Finance & Performance Committee

Wed 18 October 2023, 14:00 - 16:00

MS Teams

Agenda

14:00 - 14:05
5 min

1. Standing Items

1.1. Welcome and Introductions

John Union

1.2. Apologies for Absence

John Union

1.3. Declarations of Interest

John Union

1.4. Minutes from the Finance and Performance Committee meeting – 20 September 2023

John Union

1.4 Public Finance and Performance Minutes 20.09.23.pdf (9 pages)

1.5. Action log following the Finance and Performance Committee meeting held on 20 September 2023

John Union

1.5 Public Finance and Performance Action Log.pdf (2 pages)

1.6. Chair's Actions since previous meeting

John Union

14:05 - 15:45
100 min

2. Items for Review and Assurance

2.1. Financial Report – Month 6

15 minutes *Catherine Phillips / Robert Mahoney*

2.1 SUMMARY Finance Position Report for Month 6 (1).pdf (14 pages)

2.2. Welsh Government Strategic Cash Support Request

10 minutes *Catherine Phillips / Robert Mahoney*

2.2 WG Strategic Cash Support Request Report (1).pdf (3 pages)

2.3. Operational Performance

45 minutes *Paul Bostock*

a. Operational Performance Report
b. Mental Health Services

2.3 Operational Performance report cover paper.pdf (4 pages)
2.3a Integrated Performance Report - Finance and Performance.pdf (30 pages)

2.4. Cancer Deep Dive

20 minutes *Paul Bostock*

2.4 Cancer Standard performance.pdf (5 pages)

2.5. BREAK - 10 minutes

15:45 - 15:55
10 min

3. Items for Approval / Ratification

3.1. Business Cases

10 minutes each

3.1.1. Electronic Prescribing and Medicines Administration

3.1.1 EPMA Business Case v3.6.pdf (42 pages)

3.1.2. Paediatrics Infectious Diseases

3.1.2 Paeds ID resubmission cover sheet 1.pdf (2 pages)
3.1.2a Paediatric Infectious Disease Rationalised Case August 2023 1.pdf (26 pages)

15:55 - 16:00
5 min

4. Items for Information and Noting

4.1. Monthly Monitoring Return - Month 6

5 minutes *Catherine Phillips / Robert Mahoney*

4.1a WG month 6 MMR Covering Report.pdf (2 pages)
4.1b CV Financial Monitoring Returns 2023-24 - Month 6.pdf (11 pages)
4.1c 2023-24 MMR Template - Cardiff Vale UHB Month 6.pdf (6 pages)

16:00 - 16:00
0 min

5. Agenda for Private Finance and Performance Committee Meeting

i. *Approval of Private Finance Committee Minutes – 20.9.2023*

16:00 - 16:00
0 min

6. Any Other Business

16:00 - 16:00
0 min

7. Review and Final Closure

7.1. Items to be deferred to Board / Committee

John Union

7.2. To note the date, time and venue of the next Committee meeting:

Wednesday 22 November 2023 at 2pm Via MS Teams

7.3. Declaration

To consider a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest [Section 1(2) Public Bodies (Admission to Meetings) Act 1960]

Unconfirmed Minutes of the Public Finance and Performance Committee Meeting
Held on 20 September 2023 at 2pm
Via MS Teams

Chair:		
John Union	JU	Independent Member – Finance (IM-F)
Present:		
David Edwards	DE	Independent Member – Information Communication & Technology (IM-ICT)
In Attendance:		
Paul Bostock	PB	Chief Operating Officer (COO)
Catherine Phillips	CP	Executive Director of Finance (EDF)
Matt Phillips	MP	Director of Corporate Governance (DCG)
Charles Janczewski	CJ	UHB Chair
Abigail Harris	AH	Executive Director of Strategic Planning (EDSP)
Ceri Phillips	CP	UHB Vice Chair
Andrew Gough	AG	Deputy Director of Finance – Strategy (DDFS)
Rob Mahoney	RM	Deputy Director of Finance – Operational (DDFO)
Angela Hughes	AH	Assistant Director of Patient Experience (ADPE)
Calum Shaw	CS	Environmental Sustainability Improvement Manager (ESIM)
Matt Temby	MT	Managing Director Planned Care (MDPC)
Secretariat:		
Rachel Chilcott	RC	Corporate Governance Officer
Apologies:		
Suzanne Rankin	SR	Chief Executive (CE)
Keith Harding	KH	Independent Member – University (IM-U)
Jason Roberts	JR	Executive Nursing Director (END)

Item No	Agenda Item	Action
FPC 23/09/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FPC 23/09/002	**Apologies for Absence** Apologies for Absence were noted. **The Finance and Performance Committee resolved that:** a) Apologies for Absence were noted.	
FPC 23/09/003	**Declarations of Interest** No Declarations of Interest were noted.	
FPC 23/09/004	**Minutes of the Finance and Performance Meeting held on 23 August 2023** The minutes of the meeting held on 23 August 2023 were received. **The Finance Committee resolved that:** a) The minutes of the Finance and Performance Committee meeting held on 23 August 2023, were held as a true and accurate record of the meeting.	

FPC 23/09/005	**Action Log following the Finance and Performance Committee meeting on 19 July 2023** The Action Log was received. **The Finance and Performance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	
FPC 23/09/006	**Chairs Action since previous meeting** There had been no Chair's Actions taken since the last meeting.	
	Items for Review and Assurance	
FPC 23/09/007	**Financial Report – Month 5** The Deputy Director of Finance for Strategy (DDFS) presented the Financial Report – month 5 and highlighted the following: - They had an overspend of £42.827m; - This comprised of £4.667m unidentified savings, £1.327m of operational overspend, and the planned deficit of £36.833m (five twelfths of the annual planned deficit of £88.4m set out in the 2023/24 financial plan); - The Financial Plan approved by Board and submitted to Welsh Government (WG) was not accepted, but it was noted by WG. The components of the plan had resulted in a planned deficit of £88.4m; - They were on a trajectory currently above the £88.4m. The UHB Chair noted concern around the £5.994m gap, and highlighted that no clear timeframe had been identified. <u>Table 3 – Finance – Key Performance Indicator Dashboard at August 2023</u> It was highlighted that: - The KPIs were on red in terms of the planned deficit by the end of the financial year; - They anticipated they would remain within the capital resource limits; - Regarding the delivery of the recurrent £32m savings target – while the number of schemes identified had increased, the recurrence of some schemes was in doubt; - Their creditor compliance payments were at 97.47% at the end of August; - The UHB's working capital requirement would be discussed with WG in around November, following the finalisation of the draft plan at Q1; - They had a positive cash balance at present. The EDF suggested that it would be useful to incorporate the recurrent position into the savings section of the paper. <u>Financial Performance of Clinical Boards</u> The reasons for the change in the deficit were highlighted: - Clinical Boards were still dealing with the COVID footprint and pressures within Mental Health. However, some progress had been made within Mental Health; - WHSSC had decided not to follow the national Director of Finance Agreement around how the LTA performance would be treated, which had a £3m impact on the Health Board.	

COVID Expenditure

- They continued to receive financial support from WG for Health Protection, PPE, Long-COVID, Nosocomial, and Anti-Viral activities;
- They had forecasted £13m funding from WG, of which they relied on the full total due to uncertainty around the increased uptake of COVID around the UK, and the request from WG to use these monies for other initiatives (e.g. vaccination);
- Last year the Health Board had received more support from WG, and so it had been incorporated into the UHB's savings plans that they would continue to spend £34.2m on COVID local response measures. However, they had assessed that they would be at least £3m lower than the £34.2m, which would contribute to their savings programme.

The IM-F asked if there were any risks in this not being delivered. The DFFS provided reassurance that they were in a reasonably robust place to bank that.

Risks

The DFFS outlined the following risks:

- They could not get the three-year approved plan from WG due to their deficit position;
- They would breach their revenue funding limit;
- They were confident they could stay within their capital resource limits, despite the fairly limited capital resource allocation. This would be reviewed towards the year end;
- The big risk would be not delivering the 2023/24 savings programme, as the £88.4m target was contingent on the Health Board delivering a minimum of £32m savings;
- How their performance would operate within the one-year LTA framework. They had forecasted how the DoFs LTA agreement would work, and they had 5% leeway this year.

Savings Programme

It was highlighted that:

- In month 5 there had been an improvement in the number of green, amber and red savings against the £32m savings target;
- WG had asked organisations to identify 10%, 20% and 30% savings beyond their forecast plans – CAVUHB had identified a risk of non-achieved CRPs just to hit the £88.4m;
- They had to find another £16m of savings to safely achieve the £32m - this has had some momentum;
- £13.7m remained as red schemes, and they would need to focus on moving these schemes into green and amber.

The UHB Chair asked what progress was being made against other initiatives totalling the £16m, and explained that the Committee would need to be assured by seeing evidence of achievement in the form of a report.

The DFFS responded that actions had been taken, and that they were soon due to the progress materialised in the financial positions.

The UHB Vice Chair queried if CAVUHB were being unrealistic in achieving their savings targets compared to other Health Boards. The DFFS responded that there

	were risks, but that there was a genuine culture of commitment from the organisation. The IM-ICT asked if the Board had considered measures/precautions that they might have to take towards the end of the financial year if they did not hit the £88m. The EDF responded that their current plan was their best and focus was needed on delivering this. The COO added that the only other plan would be to stand down Planned Care, however it would require difficult conversations. The DDFS talked through the graphs in the report which illustrated the progress made on the savings schemes throughout the year. Regarding the Total Variance Forecast, they forecasted that if the planned schemes delivered, the reported deficit would peak at month 6 before turning the curve on a trajectory to hit the £88.4m planned deficit. <u>Cash Flow Forecast</u> The DFFS summarised that: - They would assess the movements in working capital later in the year; - They accounted for £11.5m in expenditure terms the previous year, which had been paid out in cash this year. At present, they would need approx. £100m from WG. The IM-F asked if there was a timeframe. The DFFS responded that this usually would be drawn down in the last month, but that they would firm this with WG in around November/December. The EDF explained that they were expecting to receive the cash, but that it was not without risk. She suggested bringing this back to the Finance Committee in the next few months for further clarity. <u>Public Sector Payment Compliance</u> – the DDFS confirmed that they were consistently above the target. <u>Capital</u> It was highlighted that: - Next month they would bring back a more detailed list of the capital schemes in the process with bids; - They have expended 17% of the capital resource limit to date – this would accelerate as the year went on; - They had £11m of discretionary capital and the balance of £18m for approved projects by WG - they were in line to spend within the resource limit. **The Finance and Performance Committee resolved that at Month 5:** a) The reported year to date overspends of £42.827m and the forecast deficit of £88.4m was noted; b) The financial impact of forecast COVID-19 costs which is assessed at £44.264m was noted; c) The month 5 operational overspend against the plan of £1.327m was noted; d) The progress against the savings target, with £36.481m (114%) of schemes identified at month 5 against the £32m target was noted.	
FPC 23/09/008	**Orthopaedics Waiting List Deep Dive**	

It was highlighted that:

- The graphs indicated that since April 2022, they had seen a change in their position. However, they had not gone as far as they would have liked, and teams were working towards moving this in the right direction of the ministerial ambitions (97% reduction in waiting lists by December 2023, and 99% reduction by March 2024);
- New patient activity was at 100% of their pre-COVID activity levels;
- Follow-up activity was at 67% due to elective inpatient activities only being at 57% of pre-COVID levels

The COO added that the Major Trauma Centre (MTC) arrived in the middle of the pandemic which took some of their theatre capacity (particularly spinal capacity).

The MDPC provided reassurance that the job planning exercise undertaken by the entire Orthopaedics Department was robust.

The MDPC continued:

- They had a high degree of confidence that the Orthopaedic component of the 97% organisational target would be met in December. The March target of 99% still needed further discussion on how to prioritise activity;
- They had a process for reallocating theatre capacity, predominantly for spinal surgery. This was a decision being taken amongst Clinical Boards;
- On a monthly basis, the Directorate Management team looked at the GIRFT and Audit Wales recommendations to track the actions which had been implemented.

The MDPC provided a summary of the Rehabilitation Programme, which supported people at every stage on the MSK Osteoarthritis Knee (OAK) pathway and Orthopaedic surgical pathway:

- There were a number of checkpoints along the pathway, including a number of community-based activities;
- This work was linked to Keepingmewell.com strategy;
- Living Well was the banner under which the teams work to give patients the best opportunity through education and access to community based-activities. They were undertaking a lot of evaluations under the Living Well programme, with CEDAR support;
- Within the Living Well programme, there was a specific Prepare Well programme for Orthopaedics, with resources dedicated to the waiting list. They had undertaken a review which showed that they had 1104 patients on the orthopaedic waiting list go right the way through the programme, and there was a social return on investments (for every £1 spent gives them £2.86 on return).

The COO stated that whilst the overall waiting list size for the Health Board was increasing, the Ortho waiting list was reducing.

The UHB Vice Chair noted that more work could be done on social investments, e.g. how prehab has improved returns to work. He asked whether this work could be rolled out to other areas in the Health Board.

The MDPC responded that this was already underway, and that the Optimisation Delivery Group were looking at how this work could be spread across other pathways within the organisation. He added that WG were adopting CAVUHB's charter on a national basis.

	The MDPC highlighted confidence in the Orthopaedics validation of waiting lists due to a regular process and cycle of validation. He stated that he was undertaking investigations into the validation process in other pathways. **The Finance Committee noted that:** a) The current position of the Orthopaedic waiting list and the work both to reduce the waits and support patients was noted.	
FPC 23/09/009	**Interventional Radiology** The MDPC summarised that: - Within two interventional rooms in UHW, there was found to be significant corrosion on the machines. It was established that from March 2024, they would not have continued support from the suppliers in the maintenance of the machines; - Teams had undertaken work with WG who afforded the Health Board £7.2m specifically for this programme to go through the procurement process of replacing both machines; - There was a programme including meteorological testing to understand why the corrosion had happened – early indications suggested that it was a combination of humidity and cleaning processes, which had since been adjusted. They would ensure revised air handling and cleaning processes were in place in the future; - They had a full programme team to ensure they procured the right equipment going forward and that the right processes were in place. The Committee was requested to support the business case to proceed with the implementation of exchanging the machines, which would then go to Board for approval. **The Finance Committee noted that:** a) The Committee supported the proposal to replace the Biplane Interventional Neuroradiology Equipment.	
FPC 23/09/010	**Regional Integration Funds** The EDSP summarised that: - The report demonstrated how the funding had been allocated across all of the projects, and provided assurance that there was a mechanism in place to track the detail in terms of the £19m spend; - The Regional Partnership Board (RPB) had committed expenditure which would have given them an overspend this financial year – conversations had been had with the two statutory partners in the Local Authorities, where it was asked as an absolute minimum for there to be no overspend against it; - There was an expectation of the RPB to identify a contribution to the Finance Recovery Plan of £0.5m – to achieve this saving, £1m was required to be identified from the programme. They were nowhere near this in terms of current spend, and the implications of this needed to be understood; - For every area of investment, they had a good system of tracking outcomes – some schemes were not delivering the value of money expected, and so it would form part of the upcoming conversations; The IM-F asked how confident they were that they would not overspend. The EDSP responded that they were very confident that there would not be an overspend, however they were less confident that they would be able to identify	

	savings from their current programme of work in line with what has been identified in the current financial recovery plan as things currently stand. Difficult conversations around initiatives would be required. **The Finance Committee noted:** a) The information on the Q1 report; and b) The partner-wide financial review of the RIF.	
FPC 23/09/011	**Decarbonisation Update** The ESIM shared a presentation with the Committee which summarised the three papers for the Decarbonisation Update. The EDSP commented that: - Conversations had been ongoing to bring work from the decarbonisation and financial agendas closer together (e.g. around Procurement); - Shared Services were looking at whether things could be sourced more locally, and were analysing company's manufacturing processes. However, it was acknowledged that it would be hard to use emissions as criteria when there was a lack of competition. **The Finance Committee noted that**: a) The Committee noted the three reports.	
FPC 23/09/012	**Operational Performance Report** The COO presented the Operational Performance Report and highlighted the following: - Urgent care – they had expected difficulties due to changes being made to their real estate in mid-July. They had started to see an improvement - ambulance handover performances and 4hr performances were better than anticipated, however 12hr trolley waits continued to be of concern. They hoped to soon see the benefits of the moves; - Planned Care – they were on track to deliver the 104-week plan by December. They had around 350 patients waiting over 3 years, and they were in the process of producing an ambitious trajectory to clear this. Diagnostic waits had increased, but the Regional Diagnostic Hub had been approved and they were waiting for a mobile solution as an interim solution to be implemented by the end of Q3/4, which would supply significant additional capacity for diagnostics; - Cancer – performance was steady at 65%. The backlog had increased, partly due to endoscopy delays. Therefore, they should soon start to see a reduction in the time for endoscopy on the cancer pathways. - Risks – risks included the potential strike action, and the published rate card for consultants pay which had resulted in some specialties stating that they were not prepared to do additional work; - CAMHS –performance for treatment was poor (0 patients were treated within 28 days) due to a large amount of capacity being moved into assessment to clear the backlog. They had a plan to achieve 65% of CAMHS patients starting their treatment within 28 days by the end of March. Assurance was provided that assessments had started within 28 days, and that the median wait for treatment was 35 days; - Dental Activity - they had around 50% of new patients being seen, they had a plan to get to 90% by the end of March. The UHB Chair asked for some assurance around the volatility of the cancer pathway. The COO responded that there would always be a bit of movement, but	

	that he understood the reasons behind the numbers. He did not accept that there were validation issues. **The Finance and Performance Committee resolved:** **a)** The Committee noted the year to date position against key organisational performance indicators for 2023-24 and the update against the Operational Plan programmes.	
FPC 23/09/013	**Winter Plan** The COO summarised that: - The plan worked in the currency of beds; - They hoped to use more of the money recurrently, and for a more programmed approach to Business As Usual (BAU) in the winter; - They needed to get to a position where they close capacity in the summer, and reopen in the winter; - Whilst there was a bit more physical capacity than the previous year, initiatives and programmes around efficiencies had started to be embedded which had helped to close the bed gap from around 150 to 90 beds; - Length of stay was not where it should be - the general rule of thumb should be that no more than 20% of the bed base should be occupied by patients waiting over 21 days (CAVUHB was around 32%), and no more than 40% of the bed base should be occupied by patients waiting over 7 days (CAVUHB was around 56%); - They had an opportunity to use money more recurrently with the space they created in the Emergency Units by moving out the assessment units, to put in place a Clinical Decision Unit. There were also plans with the Health Inclusion Service (CAVHIS), which would be brought to Board in November for an update; - If only 80% of the plan was delivered, then they should still be in a reasonably good position. The IM-F clarified that the £1.5m was in budget for this year. The EDF asked if they did not shut down the extra winter acute beds in the summer, whether this would stretch the £1.5m. The COO responded that the risk would lie with himself and the Ops team to deliver the plan, and that they needed to bring a more detailed benefits plan to the Investment Group to secure the investment. The COO noted that he had informed the EU that if they did not see the benefits of some of the programmes, some of the schemes could be reversed. **Action** – CP to take the benefits realisation piece through the Investment Group to decide as part of the Annual Plan. **The Finance and Performance Committee resolved that:** a) The Committee noted the UHB Winter Plan 23/24; b) The Committee recommended a revised approach to seasonal planning, including the recurrent allocation of the £1.5m winter reserve, to be taken to Board.	
	Items for Approval/Ratification	
FPC 23/09/014	**Interventional Radiology Case** This item was discussed during the Items for Review and Assurance section of the meeting, with the Item No: **FPC - 23/09/009**	

