 1YE	31/03/2023	Circa 1960's	None	Two-storey pitched roof of traditional construction. Timber roof on load-bearing masonry walls.	No	24
25	Central Processing Unit (CPU) x 3 no. Units	CF42 6EJ	16/03/2023	Circa 1985	None	Single-storey metal-clad steel-frame portal-type building.	No	25

APPENDIX A

Appendix B

Properties in CTMUHB portfolio that were excluded from the survey scope as they were not constructed in the period 1960 -1995.

Royal Glamorgan Hospital – constructed circa 1998

Royal Glamorgan Hospital (including the Mental Health Unit) - constructed circa 2003

Ysbyty Cwm Rhondda - constructed circa 2007

Ysbyty Cwm Cynon - constructed circa 2010

Glanrhyd Hospital - constructed circa 1865 and circa 2015

Maesteg Hospital - constructed circa 1914

Kier Hardie Health Park - constructed circa 2010

Gwaun Elai Units 2, 3 and 4 - constructed circa 2004

Tonteg Clinic - constructed circa 1909

Llwyn-yr-Eos Clinic - constructed circa 1909

Carnegie Clinic - constructed circa 1934

Maritime Resource Centre - constructed circa 2003

NIAW (National Imaging Academy Wales) - constructed circa 2007

Pinewood House, Treorchy - constructed circa 1920s

Trealaw Resource Centre - constructed circa 2003

Ynysmeurig House - constructed circa 2000+

Williamstown Records Hub - constructed circa 2000+

Ogmore Vale Clinic - constructed circa 2001

Quarella Road Clinic - constructed circa 2001 –

ARC Day Services - constructed circa 2009 –

Cefn Y Afon Rehabilitation Unit - constructed circa 2010 –

Hartshorn House - constructed circa 1950s –

11, Cedarwood Drive, Tonyrefail - constructed circa 2002 –

Pencoed Primary Care Centre - constructed circa 2011 –

North Road Stores, Bridgend - constructed circa 2000+ -

Porthcawl Primary Care Centre - constructed circa 2019 –

Leith House (Porth Dental) - constructed circa 1926

Treharris Primary Care Centre - constructed circa 2000+

Hirwaun Medical Centre - constructed circa 2000+

Ynyshir Medical Practice, Porth – constructed circa 1900-1959

PLANNING, PERFORMANCE & FINANCE COMMITTEE– FORWARD WORK PLAN 2023/24				
Origin of Request	**Category of Report / Presentation (Deferred Item/ Additional Item/ Ad-Hoc Item)**	**Item Title**	**Lead Officer**	**Intended Meeting Date**
Request received via email.	Deferred Item	Phase 2 All Wales RAAC Investigation – CTMUHB	Director of Finance & Procurement	27 June 2023
Request received via email.	Additional Item	Month12 Movements from Forecast	Director of Finance & Procurement	27 June 2023
Request received via email.	Additional Item	Mental Health - Service Improvement Funding Award 2023-24	Assistant Director of Primary, Community & Mental Health	27 June 2023
Request received via email.	Additional Item	Implementation of Robotic Surgery within CTMUHB – Business Case	Chief Operating Officer	27 June 2023
Action agreed at the February 2023 meeting.	Deferred Item from May 2023 meeting.	Six Goals for Planned Care Recovery	Director of Strategy & Transformation	27 June 2023
Action agreed at the February 2023 meeting.	Additional item	Data Analytics and Visualisation Cability and Capacity Report	Director of Digital	24 October 2023
Request made at agenda planning meeting for April 2023	Deferred Item	Estates & Facilities Annual Performance Report	Director of finance	24 October 2023

Completed Activity from the Forward Work Programme

Request made at Agenda Planning meeting for February 23	Deferred Item	Enhanced Monitoring – Assurance Processes and Governance	Director of Strategy & Transformation/Chief of Staff	4 May 2023 – **Completed**
Request made by DoST via email	Deferred Item	RISP Programme FBC Approval Process	Director of Strategy & Transformation	4 May 2023 (In Committee) – **Completed**
Action agreed at October 2022 meeting.	Additional item	Mental Health Performance – Deep Dive	Chief Operating Officer	4 May 2023 – **Completed**
Requested at meeting held with AD for Strategy & Transformation 10.02.23	Additional Item	New Velindre Cancer Centre Full Business Case	Director of Strategy & Transformation	**Completed –** 22 March 2023
Requested at meeting held with AD for Strategy & Transformation 10.02.23	Additional item	South East Wales Cataract Business Case	Director of Strategy & Transformation	**Completed -** 28 February 2023
Action following the October 2022 meeting to receive an update.	Deferred Item	Planned Care and Cancer Performance	Chief Operating Officer	**Completed** - 28 February 2023
Action following the October 2022 meeting for an update.	Deferred Item	Sepsis Compliance Programme	Medical Director	**Completed -** 28 February 2023

Request made at Agenda Planning meeting for February 23	Additional Item	Targeted Intervention and Improving Care	Chief Operating Officer	**Completed -** 28 February 2023
Request via email from DoG October 2022	Additional Item	Spinal Services Operational Delivery Network	Director of Strategy & Transformation	**Completed -** 28 February 2023
Request made by DoF via email	Additional item	NWSSP - Energy Procurement Proposal	Director of Finance	**Completed -** 28 February 2023