	The Finance and Performance Committee resolved that: a) The Committee noted the extract from the UHBs Monthly Financial Monitoring Return.	
	Items for Information and Noting	
FPC 23/09/015	**Monthly Monitoring Returns – Month 5** The Month 5 Monitoring Returns were received. **The Finance and Performance Committee resolved that:** a) The Committee noted the extract from the UHBs Monthly Financial Monitoring Return.	
FPC 23/09/016	**Any Other Business** No Other Business was discussed.	
	Review and Final Closure	
FPC 23/09/017	**Items to be referred to Board / Committee** **Action** – The UHB Chair asked if more time could be spent at Board on this item.	
	Date & time of next Meeting Wednesday 18th October 2023 at 2pm via MS Teams	

Public Action Log

Following Finance and Performance Committee Meeting
20 September 2023
(For the Meeting 18 October 2023)

Completed actions					
REF	**SUBJECT**	**AGREED ACTION**	**ACTIONED TO**	**DATE**	**STATUS/COMMENTS**
FPC 23/08/007	Savings Tracker	A detailed savings tracker would be brought to next month's committee meeting.	Andrew Gough	20 September 2023	**COMPLETED** On September agenda.
FPC 23/08/008	Dental performance	To provide robust data measuring dental performance.	Paul Bostock	20 September 2023	**COMPLETED** On September agenda.
FPC 23/08/008	CAHMS Trajectory	To provide an update on the CAHMS Trajectory.	Paul Bostock	20 September 2023	**COMPLETED** On September agenda.
Actions in progress					
REF	**SUBJECT**	**AGREED ACTION**	**ACTIONED TO**	**DATE**	**STATUS/COMMENTS**
FPC 23/09/13	Winter Plan	Benefits Realisation Piece through the IG to decide as part of the Annual Plan	Catherine Phillips	October 2023	To provide update via Action Log at October's Meeting
FPC 23/08/010	Mental Health Services	A benchmarking exercise to be	Paul Bostock	October 2023	On October agenda item 2.3

		completed since the Health Board were an outlier.			
Actions referred to Board/Committees					
AAC 4/7/23/009	Deep Dive Orthopedics Waiting Lists	Deep dive on how patients are managed whilst on the Orthopedics Waiting List.	Paul Bostock	20 September 2023	**COMPLETED** On September agenda.

Report Title:	Finance Report for the Period Ended 30th September 2023				Agenda Item no.	2.1
Meeting:	Finance Committee		Public	x	Meeting Date:	18th October 2023
			Private			
Status *(please tick one only):*	Assurance	X	Approval		Information	
Lead Executive:	**Executive Director of Finance**					
Report Author (Title):	**Deputy Director of Finance (Operational)**					

Main Report
Background and current situation:

Summary

At month 6, the UHB is reporting an overspend of £51.300m. This is comprised of £5.747m unidentified savings, £1.352m of operational overspend and the planned deficit of £44.200m (six twelfths of the annual planned deficit of £88.4m set out in 2023/24 financial plan).

Table 1: Month 5 Financial Position 2023/24

	Forecast Month 6 Position £m	Forecast Year-End Position £m
Planned deficit	44.200	88.400
Savings Programme	5.747	0.000
Operational position (Surplus) / Deficit	1.352	0.000
Financial Position £m (Surplus) / Deficit £m	**51.300**	**88.400**

Financial Plan Approved by Board and submitted to Welsh Government

- Brought forward underlying deficit of £40.3m
- Local Covid Consequential costs of £34.2m
- Additional energy costs of £11.5m
- 23/24 Demand and cost growth and unavoidable investments of £48.8m
- Allocations and inflationary uplifts of £14.4m
- A £32m (4%) Savings programme

This results in a 2023-24 planning deficit of £88.4m.

Core Financial Plan – Month 6 Position

The UHB is reporting a month 6 overspend of £51.300m. £44.200m of this being six months of the annual planned deficit. The is a £5.747m deficit on the Savings Programme, being six months of red schemes profiled into the position. There is also a £1.352m is an operational deficit in delegated and central positions.

Summary Financial Table

The following table analyses the £51.300m overspend at Month 6, between Income, Pay and Non Pay.

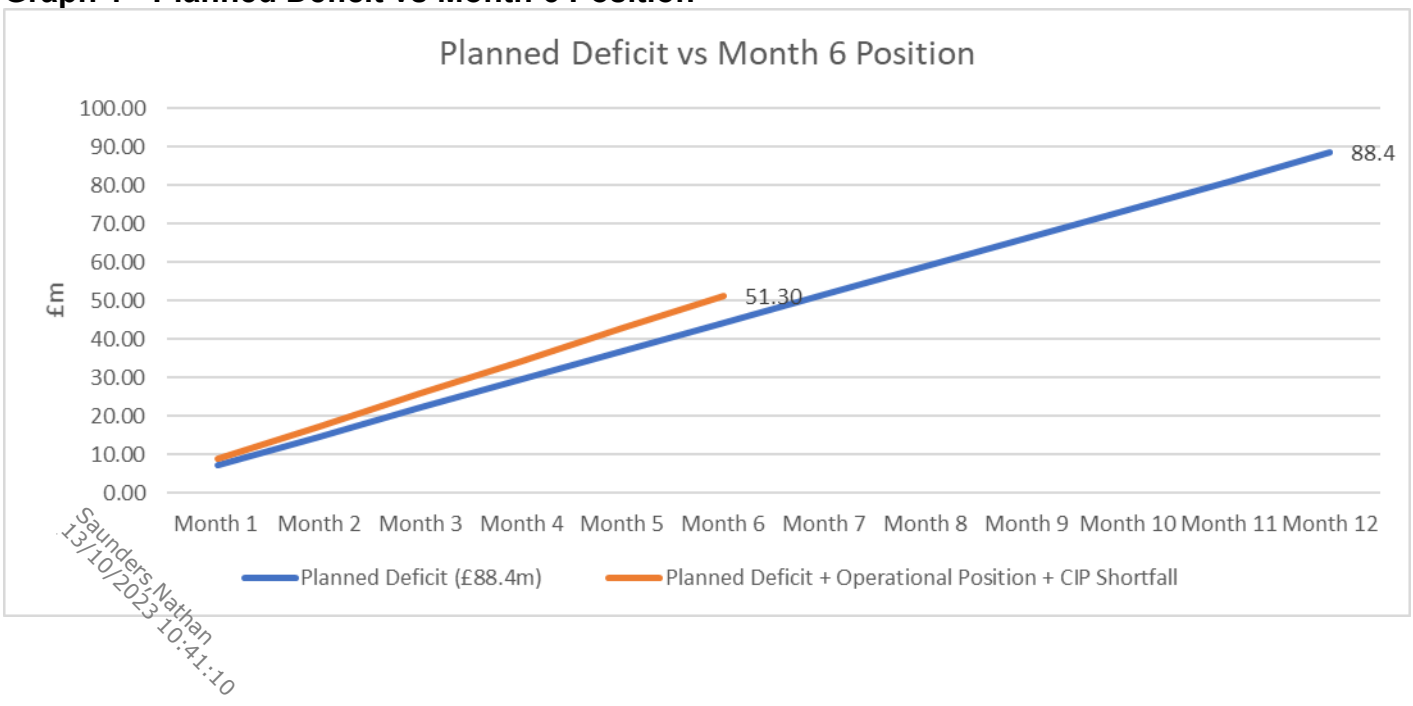
Table 2: Summary Financial Position for the period ended 30tf September 2023

Income/Pay/Non Pay	Memorandum Annual Budget £m	Current Period Actual £m	Operational Variance (Fav)/Adv £m
In Month			
Income	(1,604.993)	(148.360)	(0.925)
Pay	761.857	73.545	0.515
Non Pay	843.136	75.920	1.516
Sub Total £m	0.000	1.106	1.106
2023/24 Planned Deficit	88.400	7.367	7.367
Variance to Plan £m	88.400	8.472	8.472
Cumulative			
Income	(1,604.993)	(944.218)	(2.181)
Pay	761.857	455.487	(0.901)
Non Pay	843.136	495.830	10.182
Sub Total £m	0.000	7.100	7.100
2023/24 Planned Deficit	88.400	44.200	44.200
Variance to Plan £m	88.400	51.300	51.300

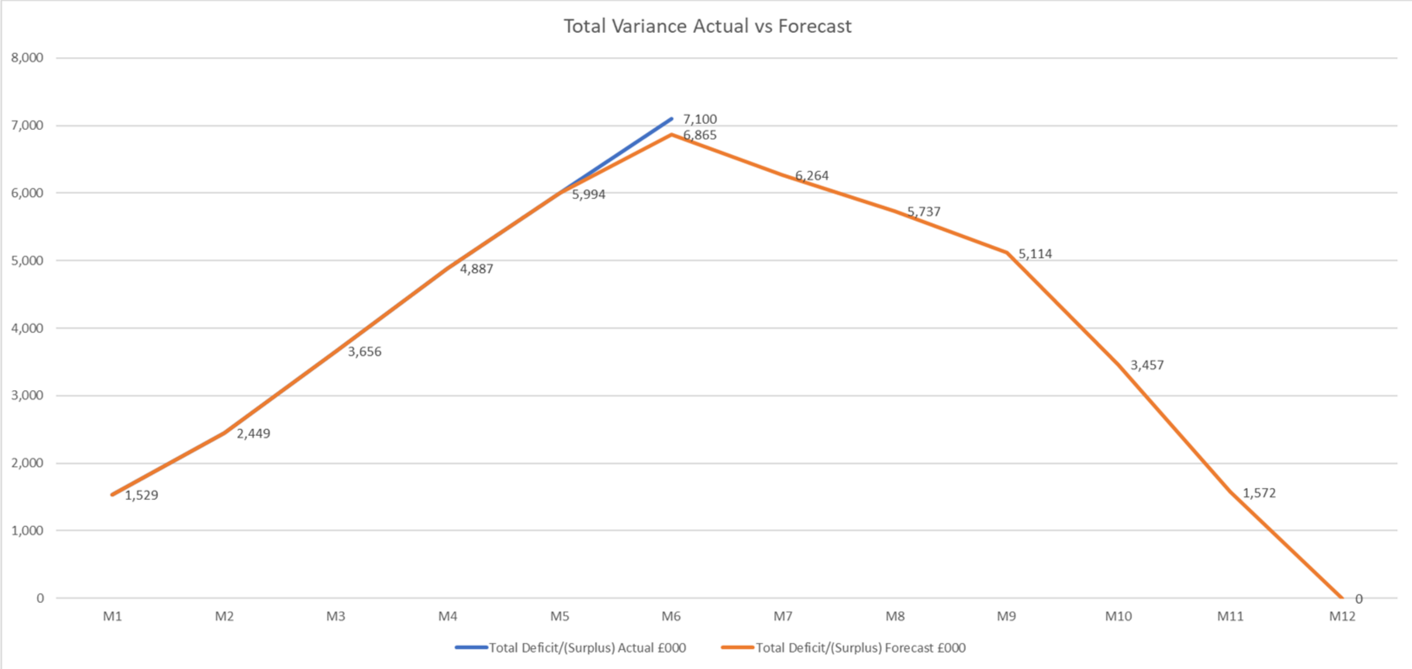
The in month adverse variance reported against pay and non pay is primarily driven by the gap against savings schemes.

Delivery of the forecast deficit of £88.4m will require continuing focus and downward pressure on the UHBs cost base, achievement of the full £32m savings programme and maintaining operational balance.

Graph 1 - Planned Deficit vs Month 6 Position



Graph 2– Total Variance Forecast



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Total Deficit/(Surplus) £000	**1,529**	**2,449**	**3,656**	**4,887**	**5,994**	**7,100**	**6,264**	**5,737**	**5,114**	**3,457**	**1,572**	0

Graph 2 shows the total operational and savings programme deficits and the profile of the additional savings actions on the total variance. If schemes deliver in line with this profile the reported deficit will peak at month 6 before turning the curve on a trajectory to hit the £88.4m planned deficit.

Financial Performance of Clinical Boards

Budgets were set in the anticipation that they were sufficient to deliver the UHB's plan. Financial performance for month 6 by Clinical Board is shown in Table 3.

Table 3: Financial Performance for the period ended 30th September 2023

Clinical Board Cumulative	Operational Position (Surplus) / Deficit Variance £m	Non Delivery of Savings Variance £m	Total (Surplus) / Deficit Variance £m	Prior Month (Surplus) / Deficit Variance £m
Clinical Diagnostics & Theraputics	(227)	565	337	584
Children & Women	230	252	482	548
Capital Estates and Facilities	294	851	1,144	1,023
Executives	(701)	122	(579)	(460)
Genomics	(20)	0	(20)	(20)
Medicine	522	1,689	2,211	1,472
Mental Health	459	422	881	938
PCIC	770	736	1,507	819
Specialist	881	681	1,561	1,276
Surgery	434	830	1,264	1,005
Sub-Total Delegated Position	**2,641**	**6,147**	**8,788**	**7,184**
Central Budgets	149	0	149	(702)
Commissioning	(1,438)	(400)	(1,838)	(488)
Cost Improvement Themes	0	0	0	0
Total (Surplus)/Deficit	**1,352**	**5,747**	**7,100**	**5,994**
Planned Deficit			44,200	36,833
Total Operational (Surplus)/Deficit	**1,352**	**5,747**	**51,300**	**42,827**

The operational deficit deteriorated in month from a £1.327m deficit at month 5 to a £1.352m cumulative operational deficit at month 6.

The UHB continues to face a significant challenge as it delivers services from an operational footprint that is still predominantly designed to address Covid demands and infection control.

In particular, the UHB experienced unprecedented demand for its Mental Health Services in the first half of the year when it was difficult to source appropriately trained and experienced staff. This has manifested itself by way of increased numbers of patients requiring inpatient care combined with longer lengths of stay. The Mental Health CB has worked to improve discharge and repatriate a number of the patients placed out of area and the actions taken have started to mitigate the pressures which have emerged.

Pressures against medical staff budgets continue across a number of Clinical areas and the UHB has reported a spike in the cost of medical staff in month.

The WHSCC provider position deteriorated in month, however this was in part offset by an improvement in the forecast commissioning position. This primarily impacts on paediatric and specialist services as a result of the stepped relationship between activity levels and the cost base. The UHB provider plan was based on the national Directors of Finance Agreement that allowed a level of contract under-performance to a 5% reflecting the ongoing restricted ability of post Covid service footprints to restore activity to full per Covid levels. During June and July WHSSC informed the UHB that it would no longer comply with the DoF agreed arrangements and expected full restoration of pre Covid levels of activity. This has the effect of redistributing resource from Cardiff and Vale UHB to other commissioning health boards in Wales and has had a £3m net impact on the UHB's contract income position after considering the Cardiff and Vale Commissioner benefits of the stance.

COVID 19 Expenditure

The expenditure for Month 6 is summarised in Table 4 below.

Table 4: Summary of Month 6 COVID 19 Net Expenditure

	Month 6 £m	Forecast £m	Funded by WG or Financial Plan £m	Variance to Plan/Funding £m
Health Protection	4.107	8.800	8.800	0.000
PPE	1.007	2.500	2.500	0.000
Long Covid	0.572	1.144	1.144	0.000
Nosocomial	0.260	0.520	0.520	0.000
Anti-Viral	0.050	0.100	0.100	0.000
Sub Total WG Funded Covid Expenditure £m	**5.996**	**13.064**	**13.064**	**0.000**
Included in Financial Plan - COVID Local Response	14.020	31.200	34.200	(3.000)
Total COVID Expenditure £m	20.016	44.264	47.264	(3.000)

Local Response expenditure is no longer funded by Welsh Government and as such is included within the UHB's Financial Plan.

The forecast cost at Month 6 is a reduction of £3.0m against the £34.2m included within the Financial Plan and is included within the UHB's savings plans.

Welsh Government is funding Health Protection, PPE, Long Covid, Nosocomial and Anti-Viral with expenditure forecast to meet funding anticipated.

Risks

Table 5 summarises the Finance Department's Risk Register. The key risk which feeds the UHB Corporate Risk Register is the failure of the UHB to deliver a breakeven position by 2023-24 year end with a current planned deficit of £88.4m.

Table 5: Risk Register at September 2023

	Risks	Rating	Comment
Key Corporate Risk	Approved Three year Financial plan (IMTP)	20	Due to a planned deficit of £88.4m for 2023/24 there is a risk of failure to achieve an Approved Three year Financial plan (IMTP) with potential for additional escalation and intervention arrangements following Enhanced Monitoring arrangements being imposed by Welsh Government.
	Revenue Funding Limit.	20	The UHB has submitted a £88.4m deficit plan and therefore will breach breakeven duty in 2023-24. There is a high risk that this will not be recovered in years two and three of the rolling performance measure.
	Remain within Cash Limit	10	The UHB has outlined the requirement for strategic cash and working capital support in 2023/24 to Welsh Government on a monthly basis through the MMR. The urgent requirement to confirm outstanding cash allocations and strategic cash assistance has now been escalated to the Deputy Director of Finance at Welsh Government NHS Finance
	Capital Funding - Three Year Rolling Breakeven Duty	12	The current 2022-23 UHB Capital Plan is structured to remain within the Capital Resource limit
Financial Performance	Failure to adequately manage budget pressures.	12	The 2022-23 Financial plan has funded 2022-23 out-turns in most delegated positions alongside the ability to call down appropriate and Covid consequential funding from dedicated UHB Reserves. This has reduced the risk of delegated positions overspending against core budgets . Monthly tripartite finance meetings are held between the COOs Office, Clinical Board Management teams and senior Finance Officers to monitor respective decisions and explore escalation actions where required. A number of additional actions are progressing to recover the month 6 operational & CRP overspend to enable the UHB to deliver the planned £88.4m deficit.
	Failure to deliver 2022-23 Savings Programme	16	At month 6 the UHB identified £36.046m schemes against the £32m savings target however £6.707m (19%) remain as red schemes. The ability to meet the UHB savings target for 2023-24 remains a major challenge that is being supported by escalation meetings with programme/theme leads and finance support teams.
	Management and reduction of COVID-19 Response costs WG indicated no funding will be provided for Local Covid Response costs, of which £34.2m is included in the financial plan.	16	Welsh Government confirmed that there will not be any Covid Response or Covid consequential cost funding in 2023-24 and consequently this has contributed to the 2023-24 planned deficit.
	2022-23 One Year LTA framework in NHS Wales	12	The 2023-24 all Wales LTA framework agreed an enhanced 5% tolerance for underperformance moving from 10% in 2022-23. This reflects the expectation that activity levels will continue to recover in 2023-24 and that the enhanced tolerance level should be reduced. During June and July WHSSC informed the UHB that it would no longer comply with the DoF agreed arrangements and expected full restoration of pre Covid levels of activity. This has the effect of redistributing resource from Cardiff and Vale UHB to other commissioning health boards in Wales. The WHSSC Joint Committee supported this position, despite its inconsistency with the DoFs agreement and the 2022-23 contracting arrangements. This has had a £3m net impact on the UHB's contract income position after considering the Cardiff and Vale Commissioner benefits of his stance

Savings Programme

At month 6, the UHB has identified £36.046m of green, amber and red savings against the £32m savings target, however £6.707m are classified as red schemes. The month 6 position includes a Savings Programme variance of £5.747m.

The month 6 Savings Programme deficit is expected to be recovered, supported by a number of additional actions as the year progresses, enabling the UHB to deliver its planned deficit position of £88.4m.

Executive Performance Reviews with the UHBs Clinical Boards are focussing on the management of operational pressures and progress in identifying and delivering recurrent savings schemes that in turn will de-risk the financial plan.

The following additional actions are progressing to recover the month 6 operational & CRP deficit to enable the UHB to deliver the planned £88.4m deficit:

Table 6: Additional Actions

Scheme	Theme	£000 Opportunity
Limit catalogue for non clinial non pay expenditure	Procurement	1,000
Eliminate non clinical agency with exception process	Workforce	1,000
Eliminate non clinical overtime	Workforce	1,000
Enhanced vacancy review through Vacancy Scrutiny Panel/Workforce reshaping	Workforce	2,240
Eliminate clinical agency with exception process	Workforce	5,390
Eliminate clinical overtime with exception process	Workforce	3,570
Waiting list initiative management following Health Board rate card	Workforce	1,120
Rationalise study leave to the minimum required to meet regulatory requirements	Workforce	700
Actions to Deliver Planned Deficit £88.4m		**16,020**

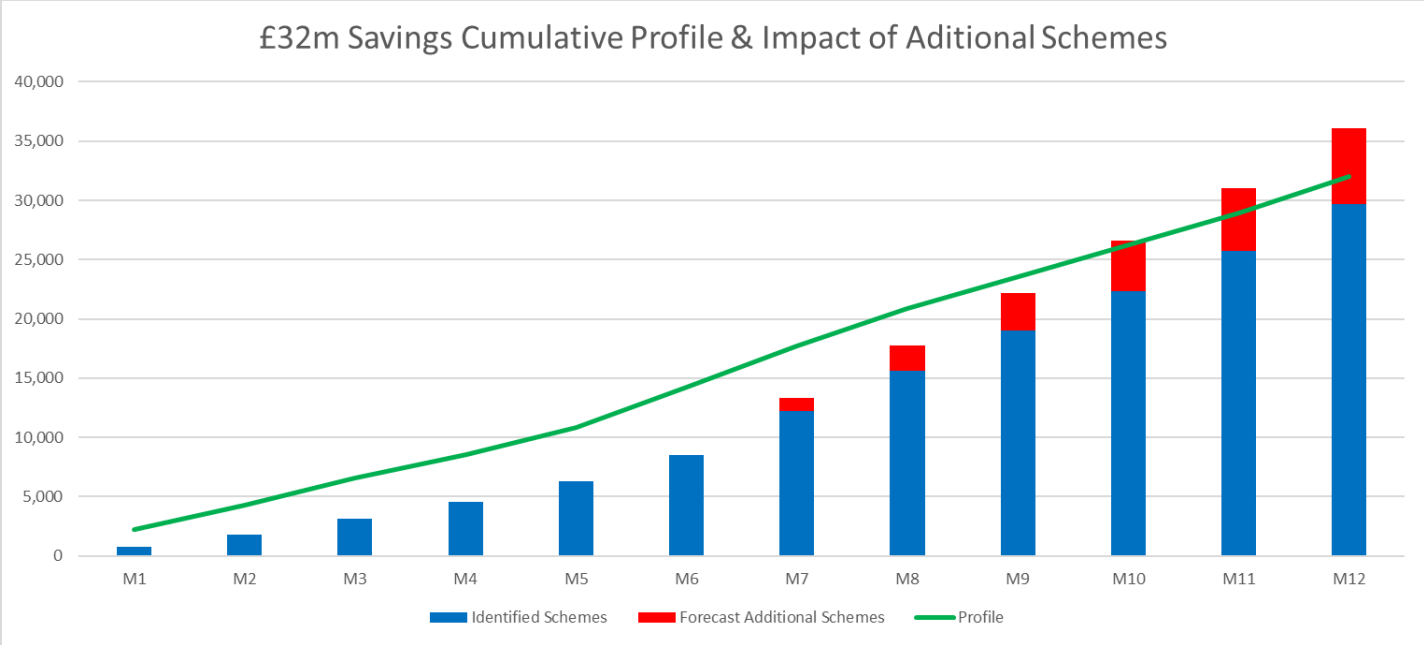
Reducing premium pay expenditure across all staff groups is a large component of the above, significant actions were taken during August to ensure the opportunities are realised. Nursing features heavily within these actions and as such have been allocated a target: a maximum of 25% of current agency and overtime used in QTR 1 can be used going forwards. If the registered nursing agency hours reduce and stay at the 25% limit, the UHB will realise £1m savings each month.

Weekly activity information is being captured and shared with the reduction in hours commencing at the end of August and expected to reduce towards the 25% limit into future months.

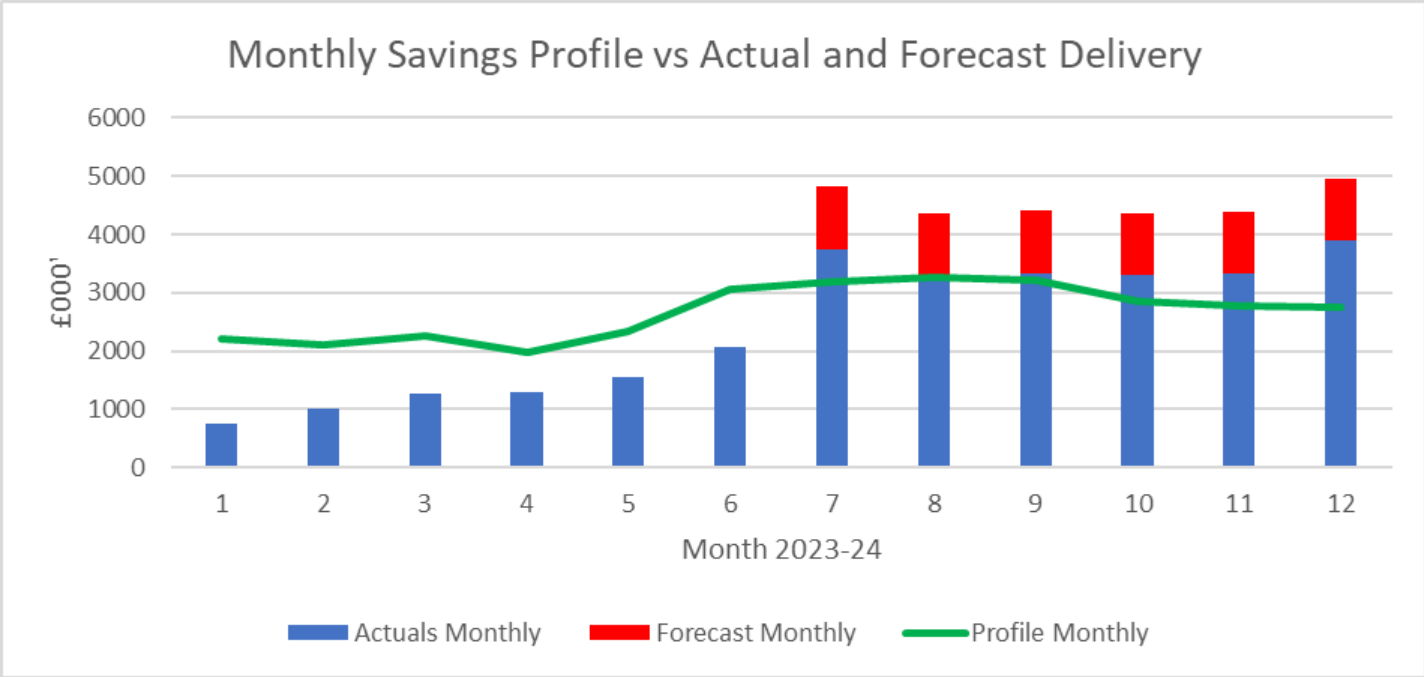
In addition to nursing improvements, the UHB has re-established the Corporate Vacancy Scrutiny Panel to provide additional scrutiny on all new posts, all non-patient facing replacement posts and replacement clinical posts band 7 and above. The impact of the panel after ten weeks is a saving of £0.614m.

In addition to the risk of non-delivery of savings, Graph 3 shows the cumulative forecast impact of the additional actions and Graph 4 shows the monthly impact. A number of the additional actions are still in red and progress is being closely monitored through the Sustainability Board. It is vital that these schemes progress to amber and green to gain further assurance of delivery.

Graph 3 – Profile of Savings Delivery



Graph 4 – Monthly Profile of Savings Delivery



The progress of reducing risk via identification of schemes can be found in Graph 5.

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Graph 5 – Progress of Identification of Schemes

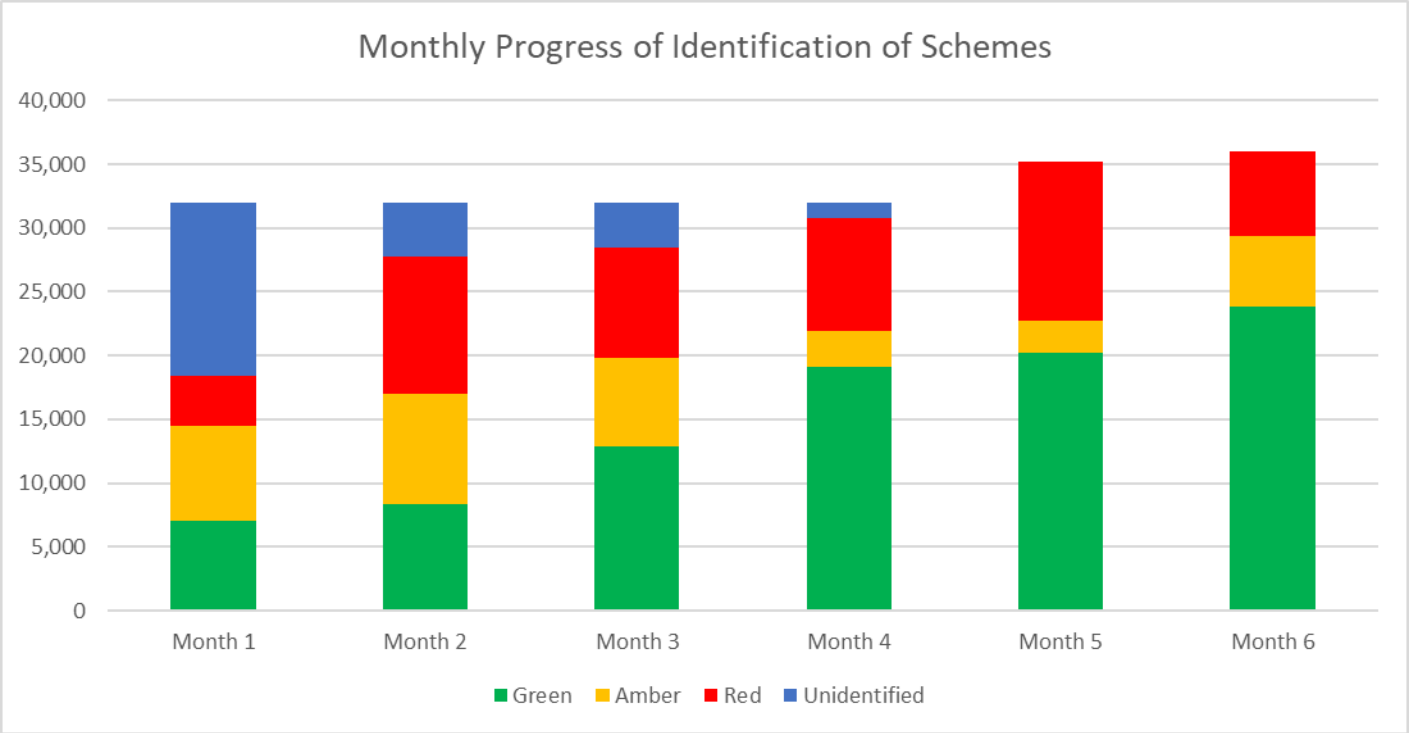


Table 7: Forecast Additional Savings

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Profile	2,205	4,318	6,568	8,536	10,881	14,222	17,722	20,896	23,600	26,261	28,943	32,000
Identified Schemes	754	1,784	3,113	4,522	6,274	8,475	12,250	15,601	18,994	22,350	25,726	29,665
Forecast Additional Schemes	0	0	0	0	0	0	1,064	2,127	3,191	4,254	5,318	6,381
Savings Shortfall/ (Surplus)	**1,451**	**2,534**	**3,455**	**4,014**	**4,607**	**5,747**	**4,408**	**3,168**	**1,415**	**(343)**	**(2,100)**	**(4,046)**
Operational Deficit/(Surplus)	83	(75)	171	832	1,327	1,352	1,855	2,570	3,699	3,800	3,672	4,046
Total Deficit/(Surplus)	**1,534**	**2,459**	**3,626**	**4,846**	**5,934**	**7,100**	**6,264**	**5,737**	**5,114**	**3,457**	**1,572**	**(0)**

Table 7 shows the current cumulative profile of identified and red schemes up to the savings target of £32m. The impact of successfully delivering the agreed £16m additional actions would meet the £32m target in month 10 and allow additional savings of £4.046m to address the operational deficit to deliver a breakeven position.

Overall progress in the identification of savings schemes is outlined in table 8 below:

Table 8: Savings Schemes

2023-24 Savings Summary

2023-24 in-year plans

Clinical/Service Board	23-24 Target £'000	Green £'000	Amber £'000	Red £'000	Total Savings Identified £'000	Savings Shortfall £'000
Capital Estates and Facilities	631	666	0	3	669	-38
Children and Women	869	779	90	0	869	0
Clinical Diagnostics and Therapeutics	799	800	0	0	800	-1
Corporate Executives	334	325	0	0	325	9
Medicine	919	919	0	0	919	0
Mental Health	719	720	0	0	720	-1
Primary, Community and Intermediate Care	1,615	1,759	0	0	1,759	-144
Specialist Services	988	986	0	0	986	2
Surgical Services	1,126	927	170	0	1,097	29
Subtotal - Grip and Control	**8,000**	**7,881**	**260**	**3**	**8,144**	**-144**
Length of Stay	3,000	1,101	0	420	1,521	1,479
Theatres Productivity	500	203	48	186	437	63
Income Generation	500	200	0	200	400	100
Medicines Management	2,000	1,691	0	0	1,691	309
Continuing Healthcare	1,500	0	313	0	313	1,187
Facilities and Estates	500	635	0	0	635	-135
Procurement	5,000	1,622	1,377	906	3,906	1,094
Workforce Efficiencies	8,000	4,940	3,488	3,572	12,000	-4,000
COVID Consequentials	3,000	3,000	0	250	3,250	-250
Review of Investments		0	0	0	0	0
Commissioning		79	0	1,170	1,249	-1,249
Non-Recurrent Opportunities		2,500	0	0	2,500	-2,500
Subtotal Cost Improvement Themes	**24,000**	**15,972**	**5,226**	**6,704**	**27,902**	**-3,902**
Total Savings Position	**32,000**	**23,853**	**5,486**	**6,707**	**36,046**	**-4,046**

Cash Flow Forecast

The cash balance at the end of September was £4.998m with a forecast deficit of £100.888m at year end pending confirmation of cash support.

A detailed monthly cashflow forecast is included in the monthly monitoring return submission to Welsh Government.

The UHB is preparing an accountable officer's letter to formally request strategic cash assistance in line with the forecast outturn that has been maintained by the UHB since the beginning of the financial year. In addition, the UHB has asked for urgent confirmation and action of outstanding cash allocations outlined in the Monthly Monitoring return to Welsh Government since the beginning of the year.

Due to the significant requirement for strategic cash support in 2023/24, combined with the timing of pay award cash flows and the level of outstanding allocation, the UHB will review the schedule of payments to suppliers from November 2023 onwards if additional cash support in not confirmed. This will impact the Public sector Payment Policy (PSPP) performance and from December onwards the UHBs cashflow will be severely impaired.

The combination of strategic cash support and outstanding allocations not confirmed is circa £175m.

The UHB's working cash assumption for 2023-24 assumes Welsh Government cover for the forecast deficit and movements in working cash as described below:

- Strategic Cash support for the £88.4m deficit of the UHB 2023-24 Financial Plan. Health Boards are required to submit an Accountable Officer letter (once requirements are established) in support of a request for Strategic Cash Support. In this context, the UHB is seeking approval for its application to Welsh Government for Strategic Cash Support in support of its 2023/24 forecast deficit at its Finance Committee of the 18th October and its Board meeting of 26th October. Given the significant level of strategic cash support the UHB requires confirmation of the associated cash cover in advance of March 2024.

- £12.488m of resource cover provided in 2022-23 where additional cash cover was not provided because of the proximity to year end . This includes the additional 1.5% consolidated pay award (£11.8m) for which Resource cover was received from Welsh Government in 2022-23 but has been paid out in 2023-24 and requires cash support.

- Movements in Revenue and Capital working capital from the 2022-23 Balance Sheet including circa £7m of capital payments relating to 2022/23 where the cash was paid to suppliers in 2023/24. This will continue to be assessed as the year progresses.

- In addition to the UHBs strategic and working cash requirements there are a significant amount of anticipated allocations as per the table below, (circa 74m including £44m of pay increase funding) which are yet to be confirmed. The UHB is not able to draw down the associated cash until these allocations are confirmed and this in turn is expected to impact on the UHBs scheduling of payments from month 8 onwards whilst confirmation of the allocations remain outstanding and additional cash support remain outstanding.

Table9 - Outstanding Cash Limit Allocations @ Month 6

Description	Amount £
Consolidated Pay Uplift 2023_24 5% AFC	**32,000**
2022_23 Consolidated Award 1.5%	**11,505**
COVID-19 TTP,PPE & Vaccinations	**10,337**
Planned Care Funding South West Region	**6,400**
Inflation - RLW 22/23 & 23/24	**7,311**
Six Goals for Urgent and Emergency Care Programme	**2,960**
Digital Priorities Investment Fund for AWIP	**1,600**
Clinical Excellence/Distinction Awards	**1,497**
Welsh Government Funded New Medical Posts _ 6691	**1,313**
GP IM&T Refresh Programme and Maintenance	**1,225**
Other Allocations (includes (£3.036) deduction for IFRS12 leases and (£3.823) deduction for Welsh Risk Pool)	**(2,158)**
Total Unconfirmed Cash Limit Allocations as at Month 6 £'000s	**73,990**

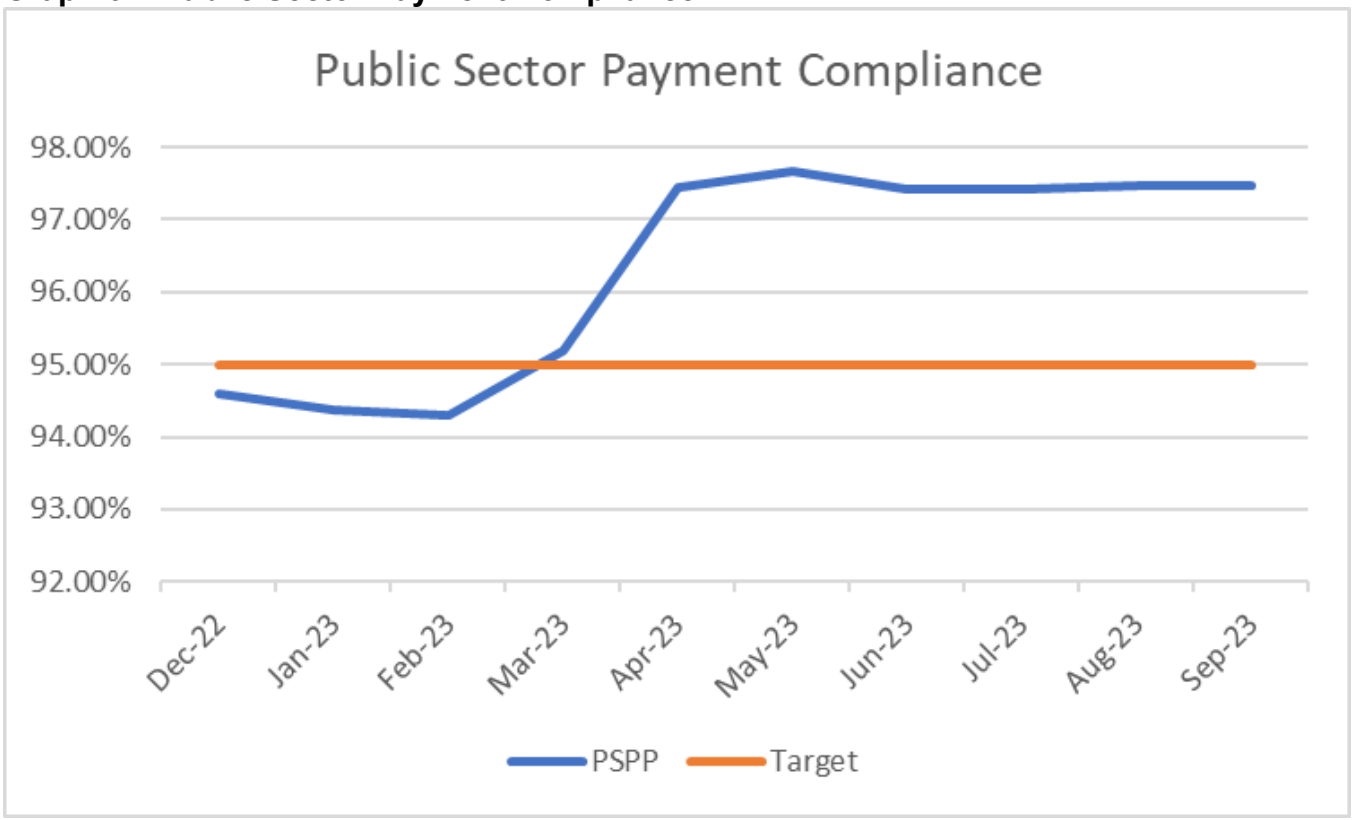
The cashflow is included in Table G of the Monthly Monitoring Returns which is provided to the Finance Committee each month.

Welsh Government have been engaged in a review of public sector finances since summer 2023, in light of the challenging financial environment. The Minister for Health is due to make an announcement concerning heath finances on Tuesday 17th October. The UHB does not know the details of this announcement and anticipates that it will provide greater clarity for the financial targets to be met by the end of 2023/24 and allow confirmation of the cash support available. Following this announcement, the UHB will re-assess the risks concerning cashflow management in this financial year.

Public Sector Payment Compliance

The UHB's public sector payment compliance performance is above the target of 95%. Performance for the month to the end of September was 97.48% and improvements are illustrated in Graph 6 below.

Graph 6 – Public Sector Payment Compliance



Work is ongoing with departments within the UHB, including training, to address the level of orders not receipted, and the high number of workforce and nursing holds, which should improve the UHB's position.

Capital

Of the UHB's approved Capital Resource Limit, 20% has been expended to date.

One capital scheme is currently classified as medium risk:

- Genomics - forecasting a potential £1.041m overspend. This is to be managed through the discretionary programme. The overspend is due to a number of factors including inflation, IT spec and the rerouting of drainage.

Eye Care – discussions are ongoing with DCHW in relation to the transfer of this service from C&V.

Neuroradiology Equipment at University Hospital of Wales – The project is currently being reviewed to confirm what is deliverable in 2023/24

All other schemes are currently in line with the annual forecast. UHL infrastructure, Endoscopy, Genomics and Park View are all slightly behind plan year to date however these are currently still expected to deliver in 2023/24.

Planned expenditure for the year reflects the CRL received from Welsh Government dated 1st September 2023 - £29.644m.

Table 10: Finance - Key Performance Indicator Dashboard at September 2023

	STATUS REPORT				
Measure	**September 2023**	**RAG Rating**	**Latest Trend**	**Target**	**Time Period**
Deliver 2023/24 Draft Financial Plan	£51.300m deficit at month 6. £44.200m planned deficit, £5.747m savings gap and £1.352m operational deficit.	R	↓	Deliver 2023/24 £88.4m Planned Deficit	M6 2023-24
Remain within capital resource limits.	The UHB expects to remain within it's Capital Resource Limit which was £29.644m at month 6	G	⊖	Remain within approved planned expenditure	M6 2023-24
Delivery of recurrent £32m savings target	£36.046m Green, Amber and Red schemes identified at month 6 of which £18.692m were recurrent.	R	↑	£32m	M6 2023-24
Creditor payments compliance 30 day Non NHS	97.48% at the end of September	G	⊖	95% of invoices paid within 30 days	M6 2023-24
Remain within Cash Limit	The UHB's working and strategic cash requirement requirement has been highlighted monthly to Welsh Government and a formal request is now subject to Board approval	A	⊖	To remain within Cash Limit	M6 2023-24
Maintain Positive Cash Balance	Cash balance = £4.998m	G	⊖	To Maintain Positive Cash Balance	End of Sept 2023

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The Financial Plan includes an annual forecast deficit of £88.4m.

Delivery of the core financial plan includes a 4% (£32.0m) recurrent savings requirement. At Month 6 £36.046m of savings were identified, representing 113% of the target.

The UHB also needs to manage its operational position and mitigate any emerging pressures as its Covid response costs are collapsed. The operational overspend is £1.352m in month 6. Enhanced monitoring is in-place for both operational positions and to further progress the gap in the Savings Programme. Alongside this, further additional actions are progressing to recover the month 6 operational & savings deficits.

In addition, the UHB increasingly requires confirmation of strategic cash support and outstanding allocations to maintain its cash position and PSPP performance.

Recommendation:

At Month 6 the Committee are requested to:

- **NOTE** the reported year to date overspend of £51.300m and the forecast deficit of £88.400m.
- **NOTE** the financial impact of forecast COVID 19 costs which is assessed at £44.264m.
- **NOTE** the month 6 operational overspend against plan of £1.352m
- **NOTE** the progress against the savings target, with £36.046m (113%) of schemes identified at Month 6 against the £32m target.
- **NOTE** the request to Finance Committee for recommendation to Board for approval of the UHBs application to Welsh Government for Strategic Cash Support in support of its 2023/24 forecast deficit.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please tick as relevant*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant*									
Prevention		Long term	x	Integration		Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: Yes
No
Safety: Yes/No
No
Financial: Yes
As detailed in the report.
Workforce: Yes/No
No
Legal: Yes/No
No
Reputational: Yes/No
Yes, if forecast financial position is not delivered.
Socio Economic: Yes/No

No	
Equality and Health: Yes/No	
No	
Decarbonisation: Yes/No	
No	
Approval/Scrutiny Route:	
Finance Committee	Date: 18th October 2023

Report Title:	**2023-24 Strategic Cash Request Submission**				Agenda Item no.	2.2	
Meeting:	**Finance Committee**		Public	X	Meeting Date:	**18th October 2023**	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	**Executive Director of Finance**						
Report Author (Title):	**Deputy Director of Finance**						

Main Report
Background and current situation:

SITUATION

Technical UPDATE NOTE – 1 (2022-23) issued by the Finance Directorate, Health and Social Services Group, Welsh Government on the 8th November 2022 confirmed that the cash implications of the UHBs operational deficit are a separate issue to the annual movement of working balances cash exercise. In lieu of further direction, the guidance continues to apply.

Health Boards are required to submit an Accountable Officer letter (once requirements are established) in support of a request for Strategic Cash Support.

The following application requirements are in place for Strategic Cash Support to ensure appropriate oversight from LHB Boards:

- All applications for Strategic Cash Support are required to be made to the Chief Executive NHS Wales
- All applications are to be approved by the Board prior to submission, including consideration of the cumulative cash support position of the LHB and the actions management are taking to mitigate the cash support requirement;
- All applications to be made by the Accountable Officer of the LHB.

Welsh Government is expected to confirm that application requests should be submitted by close of play Monday 20th November.

The UHB has highlighted its 2023/24 year end cash deficit arising from its forecast deficit within the monthly monitoring return provided to Welsh Government on a monthly basis. The UHB intends to submit a formal request for strategic cash support in line with its forecast deficit through an Accountable Officer Letter in line with the Welsh Government timetable. At month 6, the UHB reported a forecast deficit of £88.4m, subject to the management of a number of risks and progress of additional remedial actions to recover the year to date operational & CRP deficit.

In addition to the Strategic Cash Support required in respect of the UHB's forecast 2023/24 deficit, the UHB identified an estimated Revenue working cash balance requirement of £12.487m to Welsh Government within the September 2023 Monitoring Return. This is comprised of £11.781m of payments in respect of the 2022/23 1.5% Consolidated Pay Increase which was paid in 20223/24 and a further £0.706m in respect of 2022/23 Welsh Government funding confirmed in April 2023, which was not backed by cash as confirmation was received after the end of the financial year.

In addition, work is ongoing to assess any working capital requirement in respect of Capital expenditure.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The UHB request for Strategic Cash Support in 2023/24 will be consistent with the forecast deficit reported through the UHBs Finance Committee.

Recommendation:

The Board / Committee are requested to:

Note the UHBs working cash balance requirement of £12.487m identified in the September 2023 Welsh Government Monitoring return.

Note the ongoing work to assess any requirement working cash associated with the UHBs Capital expenditure programme.

Recommend to that UHB's Board approves the UHB's application to Welsh Government for Strategic Cash Support in support of its 2023/24 forecast deficit.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term	x	Integration		Collaboration		Involvement	

Impact Assessment:

Please state yes or no for each category. If yes please provide further details.

Risk: No

Safety: No

Financial: Yes

As detailed above.

Workforce: No

Legal: No

Reputational: Yes

Yes, if forecast financial position is not delivered.

Socio Economic: No	
Equality and Health: No	
Decarbonisation: No	
Approval/Scrutiny Route:	
Finance Committee	Date: 18th October 2023

Report Title:	Operational Performance Report			Agenda Item no.	2.3
Meeting:	Finance and Performance Committee	Public	✔	Meeting Date:	18/10/2023
		Private			
Status *(please tick one only):*	Assurance	✔	Approval	Information	
Lead Executive:	Chief Operating Officer				
Report Author (Title):	Head of Performance				

Main Report
Background and current situation:

Background and current situation:

The Operations and Information Teams have redesigned the Integrated Performance Report to better meet the requirements of the Board, it's Committees and improve performance reporting for the Health Board as a whole, both internally and externally. This updated report incorporates progress against the ministerial priorities and our performance ambitions/IMTP priorities. It will also include performance against the NHS Performance Framework, which was finalised in June 2023

The sections of the full report covering Operation Performance, which are pertinent to the Finance and Performance Committee are:
Section 1: Ministerial Priorities
Section 2: Quadruple Aim 2

This report is intended to be iterative and feedback from the Committee will be useful as we develop this resource.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The enclosed performance report details the Health Board's performance against the Ministerial priorities, Health Board commitments from our IMTP and the wider NHS Wales Performance Framework.

We continue to see a high level of demand for our urgent and emergency care services. Despite this we have seen performance improvement in areas we have given operational focus. The focussed work on ambulance handovers through this year has led to significant reductions in the number of patients waiting more than 1 hour on an ambulance outside our Emergency Department, in addition to an overall reduction in the average handover time, surpassing our commitments.

September has seen an improvement from August across our suite of EU metrics: however, one hour ambulance handover breaches have increased, in addition to our average handover time. Nevertheless, our ambulance performance remains in excess of our IMTP commitments and continues to show a considerable improvement from our historic performance.

The number of patients waiting 12 and 24 hours in our Emergency Department reduced during September. The improvements resulting from the significant number of ward moves and redesign of our ED/AU footprint in July are taking time to fully imbed and will have impacted our performance, we continue to analyse breaches to better understand and improve our flow processes.

Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown some improvement. However, the improvements are not necessarily reflected by the annualised KPI metrics. Rapid fracture pathway improvements have led to a significant reduction in the median time taken for patients to get to the ward and continued improvement in the door to ward

and prompt surgery performance for July. Compliance with the KPI for Prompt Surgery improved in July and our performance remains above the NHFD average.

August saw an improvement in our compliance against the SSNAP measures for our Stroke Pathway. The percentage of patients directly admitted to the stroke unit within 4-hours increased to 64.8% and remains significantly above the all Wales average. Our percentage compliance and median time to ward and CT scan remains improved from our performance in 2022 and we continue to work across Clinical Boards to progress the Stroke Service Improvement Plan. Our SSNAP grade has improved to B for the period April-June 2023, this is a significant 8-point improvement from the previous quarter and a reflection of the work undertaken by the teams. We continue to experience challenges in increasing the number of patients thrombolysed and this remains an area of continued focus, working with colleagues from the NHS Executive.

In terms of our compliance with the 62-day single cancer pathway standard, whilst we did not deliver the 75% standard as we had originally intended, our performance in July increased to 65.6% and has remained above 60% since February this year. A separate paper on Cancer has been submitted to the Committee this month.

The numbers of patients waiting on an RTT waiting list has increased this month. We continue to focus on long-waiting cohorts and Cancer pathways with weekly scrutiny against the national standards and ministerial ambitions. We remain on track to deliver our commitments to eliminate 3-year Outpatient waits, and reduce our 3- and 2-year treatments waits in line with Ministerial ambitions.

We are currently over our trajectory to deliver our commitment on 52-week outpatient waits. While we have made progress in reducing the cohort of patients who will breach by March 2024 the number of in month breaches remains above our ambition. Our work to eliminate 3- year outpatient waits and reduce the number of 2-year waits has improved outpatient waiting times, but we continue to see high volumes of 52-week outpatient waits within some of our treatment specialties where we are focusing on reducing long waits across the pathway. We continue to address outpatient waits through activity, validation and pathway redesign to ensure only those who need secondary care intervention are referred. This is not a UHB wide issue and we are working with specialties, particularly in Paediatrics and Medicine, to reduce to or maintain their outpatient waits below 52 weeks.

We have seen a reduction in the number of 100% delayed follow-up outpatient appointments in recent months, however, the number of delays is still higher that our ambition. Clinical Boards have developed action plans to reduce these numbers with specific focus on the longest delays. We continue to validate the waiting lists and work is ongoing to refine our patient management systems to improve data quality of follow-up outpatient lists. The use of See on Symptoms (SOS) and Patient Initiated Follow-up (PIFU) pathways is an important tool in the management of follow-up services and we continue to develop their use across our services.

The waiting list position for Diagnostics has deteriorated in recent months, with particular challenges in Radiology and Endoscopy. It is hoped that the upcoming development of a Community Diagnostic Hub, and interim use of mobile facilities will address radiological backlogs. Endoscopy capacity has been focused on Cancer, Urgent and long waiting surveillance patients. The service have an improvement plan, with additional theatre and insourcing capacity, aligned to a longer term workforce plan to further address the deterioration in the length of wait.

In October the UHB is undertaking a deep dive into the provision of General Dental Services with Cardiff and the Vale. Dental services are going through a period of reform as Welsh Government assess the impact of contract reforms on the provision of services and access to primary care dentistry. A report will be brought to a future Committee meeting for discussion.

Demand for adult and children's Mental Health services remains significantly above pre-Covid levels, including an increased presentation of patients with complex mental health and behavioral needs. Part 1a compliance for adults fell to below 50% in April following an exceptionally high number of referrals

in March. However, the teams have managed to recover their waiting list position and June's reported compliance with the 28-day standard returned to 100%, remained high in July at 99.8% and was 100% in August. Part 2 compliance remains challenged, an improvement trajectory has been shared with NHS Executive colleagues, with Part 1 service developments supporting improvements to Part 2 compliance.

As previously noted, we have made changes to the Emergency Unit and Assessment Unit areas as described in July's paper. We anticipated that this would impact our EU attendance and 4-hour performance, beginning in July, will full month effect from August's data. This has been evidenced in the August and September data with reported attendances and 4-hour compliance reduced from May, June and July. Welsh Government have been notified of the changes and our teams are working to ensure these changes will help to better align our reporting with ongoing national proposals. Cardiff and Vale have been asked to lead an All Wales task and finish group to explore how we capture and report activity from an emergency and urgent perspective nationally. The changes developed will part of the Welsh Emergency Care Data Set (WECDS) development which will replace EDDS. The Health Board are meeting with the Delivery Unit regularly to develop a dataset as an exemplar in Wales. The aim is that this will be adopted across the whole of Wales to ensure we can compare services in an equitable and fair way.

Recommendation:

The Finance and Performance Committee is asked to **NOTE** the year to date position against key organisational performance indicators for 2023-24 and the update against the Operational Plan programmes.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	✔
2. Deliver outcomes that matter to people	✔	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✔
4. Offer services that deliver the population health our citizens are entitled to expect	✔	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	✔	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term	✔	Integration	✔	Collaboration		Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: No

Saunders Nathan 13/10/2023 10:41:10

Safety: No

Financial: No

Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
13/10/2023 10:41:10

Cardiff and Vale
Integrated Performance Report

October 2023

Report Contents

Click on a hyperlink to navigate directly to the section required

Section 1: Ministerial Priorities

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The Minister for Health and Social Services has set out 6 priority areas to help address the immediate pressures and help to build a sustainable health and care service over the next year.

Section 1 provides an overview of the Health Boards performance in relation to the 16 measures that are included within these 6 priority areas. As many of the measures are not specific, detail is provided on the specific measurement(s) that has been used to monitor compliance.

For a more in depth view on performance for each priority, please follow the links in the NHS Performance Framework column.

Priority	Aim	C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment	Link in Performance Report
Delayed Transfers of Care	**Reduction in backlog of delayed transfers** Measure: number of delayed transfers of care. Reporting period: monthly	217	Yes	June 2023	173 September	Hyperlink to section
Primary Care Access to Services	**Improved access to GP and Community Services** Measure: >95% achievement of core access to in-hours GMS Services Reporting: monthly	95%	Yes	June 2023	98% June	Hyperlink to section
	Increased access to dental services Measure: 50% of expected new patient target Reporting: monthly	50%	Yes	June 2023	99.8% September	Hyperlink to section
	Improved use of community pharmacy Measure: >90% of all eligible community pharmacies providing CCPS (June 2023) Reporting: monthly	90%	Yes	June 2023	98% June	Hyperlink to section
	Improved use of optometry services Measure: Reduce number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services Reporting: monthly	877	Yes	Dec 2023	840 September	Hyperlink to section
Urgent and Emergency Care	**Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales** Measure: Performance response time in NHS 111 Reporting: TBC	tbc	tbc	June 2023	tbc	Hyperlink to section
	Implementation of Same Day Emergency Care services Measure: Increase in SDEC attendances Reporting: monthly	1233	Yes	June 2023	1850 August	Hyperlink to section
	Honour commitments that have been made to reduce handover waits Measure: Eliminate 4 hour ambulance handover delays Reporting: monthly	0	Yes	June 2023	0 September	Hyperlink to section

Performance Key: Meeting standard / trajectory | over target/trajectory

Section 1: Ministerial Priorities

Performance Key: Meeting standard / trajectory | over target/trajectory

Return to Main Menu

Priority	Aim		C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment	Link Performance Report
Planned Care, Recovery, Diagnostics and Pathways of Care	**Achieve RTT waiting time targets** Measure 1: 52 week new outpatient target by March 2024 Reporting: monthly		8999	No	Mar 2024	11230 August	Hyperlink to section
	Measure 2: 104 week treatment target by December 2023 Reporting: monthly		3788	Yes	Dec 2023	4085 August	Hyperlink to section
	Set foundations for achieving waiting list targets Measure: Reduce outpatient overdue follow by 25% against 2019/20 levels Reporting: monthly		37623	Yes	Mar 2024	44993 August	Hyperlink to section
	Implement regional diagnostic hubs Measure 1: progress reporting on regional diagnostic hub Reporting: quarterly		Go-Live	Yes	Sept 2024	On track	Hyperlink to section
	Measure 2: Achieve 8-week diagnostic Reporting: monthly		0	No	June 2025	11415 August	Hyperlink to section
	Implement straight to test model Measure: progress reporting on straight to test Reporting: quarterly		Go-Live	Yes	Sept 2024	On track	Hyperlink to section
Cancer	**Achieve SCP target** Measure: 75% of patients starting their first definitive cancer treatment within 62 days Reporting: monthly		75%	Yes	June 2024	65.6% July	Hyperlink to section
	Implement the national cancer pathways within the national target Measure: progress reporting on national cancer pathways Reporting: quarterly		Go-Live	Yes	Sept 2024	On track	Hyperlink to section
Mental Health and CAMHS	**Achieve waiting wait performance for Local Primary Mental Health Support Services and Specialist CAMHS** Reporting (for all): monthly	Measure 1: Part 1a (adults)	80%	Yes	June 2024	100% August	Hyperlink to section
		Measure 2: Part 1b (adults)	80%	Yes	June 2024	100% August	
		Measure 3: Part 2 (adults)	80%	Yes	June 2024	45.7% Aug	
		Measure 4: Part 1a (children)	80%	Yes	June 2024	84% July	
		Measure 5: Part 1b (children)	80%	Yes	June 2024	0% August	
		Measure 6: Part 2 (children)	80%	Yes	June 2024	76.6% Aug	
	Implement 111 press 2 on a 24/7 Measure: progress on implementing NHS 111 press 2 Reporting: quarterly		Go-Live	Yes	Sept' 2024	Delivered	Hyperlink to section

Section 2: Cardiff and Vale Performance Report

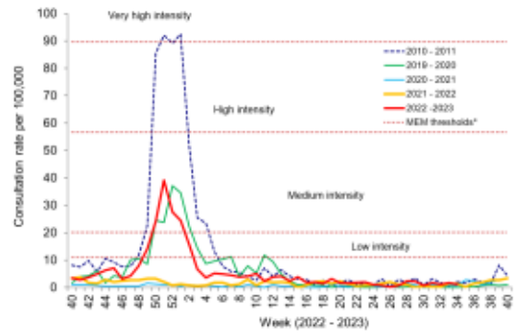
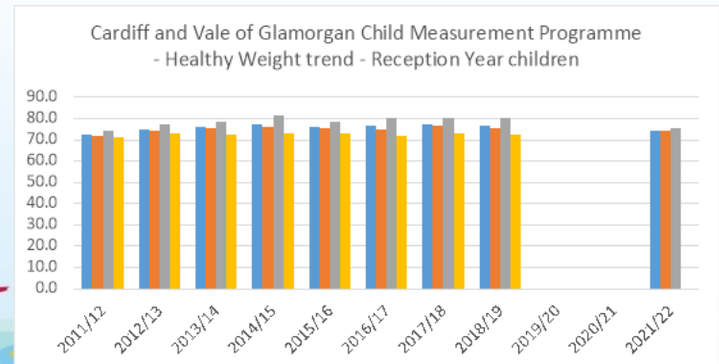
The Performance Report section provides detail of UHB performance across the quadruple aims.

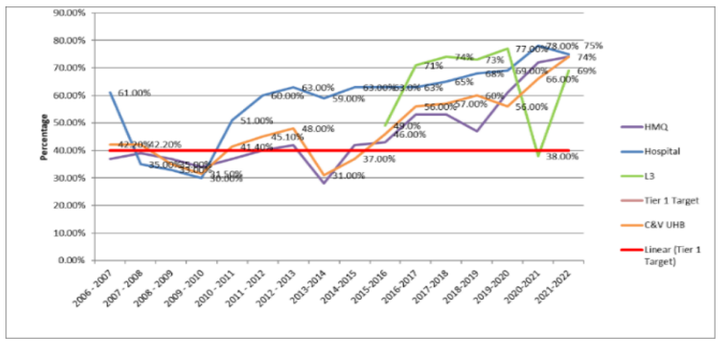
Detail on what is included under each quadruple aim is provided below.

A summary of performance is provided against the priority UHB ambition under each aim, including detail of annual plan commitments. Performance against the relevant NHS Performance Frameworks measures is provided under each aim (under development)

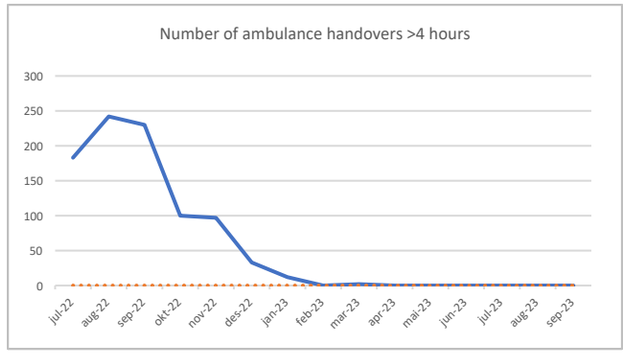
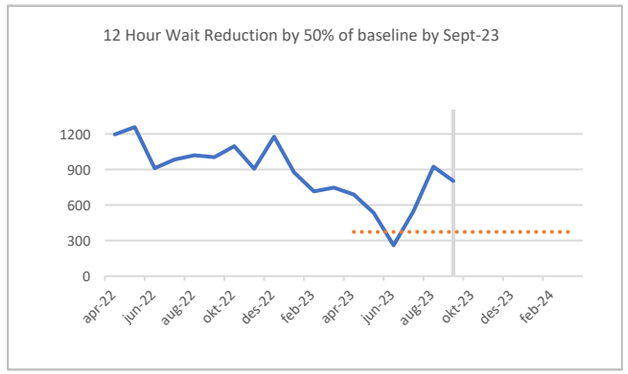
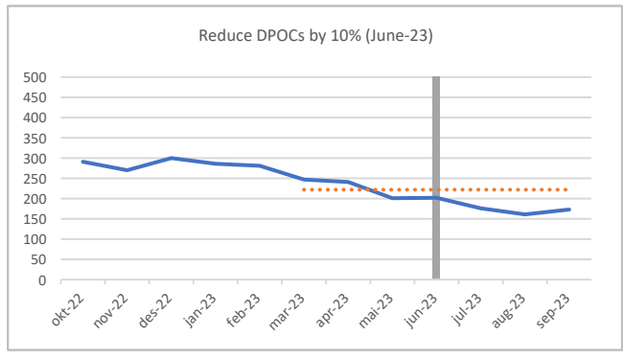
Return to Main Menu

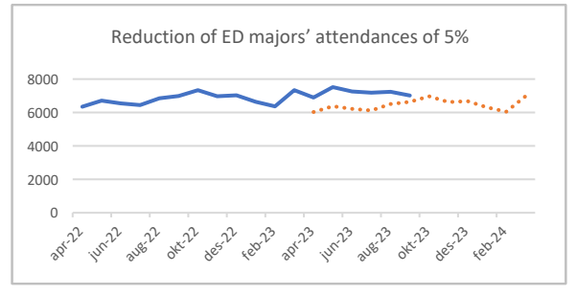
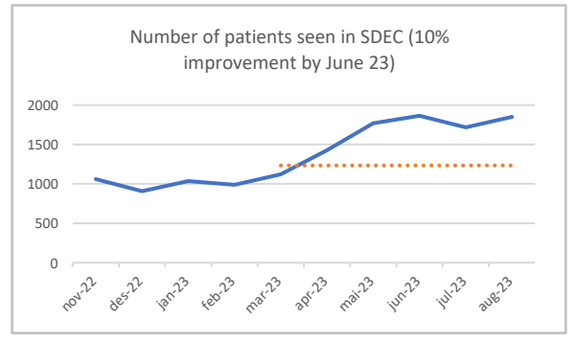
Number	Aim	Contents
Aim 1	People in Wales have improved health and well-being with better prevention and self-management	Public Health
Aim 2	People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	Urgent and Emergency Care Inpatient Flow, Discharge and Front Door Alternatives to Admission Community and Urgent Primary Care Priority Services RTT Waiting Times Planned Care Cancer, Diagnostics and Therapies Primary and Community Care Whole System Evaluation and Supporting Patients Whilst Waiting Mental Health
Aim 3	The health and social care workforce in Wales is motivated and sustainable	People and Culture
Aim 4	Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes.	Quality, Safety and Experience Financial Performance

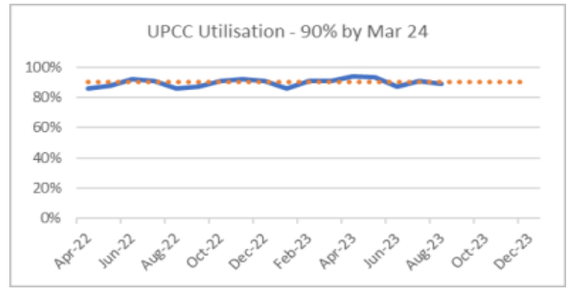
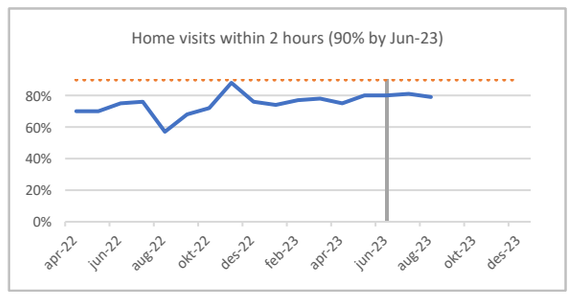
Priority	Performance Summary	Reported Period	Data
Health Protection Acute Respiratory Infections (ARI)	Acute Respiratory Infections (ARI) • Baseline (inter-seasonal) levels of influenza activity • Hospital admissions for Covid-19 have been increasing during August. A new sub-variant of omicron, BA.2.86, has recently been identified at low prevalence across a number of countries including the UK and has been designated a 'variant under monitoring' by the WHO. It is not yet clear what, if any, adverse impact this new variant will have on Covid-19 cases and morbidity. • RSV activity in children under 5 years is at levels which indicate the season has started, although there has been a decrease to low levels in the most recent week.	Week 34	 Source:10 (wales.nhs.uk)
Health Protection Immunisation	• Eligible cohorts have received the Covid-19 Spring Booster, with 37,253 doses given in Cardiff and Vale by 5 July 2023, and 69.15% uptake to date (cf Wales average 67.91% uptake). • Following JCVIs announcement on 6 April, the Covid-19 infant vaccination programme commenced on 22 May 2023, running alongside the Spring Booster Campaign. The latest available public data by Public Health Wales (accessed on 21/08/2023) for the whole of Wales shows 47,541 (18.6% of the eligible) 1st doses were administered to 5-11 year olds and 34,964 second doses (13.7% of the eligible). In the geographical areas of Cardiff and in the Vale this was respectively 26.8% and 24.5% for the first dose and 21.1% and 19.6% for the second dose. • Operational preparations are underway for the Winter Respiratory Vaccination Programme. Eligible groups have been identified and the vaccination campaign is due to start from the 11th of September 2023. • The Staff Winter Respiratory Vaccination campaign will also start concurrently and it will see the co-administration of Covid-19 and Influenza vaccinations via appointments at Mass Vaccination Centres, occupational health and with opportunistic vaccination through vaccination champions.	Q1 2023/24	Wales COVID-19 vaccination surveillance weekly report.pdf Infant covid 19 vaccination. https://public.tableau.com/app/profile/public.health.wales.health.protection/viz/RapidCOVID-19virology-Public/Vaccination
Health Protection Health Protection System	• Planning for a regional, all hazards Integrated Health Protection Partnership continues, with expected full implementation by end of year • A draft Health Protection Plan has been developed with key partners. Consultation with stakeholders will take place in early Autumn.	Q2 2023/24	
Health Improvement Healthy weight	• 74.6% of reception aged children in Cardiff and the Vale of Glamorgan are categorised as healthy weight (CMP, 2021/22). Cardiff and Vale have the second highest proportion of healthy weight children compared to other Health Board areas based on the latest available data. • 40% of adults in Cardiff and the Vale of Glamorgan are of a healthy weight (NSfW, 2021/22+2022/23)*; 39% are eating five portions of fruit/vegetables a day (NSfW, 2021/22+2022/23)* and 68% are meeting physical activity guidelines of being active for at least 150 minutes per week (NSfW, 2021/22+2022/23)*. • Differences remain between our most and least deprived communities with levels of healthy weight lower, and consumption of fruit and vegetables/physical		

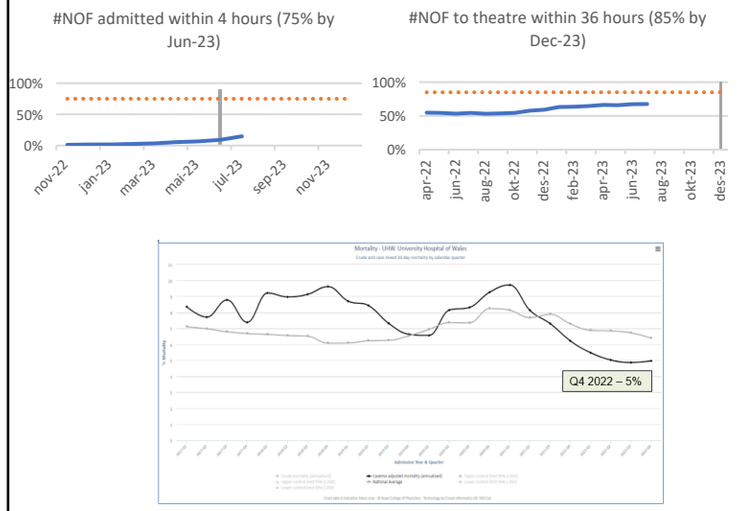
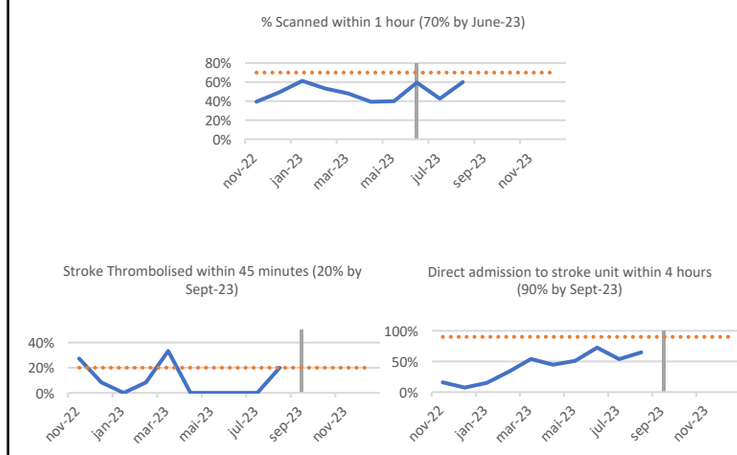
Priority	Performance Summary	Reported Period	Data
Health Improvement Tobacco	• 12% of Cardiff and Vale of Glamorgan smoke), one of the lowest prevalence rates in Wales • 2.3% of smokers set a firm quit date in 2022-2023 with 71% quitting smoking at 4 weeks • 9% of pregnant women smoke on booking – the lowest in Wales. 8% of pregnant women smoked on booking, Cardiff and Vale UHB, Qtr 4, 2022-2023) • 85% of patients quit smoking by accessing the Hospital HMQ programme, Qtr 4 2022-2023	Quarter 3 2022-2023	

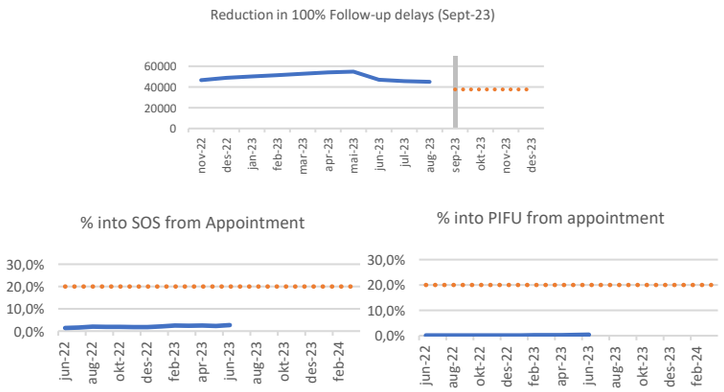
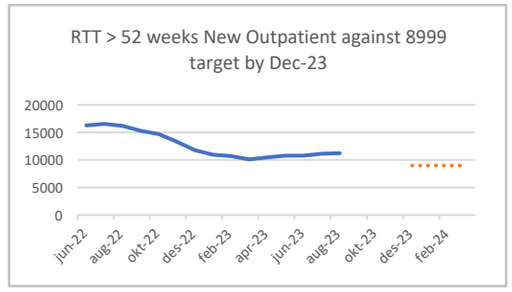
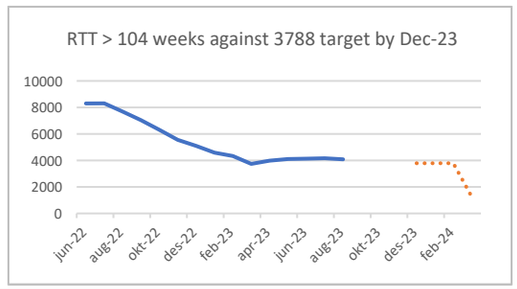
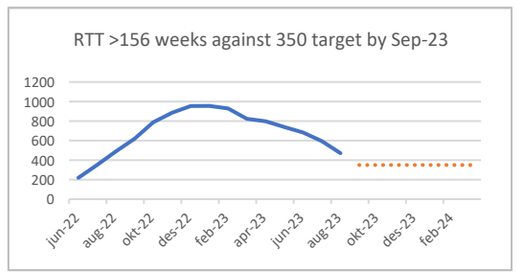
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
1.	Percentage of adult smokers who make a quit attempt via smoking cessation services	1 Jan 23 to 31 Mar 23	0.8% per quarter	**0.7%**	Q1: 0.50% | Q2: 0.50% | Q3: 0.40% | Q4: 0.70%
2.	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs and alcohol)		Improvement trend	Work in progress with substance misuse	
3.	Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	1 Jan 23 to 31 Mar 23	95%	**84.8%**	Q1: 86.80% | Q2: 87.20% | Q3: 86.80% | Q4: 84.80%
4.	Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15 (Applicable during: 01.04.2023 - 30.06.2023 and 01.01.2024 - 31.03.2024)	1 Jan 23 to 31 Mar 23	90%	**71.3%**	Q1: 72.00% | Q2: 72.60% | Q3: 70.30% | Q4: 71.30%
5.	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over (Applicable during: 01.09.2023 - 31.03.2024)	1 Sept 22 to 31 Mar 23	75%	**75.7%**	
6.	Percentage uptake of the COVID-19 vaccination for those eligible (Applicable during: Spring Booster 01.04.2023 - 30.06.2023) (Autumn Booster 01.09.2023 - 31.03.2024)	1 Apr 23 to 30 Jun 23	75%	**67%**	w/e 11/06: 64.00% | we 18/06: 65.00% | w/e 25/06: 66.00% | w/e 02/07: 67.00%
7.	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	Jun-23	90%	**4.7%**	Mar-23: 8.00% | Apr-23: 16.70% | May-23: 3.40% | Jun-23: 4.70%
8.	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	Jun-23	90%	**97.7%**	Mar-23: 96.30% | Apr-23: 95.60% | May-23: 98.00% | Jun-23: 97.70%
9.	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	Jul-23	95%	**93.5%**	Apr-23: 93.70% | May-23: 95.10% | Jun-23: 97.30% | Jul-23: 93.50%

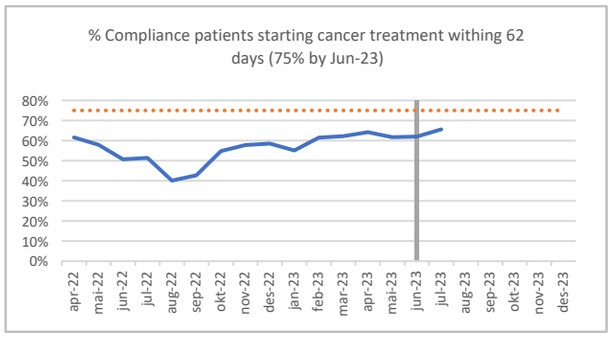
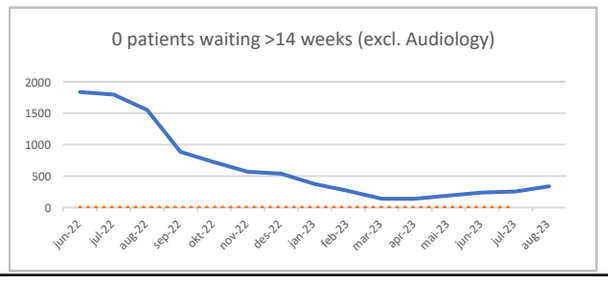
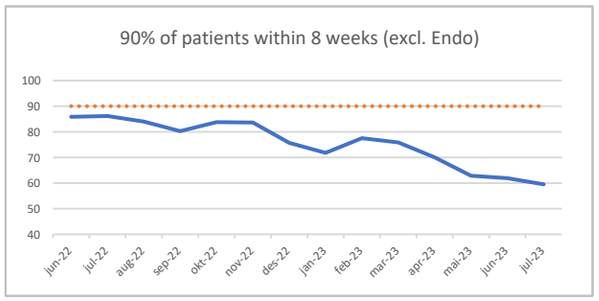
Priority	Performance Summary	Reporting Period	Data
Ambulance Handover Annual Plan Commitments: • Zero 4-hour ambulance delays (June 23) • Reduce average lost minutes to 30 (Sept 23)	• The number of ambulance handovers >4 hours has reduced from 230 in September 2022 to zero in June, July, August and September 2023. We are now giving the same focus to patients waiting 2-hours for an ambulance handover. In June there were two 2-hour holds, a reduction from 206 in March, in July we reported 15, in August 20 and September 27. • Average lost minutes per arrival remains reduced but increased to 27 minutes in September from 26 in August. This performance remains better than our annual plan commitment.	Sep-23	
Emergency Department Annual Plan Commitments: • Zero 24-hour ED waits (June 23) • Reduce 12-hour ED waits by 50% (Sept 23)	• In September, 11 patients waited 24-hours in the EU footprint without a stop-clock, a decrease from the 23 patients reported in July and 41 in August • 12-hour ED waits decreased from 924 in August to 803 in September, this is above our IMTP ambition. Work continues to embed the improvements following the significant number of ward moves and EU/AU redesign over the summer, which has impacted our performance for August and September	Sep-23	
Delayed Pathways of Care, LOS and Beds Annual Plan Commitments: • Reduce DPOCs by 10% (June-23) • Reduce >21 day LOS by 5% (June-23) • Re-establish dedicated AOS beds (Sept)	• Delayed pathways of care remain a national challenge, the September 2023 census reported 173 delayed pathways an increase from 160 in August • We are currently tracking the numbers of stranded (7-day LOS) and superstranded (>21-day LOS) patients in our Acute beds. This is a more operationally useful measure than LOS measures which include rehabilitation and integrated care beds. We will be monitoring these going forward against the standards of <40% stranded and < 20% superstranded. At the time of writing our analysis showed 31% and 55% respectively. • Work continues to evaluate the most appropriate and effective approach for the Acute Oncology Service (AOS), including consideration of dedicated beds following a recent pilot. An update and proposal is now planned for the beginning of Q3.	Sep-23	

Priority	Performance Summary	Reporting Period	Data
ED Attendances Annual Plan Commitment • Reduction of ED majors' attendances of 5% compared to same period 2022/23 (every quarter)	• In September 2023 we reported 12,405 EU attendances, an increase from the 11,717 reported in August • The number of EU Majors attendances in September 2023 was 7,025, an increase from August and above our ambition of 6507.	Sep-23	
Same Day Emergency Care Annual Plan Commitment • 10% increase in the total number of patients managed through SDEC (June 2023) • Reduced number of unplanned re-presentations within 7-days of SDEC attendance (September 2023) • Improve % of take managed in SDEC without requiring admission	• In August 2023 we saw 1,102 patients seen via surgical SDEC and 748 via the medical SDEC. In total 1,850 patients were seen, above our commitment of a 10% increase by the end of Q1. The number of attendances to medical SDEC had been increasing month on month since June 2022, but showed a small reduction from June to July but increased again in August. • A new process for national submissions has been undertaken and we hope to report on the other measures from September	Aug-23	

Priority	Performance Summary	Reporting Period	Data
Urgent Primary Care Annual Plan Commitments: • 80% appointment utilisation in UPCCs (June 2023), 85% (September 2023), 90% (March 2024) • All clusters to have adequate access to UPCC capacity (September 2023) • NHS 111 - >90% urgent calls logged and returned within 1 hr (December 2023) • Increased redirections from ED to UPCC (March 2024)	• Average utilisation of 89% achieved across Cardiff and Vale for August, a decrease from 91% in July. • Work in progress – Delivery plan in place to ensure full/equitable UPCC provision across all Cluster areas • Average rate for June 89% • Work in progress – Pilot commenced to re-direct ED patients to UPCC slots. Work ongoing to expand this to 24/7 and to include Paediatrics. Average referrals for Q1 = 21 (adults)	Aug-23 Q1 – June-23	
Community Services • Home Visit (P2) f2f in 2 hrs >90% (June 2023)	• The Health Board was 100% compliant in August 2023 against the standard of 100% for 'Emergency' GP OOH patients requiring a home visit within one hour, with 3 of 3 patients receiving their visit with one hour. • For patients that required an 'Emergency' appointment at a primary care center in July the Health Board was 100% compliant, with 5 of 5 patients receiving an appointment within 1 hour • The Health Board was 79% compliant against the commitment of 90% for 'Urgent' GP OOH patients requiring a home visit within 2 hours, with 93 of 118 patients receiving their visit within 2 hours	Aug-23	

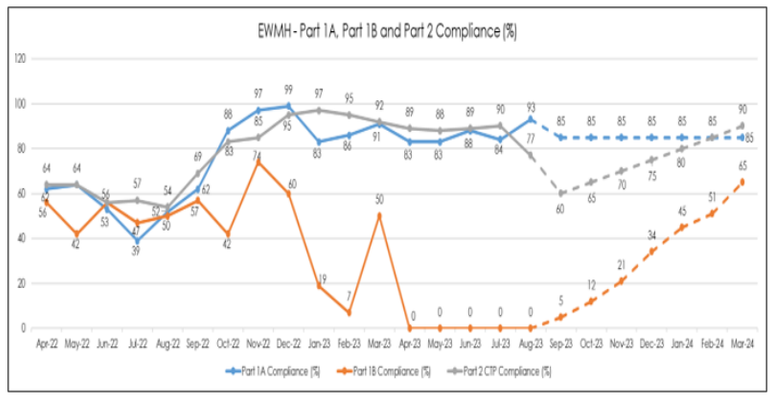
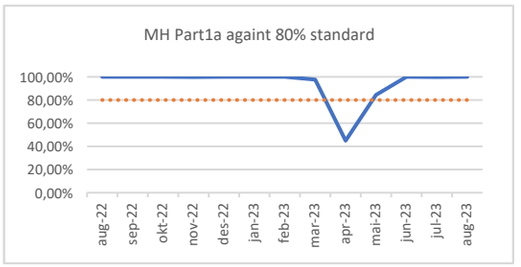
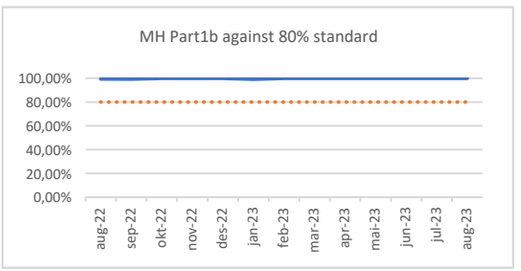
Priority	Performance Summary	Reporting Period	Data
Fracture Neck of Femur IMTP Commitments: • 75% admitted within 4 hours (June-23) • 85% to theatre within 36 hours (December-23)	Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown some improvement. In July 2023 the annualised data shows 14.8% of patients were admitted to a specialist ward with a nerve block within 4 hours. In July, 67.6% of patients received surgery within 36 hours, this has been increasing since August 2022 and our performance is above the national average of 57% over the last 12 months. A third summit with key stakeholders was held in June with a follow up scheduled for the end of September. We have an ambition for significant increases in our performance moving forwards to make Cardiff and Vale an upper quartile performer when compared to UK peers. In addition to pathway improvements, we are committed to improving outcomes for patients. Data from the National Hip Fracture Database shows that annualised Casemix Adjusted Mortality rates have falls from early 2021 and is now below the national average at 5% for Q4 22/23.	Jul-23	
Stroke IMTP Commitments: • 70% scanned within 1 hour (June-23) • 90% admitted within 4 hours (Sept-23) • 20% thrombolysis rate (Sept-23)	While overall Stroke performance remains below the standards set out in the Acute Stroke Quality Improvement Measures and The Sentinel Stroke National Audit Programme (SSNAP), we have seen recent improvements in compliance with the 4-hour door to Ward standard. In August : • 20% of patients were thrombolysed within 45 minutes of arrival, the All-Wales average was 24.0% • The percentage of CT scans that were started within 1 hour in August was 60%, the All-Wales average was 56.0% • The percentage of patients who were admitted directly to a stroke unit within 4 hours was 64.8% in August, the All-Wales average was 30.3% The UHB has held a number of internal Stroke summits and improvements to the stroke pathway are now being implemented including increased Clinical Nurse Specialists during out of hours, additional middle grade medical cover for the Emergency Unit and ringfencing of additional stroke beds to deploy the pull model from EU effectively. The UHB aspires to achieve a rating of grade 'A' for SSNAP. At the most recent SSNAP audit the service we awarded grade 'B', a significant improvement from the previous quarter.	Aug-23	
Intensive Care Unit IMTP Commitments: • Patient at risk team 24/7 (Sept 23) • ITU - 1 additional staffed bed (Sept 23) • ITU - 2 additional staffed beds (March 24)	• The patient at risk team (PART) is due to move from a 12/7 service to a 24/7 service from the 1st October following successful staff recruitment. This change will be pivotal in supporting the wards and ITU with the save management and transfer of patients. • 3 additional ITU Level 3 beds will be resourced over the course of this financial year. The first of those beds is on-track to be resourced from September 2023 following successful recruitment of staff		

Priority	Performance Summary	Reporting Period	Data
Outpatient Follow-up Management Annual Plan Commitment • Follow up outpatients–reduce 100% delayed follow up by 25% on Jan'23 baseline of 50163 (September 2023) • SOS and PIFU –10% of appropriate outpatient appointments (September 2023); 20% (March 2024) • SOS and PIFU –20% of appropriate outpatient appointments	• In total there were 191,698 patients awaiting a follow-up outpatient appointment at the end of August • Of these, there were 44,993 patients who were 100% delayed for their follow-up outpatient appointment, a decrease noted from July • 2.9% of outpatient appointments saw patients moving into a See on Symptoms pathway • 0.4% of outpatient appointments saw patients moving into Patient Initiated Follow-up pathway	Aug-23	
52 Week New Outpatient Annual Plan Commitment • <8999 > 52 weeks (March 2024)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. A separate paper was submitted to Finance and Performance Committee last month detailing our plan to meet the revised ministerial ambitions and we will update here from September. Weekly assurance is provided to the Chair. At the time of submission we are not able to update on the validated September position	Aug-2023	
104 Week Treatment Annual Plan Commitment • 3788 patients > 104 week waits for treatment (December 2023) • 1263 patients > 104 week waits for treatment (March 2024)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. A separate paper was submitted to Finance and Performance Committee last month detailing our plan to meet the revised ministerial ambitions and we will update here from October. Weekly assurance is provided to the Chair. We are on track to meet our December commitment	Aug-2023	
156 Week Waits Annual Plan Commitment • <350 patients >156 week wait for treatment (September 2023) • 0 patients >156 week wait for treatment (December 2023)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. A separate paper was submitted to Finance and Performance Committee last month detailing our plan to meet the revised ministerial ambitions and we will update here from October. Weekly assurance is provided to the Chair.	Aug-2023	

Priority	Performance Summary	Reporting Period	Data
Cancer Annual Plan Commitment • >75% compliance with the 62-day SCP standard (June 2023), 80% (December 2023) • Develop draft UHB strategy to deliver national cancer pathways (June 2023)	• There continues to be an improvement against the Single Cancer Pathway and the backlog trajectories agreed with the Delivery Unit. July saw 65.6% of patients receiving treatment within 62 days. At the time of writing there are a total of 2386 suspected cancer patient on the SCP. 261 have waited over 62 days, of which 75 have waited over 104 days. There have been a number of actions taken to improve the oversight and operational grip of the process for overseeing patients. Three cancer summits have taken place with the tumour group leads and operational teams to understand the demand, the causes for delay in the 62-day pathway and what actions are required to reduce the delays experienced by our patients.	Jul-23 No date	
Therapies Annual Plan Commitment • 0 patients waiting over 14 weeks (excluding audiology) (June 2023)	• Excluding Audiology there were 337 patients waiting over 14-weeks for Therapy in at the end of August. In total there were 1373 patients waiting longer 14 weeks for Therapy, an increase from July.	Aug-23	
Diagnostics Annual Plan Commitment • 90% of patients within 8-weeks (excl. endoscopy) (December 2023) • Endoscopy – urgent <6weeks; SCP<14days; 0 surveillance patients 100% past target date (December 2023) • Regional Diagnostic Centre go-live (December 2023)	• Excluding endoscopy there were 7858 diagnostic patients waiting longer than 8 weeks for a Diagnostic at the end of August. In total there were 11415 patients waiting longer than 8 weeks for a diagnostic test, an increase from July. • 55% of patients seen within 8 weeks in August-23 (excluding Endoscopy), a reduction from June and July. • Planning for the Community Diagnostic Hub is underway following agreement of central funding from WG. Expected go-live is estimated to be Q1 2024/25. Plans are in development to provide additional diagnostic capacity through mobile units in advance of this.	Aug-23 No date	

Priority	Performance Summary	Reporting Period	Data
Community Pharmacy Annual Plan Commitment: • >90% of all eligible community pharmacies providing CCPS (June 2023) • 10% increase in pharmacy independent provider access (December 2023)	• 98% of all eligible community pharmacies providing CCPS • 102 Community Pharmacies currently eligible to provide CCPS • 101/103 Community Pharmacies signed up to deliver CCPS. • 2,395 consultations undertaken in Q1, with 21% increase in PIP sites expected in Q2.	Q1-June 2023	
GMS Escalation Annual Plan Commitment: • >95% of practices reporting escalation levels (June 2023) • >95% achievement of core access to in-hours GMS Services (September 2023)	• 88% of Practices reporting escalation levels (Average for Q1 88%) - Number of escalations from practices reducing (of practices reporting of which 8% at Lvl3, 92% >Lvl3) • 98% achievement of core access standards to in hours GMS	Q1-June 2023	
Dental Annual Plan Commitment: • 50% of expected target for new patients, urgent and historic (June 2023); 90% (March 2024)	• % of Primary Care Dental Services Contract value (GDS) delivered for new patients seen – 99.8% • % of Primary Care Dental Services Contract value (GDS) delivered for new urgent patients seen - 45.1% • % of Primary Care Dental Services Contract value (GDS) delivered for historic patients seen – 43.8%	Q2-Sept 2023	Jun-23 / Jul-23 / Aug-23 / Sep-23 New: 46.1% / 64.1% / 84.2% / 99.8% New Urgent: 22.0% / 29.5% / 37.3% / 45.1% Historic: 16.0% / 27.5% / 36.9% / 43.8%
Optometry Annual Plan Commitment • >90% of eligible practices offering Clinical Community Optometry Services (CCOS) (June 2023); 95% (December 2023)	• Contract reform and implementation still in progress – Awaiting data • 12 Optometric Practices currently offer Optometry Independent prescribing service (18.75%)	Q1-June 2023	
Respiratory Annual Plan Commitment • 50% of backlog of suspected COPD patients receive spirometry (June 2023); 100% (March 2024)	• Community Spirometry service available in both Cardiff and Vale regions. • 541 referrals received - 69.5% have attended appointments, 30.5% on waiting list	Q1-June 2023	

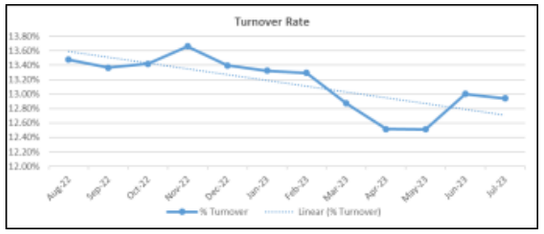
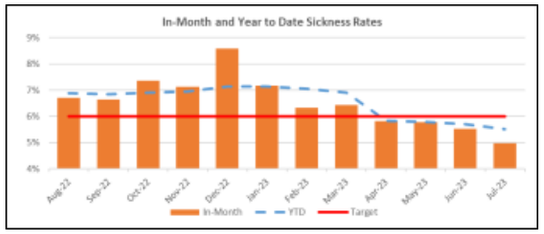
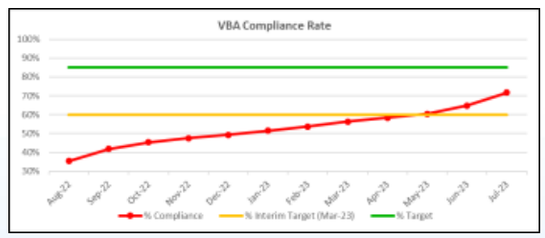
Priority	Performance Summary	Reporting Period	Data
Whole System Evaluation Annual Plan Commitment: • Undertake high impact evaluations of three key specialities (June 2023) • Undertake high impact evaluations of three key specialities (Sept 2023)	Evaluations completed in Therapies and Cardiac Services. At the Theatres Summit in September Endoscopy, Gynecology and dental services presented their evaluations. Work is ongoing to expand the evaluation process across key specialties and we are refining how we approach this across the UHB, working with colleagues from the NHS Executive.	Sept-23	
Supporting Patients Whilst Waiting Annual Plan Commitment: • Produce models of care (June 2023) • Develop pathways (Sept 2023) • Expand services (December 2023)	Models of care and pathways have so far been produced for 8 services including Prepare Well (Orthopaedics), ESCAPE Pain and Cancer Prehab2Rehab The expansion of services to include a single point of access is planned for delivery in this financial year.	Sept-23	

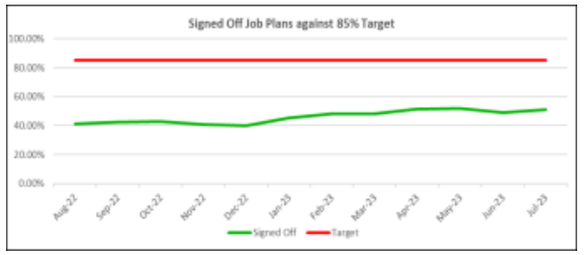
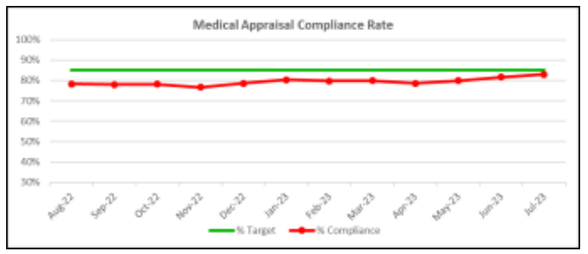
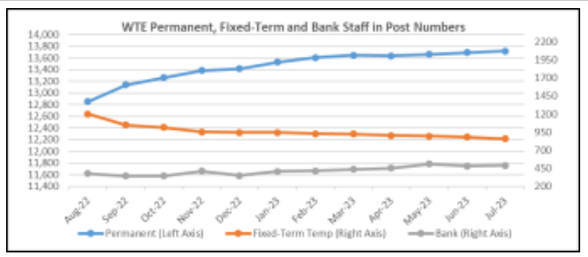
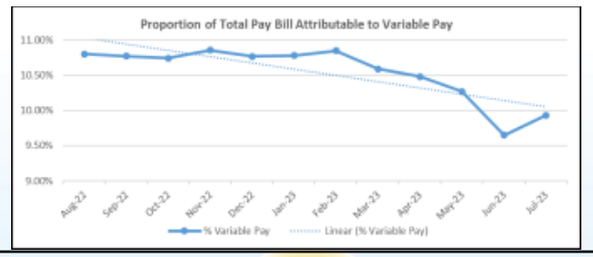
Priority	Performance Summary	Reporting Period	Data
Children's Mental Health Annual Plan Commitments: • >80% Part 1a performance – SCAMHS • Part 1b – 10% improvement (September 2023); further 10% (December 2023); achieve >80% compliance (March 2023) • Reduce SCAMHS Intervention longest wait to no longer than 6 weeks	Part 1a compliance remains above the 80% target at 93% in August. Part 1b performance was 0% due to additional assessment undertaken to meet Part 1a and high referral levels in June 23. The number waiting and longest wait for Part 1b has also increased due to the merge in data reporting for PMH and CAMHS. There have been data quality issues and a through improvement in the capture of data which has further impacted reported performance. In line with the new integrated model and focus on ensuring that children and young people access the most appropriate pathway under the mental health measure, we have redesigned the PARIS record keeping module and associated reporting to accurately capture the children and young people accessing and waiting for interventions for both Part 1b and Part 2 (SCAMHS). It is planned for this to go live in September so we expect to be able to provide accurate reporting from October. Improvement trajectories for the Emotional Wellbeing and Mental Health Service are in place following implementation of the changes.	Aug-23	
Adult Mental Health Annual Plan Commitments: • >80% Part 1a performance • >80% Part 1b performance	Demand for adult and children's Mental Health services remains significantly above pre-Covid levels, with referrals for the Local Primary Mental Health Support Service (LPMHSS) at 1267 referrals in August 2023. As highlighted at the previous Board meetings, this demand increase includes an increased presentation of patients with complex mental health and behavioral needs. Significant work has been undertaken to improve access times to adult primary mental health: • Part 1a: in August the percentage of Mental Health assessments undertaken within 28 days was 100% • Part 1b compliance remains at 100%	Aug-23	 

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
10.	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	May-23	100%	(Annual) 98%	Reporting from Q2 – Expected Nov-23
11.	Percentage of primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Sept-23	30% (Sept 23) 100% (Mar 24)	New 99.8% New Urgent 45.1% Historic 43.8%	Jun-23 / Jul-23 / Aug-23 / Sep-23 46.1% / 64.1% / 84.2% / 99.8% 22.0% / 29.5% / 37.3% / 45.1% 16.0% / 27.5% / 36.9% / 43.8%
12.	Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Sept-23	Reduction by Mar 24	840	Jun-23 / Jul-23 / Aug-23 / Sep-23 956 / 997 / 947 / 840
13.	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Aug-23	Increase against 22/23	1035	May-23 / Jun-23 / Jul-23 / Aug-23 904 / 781 / 1106 / 1035
14.	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	Aug-23	80%	**93%**	May-23 / Jun-23 / Jul-23 / Aug-23 83.00% / 88.00% / 84.00% / 93.00%
15	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years	Aug-23	80%	**0%**	May-23 / Jun-23 / Jul-23 / Aug-23 0.00% / 0.00% / 25.00% / 0.00%
16	Percentage of Local Primary Mental Health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	Aug-23	80%	**100%**	May-23 / Jun-23 / Jul-23 / Aug-23 84.40% / 100.00% / 99.80% / 100.00%
17	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults aged 18 years and over	Aug-23	80%	**100%**	May-23 / Jun-23 / Jul-23 / Aug-23 100.00% / 100.00% / 100.00% / 100.00%

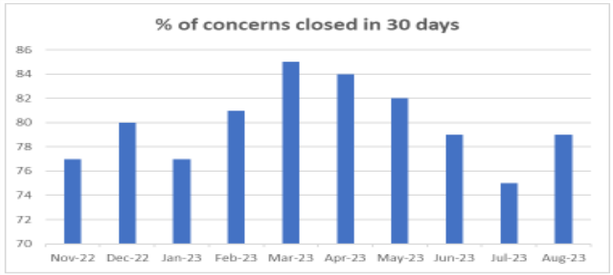
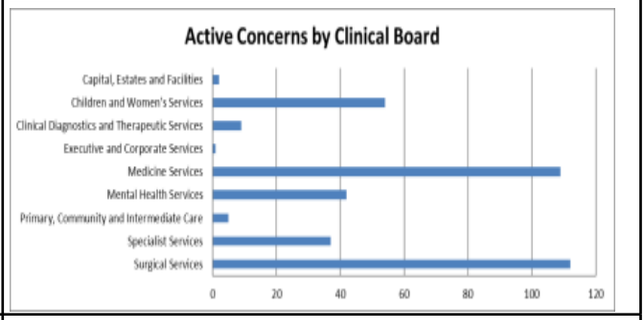
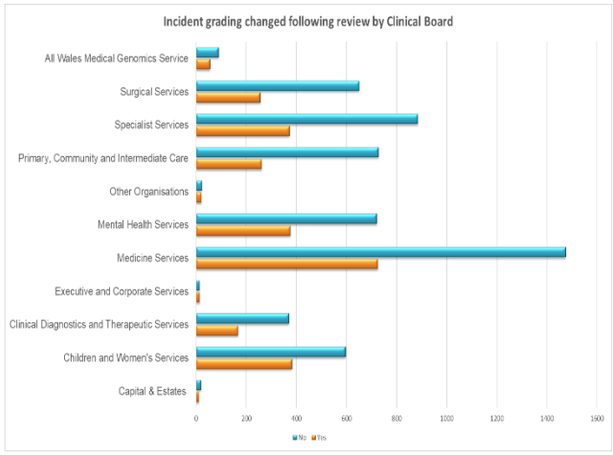
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
18.	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Sep-23	65%	**52%**	Jun-23: 60% / Jul-23: 57% / Aug-23: 51% / Sep-23: 52%
19.	Median emergency response time to amber calls		12m improvement trend	Work in Progress	WIP – Expected Oct-23
20.	Median time from arrival at an emergency department to triage by a clinician		12m reduction trend	Work in Progress	WIP – Expected Oct-23
21.	Median time from arrival at an emergency department to assessment by a senior clinical decision maker		12m reduction trend	Work in Progress	WIP – Expected Oct-23
22.	Percentage 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	Sep-23	95%	**70.5%**	Jun-23: 75.3% / Jul-23: 75.6% / Aug-23: 68.8% / Sep-23: 70.5%
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	Sep-23	0 (Mar 2024)	**803**	Jun-23: 260 / Jul-23: 548 / Aug-23: 924 / Sep-23: 803
24.	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Jul-23	80% (Mar 2026)	**65.6%**	Apr-23: 64.2% / May-23: 61.7% / Jun-23: 62.0% / Jul-23: 65.6%
25.	Number of patients waiting more than 8 weeks for a specified diagnostic	Aug-23	0 (Mar 2024)	**11415**	May-23: 8113 / Jun-23: 9175 / Jul-23: 10009 / Aug-23: 11415
26.	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	Aug-23	Improvement trend	**82.79%**	May-23: 89.40% / Jun-23: 85.00% / Jul-23: 85.23% / Aug-23: 82.79%
27.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Aug-23	0 (Mar 2024)	**1373**	May-23: 1121 / Jun-23: 1240 / Jul-23: 1282 / Aug-23: 1373

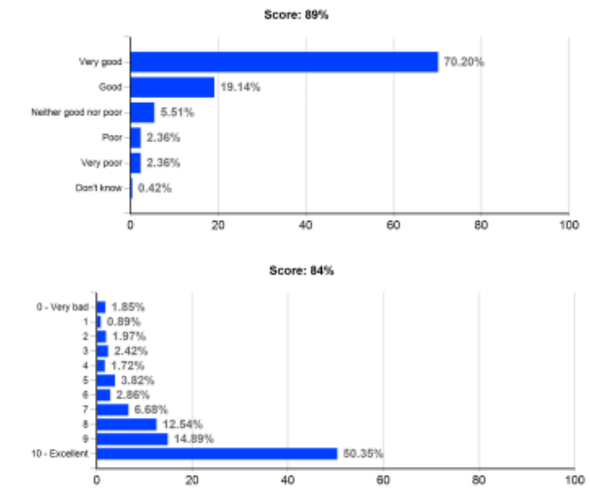
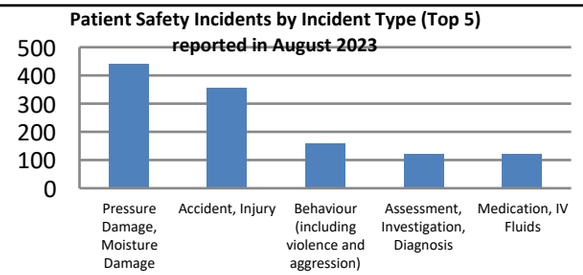
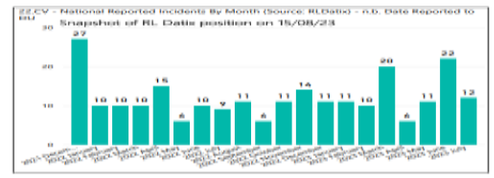
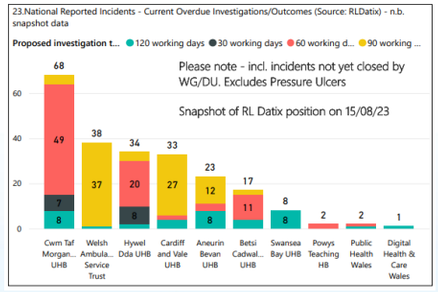
No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
28.	Number of patients waiting more than 52 weeks for a new outpatient appointment	Aug-23	Improvement trajectory towards 0	**11230**	May-23: 10779; Jun-23: 10789; Jul-23: 11138; Aug-23: 11230
29.	Number of patients waiting more than 36 weeks for a new outpatient appointment	Aug-23	TbImprovement trajectory towards 0	**21018**	May-23: 19629; Jun-23: 19839; Jul-23: 20580; Aug-23: 21018
30.	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Jul-23	Improvement trajectory towards 0	**45644**	Apr-23: 54064; May-23: 54788; Jun-23: 46981; Jul-23: 45644
31	Number of patients waiting more than 104 weeks for referral to treatment	Aug-23	Improvement trajectory towards 0	**4085**	May-23: 4107; Jun-23: 4133; Jul-23: 4164; Aug-23: 4085
32.	Number of patients waiting more than 52 weeks for referral to treatment	Aug-23	Improvement trajectory towards 0	**25463**	May-23: 24396; Jun-23: 24778; Jul-23: 25653; Aug-23: 25463
33.	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS)	Jul-23	80%	**84%**	Apr-23: 83%; May-23: 83%; Jun-23: 88%; Jul-23: 84%
34.	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Aug-23	80%	**17%**	May-23: 29%; Jun-23: 26%; Jul-23: 20%; Aug-23: 17%
35.	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Aug-23	80%	**57%**	May-23: 59%; Jun-23: 58%; Jul-23: 60%; Aug-23: 57%

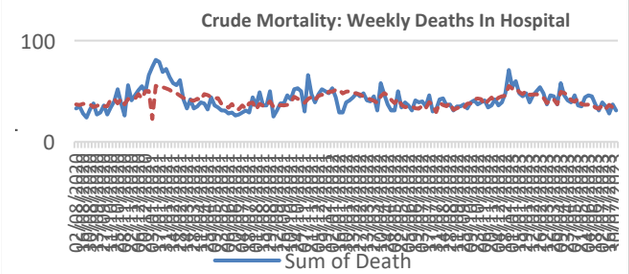
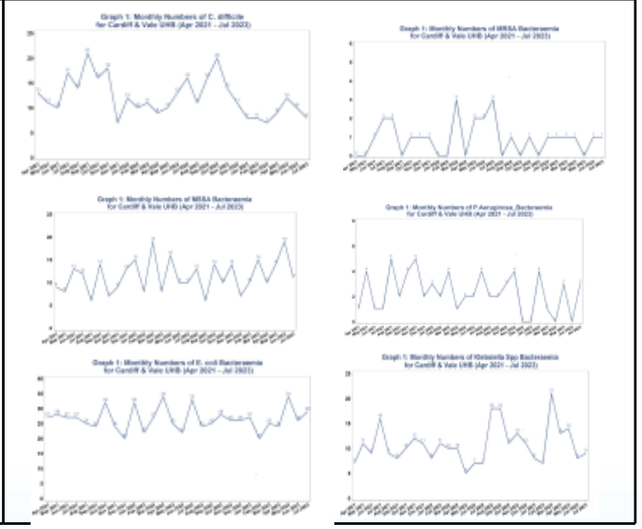
Priority	Performance Summary	Reported Period	Data
Turnover	The overall trend is downwards since Aug-22; the rates have fallen from 13.66% in Nov-22 (the highest rate of turnover in the past 12 months) to a low of 12.51% in May-23 UHB wide. The rate for Jul-23 is 12.94%. This is a net 0.72% decrease, which equates roughly to 99 WTE fewer leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Other/Not Known', 'Retirement Age', 'Voluntary Resignation – Relocation', 'Voluntary Resignation – Work Life Balance' and 'Voluntary Resignation – Promotion'.	July 2023	
Sickness Absence	Rates remain high; although the rates appear to be the falling towards more 'normal' levels. The monthly sickness rate for Jul-23 was 4.97% after an all-time high of 8.58% for Dec-22. The 12-month cumulative rate has fallen steadily over the past 7 months to 6.53% (by comparison with Jul-22, which was 7.24%).	July 2023	
Statutory and Mandatory Training	Compliance rate has risen to 81.20% for Jul-23, 3.80% below the overall target. The compliance for the All-Wales Genomics Services, Capital, Estates & Facilities and Clinical Diagnostics & Therapeutics are all above the 85% target, and Children & Women's, PCIC, Corporate Executives and Specialist Services are above 80% compliance. Compliance with Fire training has also risen during Jul-23, to 74.87%. Again, Capital, Estates & Facilities and the All-Wales Genomics Services have exceeded the 85% compliance target, and Clinical Diagnostics & Therapeutics is above 80%.	July 2023	 
Values Based Appraisal	Compliance has more than doubled over the last year; the compliance at Jul-23 was 71.64%. Clinical Boards had been set an improvement target of 60% by the end of March 23, then 85% by the end of June 2023. Capital, Estates & Facilities (91.77%) are the only Clinical Board to have exceeded the 85% target, but all of the Clinical Boards with the exception of Mental Health and the Corporate Executive group are now above the 60% transitory target.	July 2023	

Priority	Performance Summary	Reported Period	Data
Employee Relations	As can be seen in the graph the number of employee relations cases the People Services team are supporting has risen in the past three months but remains below the UHB Target. Further work is being undertaken to help embed the Just Culture principles within the UHB and a Just Culture Toolkit is being developed. The People Services Team continue to analyse trends of employee relations cases to develop bespoke training packages or additional toolkits/support services where appropriate.	July 2023	
Job Plans	91.14% of clinicians have engagement with job planning and have a job plan in the system, however only 51.25% of these plans are fully signed off. Focus continues to be on supporting the approval and sign off process.	July 2023	
Medical Appraisals	The rate of compliance with Medical Appraisal has risen during the past 12 months. At Jul-23 the compliance was 83.05%, by comparison with the target 85%.	July 2023	
Staff in Post	The overall Health Board Staffing Numbers have increased in the last 12 months by 522.29 WTE, to 14,573.19 WTE. The change in the split between permanent and fixed-term as shown in the graph below is largely due to validation of the ESR data held for staff contract type. The quantity of 'replacement' WTE by bank is increasing; in Aug-22 this represented 378.34 WTE, in Jul-23 this had risen to 488.93 WTE.	July 2023	
Variable Pay (Bank, Agency, Overtime..)	The trend of proportion of the pay bill spend on variable pay (Bank, Agency, overtime etc.) is falling. It has been as high as 10.85% of the total spend on pay, but in Jul-23 was 9.93%. It must however be borne in mind that the total pay bill is increasing.	July 2023	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
36.	Percentage of sickness absence rate of staff	Jul-23	6%	**4.97%**	Apr-23: 5.82% | May-23: 5.77% | Jun-23: 5.52% | Jul-23: 4.97%
37.	Staff turnover measure tbc starters and leavers and/or vacancies?	Jul-23	7%-9%	**12.94%**	Apr-23: 12.52% | May-23: 12.51% | Jun-23: 13.00% | Jul-23: 12.94%
38.	Agency spend as a percentage of the total pay bill	Jul-23	12 month reduction trend	**2.41%**	Apr-23: 2.48% | May-23: 1.86% | Jun-23: 1.99% | Jul-23: 2.41%
39.	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training)	Jul-23	85%	**72.37%**	Apr-23: 59.60% | May-23: 61.63% | Jun-23: 65.86% | Jul-23: 72.37%

Priority	Performance Summary	Reported Period	Data
Concerns 30 day performance	• **Welsh Government target for responding to concerns is 75% within 30 working days** • During July and August 2023, the Health Board received : • 697 Concerns • 77% closed within 30 working days (including Early Resolution) • 63 % closed under Early Resolution • 102 Compliments We currently have 371 active concerns Top 3 themes and trends 1. Communication 2. Concerns around appointments (waiting times/cancellations) 3. Clinical Treatment and Assessment	July and August 23	 
Duty of Candour	• 8409 incidents have been reported by staff across the Health Board, reflecting an open culture where staff feel comfortable to speak up. • Approximately 32% incidents regraded with feedback provided to reporter, investigating manager and investigator • Approximately 78 incidents reviewed per day • We have led 11 DOC awareness sessions across the Health Board so far and continue undertake these monthly and when requested. • Since 1st April 2023 we have triggered the DOC on 25 occasions		

Priority	Performance Summary	Reported Period	Data
Patient Feedback – Civica	• Went live on Friday 28th October 2022 and we are currently surveying up to 600 patients daily via SMS. As of the end of July 2023, we have contacted some 83,672 people for feedback via text messaging and are seeing a return rate of 18%. • In June, we contacted 8908 people via text and had 1615 completions (18% rr) • In July, we contacted 11312 people via text and had 1977 completions (17% rr) • Combined, we contacted 20220 people via text and had 3285 completions (18% rr). Of those who attended/discharged during June/July, 87% of those who answered the rating question were satisfied with our service. • Our return rate is 18% it is our understanding this is higher than many organisations but will be a focus for improvement with more targeted experience data collection over the next year, with an ambitious aim for a minimum return of 25% by end of March 24.	Jun-23 Jul-23	
Incident Reporting	During August, 1676 patient safety incidents were reported, pressure damage was again the most common reported patient safety incident type, followed by accident injury (falls), behaviour (including v&a), assessment/assessment and diagnosis, and finally medication errors (see chart in side bar). <u>NRI performance</u> • Number of open NRIs – 65 • Number of closures submitted in August – 13 • Number of overdue NRIs – 26 This is an improved position on the previous month, which had 64 open NRIs, 11 NRI closures were sent and 32 were overdue in July.	Jul-23	  

Priority	Performance Summary	Reported Period	Data
Tier 1 Mortality	• The Crude inpatient Mortality chart demonstrates the numbers of inpatient deaths that occur in the Health Board on a weekly basis and compares this measure with the average for the previous 5 years for the same week. The blue line demonstrates the rolling crude inpatient mortality rate compared to the 5-year average for the same reporting week (red line), with the exception of March 2020 and December 2020 to February 2021, the first and second waves of Covid-19.Inpatient crude mortality continues to track the five year average • Crude all-cause mortality, demonstrates the weekly number of deaths registered in Cardiff and the Vale of Glamorgan, regardless of where they occurred. COVID – 19 deaths the pink line, illustrates the number of deaths where COVID-19 features anywhere on the death certificate. There is a correlation between increases above the five-year average and deaths where the patient had Covid on their death certificate during the first two waves of the pandemic. An increase above the five year average has been noted across wales since April 2023 with a similar increase noted in Cardiff and Vale UHB with five year average crude mortality in week 28 being recorded as 76 compared with 63.6 for the previous five year average.	July-23 May-23	 
Infection Control	The WHC for the 2023/24 financial year has not yet been released. Therefore, the reduction expectations are based on those released for the 2022/23 financial year. • Between April 23 and July 23, there were 44 cases of ***Klebsiella sp*** **bacteraemia**. The reduction expectation for this period is 23 cases, thus the number of cases is 21 over the reduction expectation. • There were 6 cases of ***P. aeruginosa*** **bacteraemia**. The reduction expectation for this period is 8 cases, thus the number of cases is 2 below the reduction expectation. • There were 133 cases of **E. coli bacteraemia**. The reduction expectation for this period is 83 cases, thus the number of cases is 30 over the reduction expectation. • There were 57 cases of **S. aureus bacteraemia**. The reduction expectation for this period is 26 cases, thus the number of cases is 31 over the reduction expectation. • There were 39 cases of **C. difficile**. The reduction expectation for this period is 26 cases, thus the number of cases is 13 over the reduction expectation.	Apr-23 – July-23	

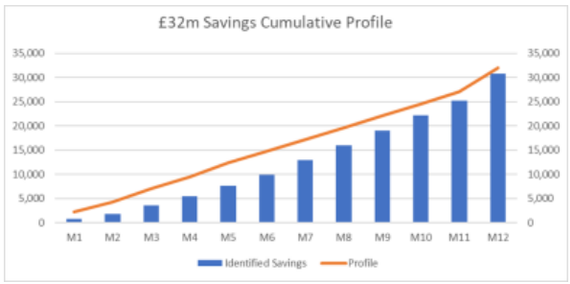
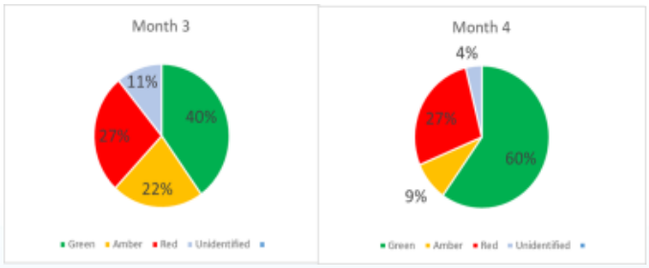
<table>
<tr><th>Priority</th><th>Performance Summary</th><th>Reported Period</th><th>Data</th></tr>
<tr><td>Deliver 2023/24 Draft Financial Plan</td><td>Financial Plan Approved by Board and submitted to Welsh Government

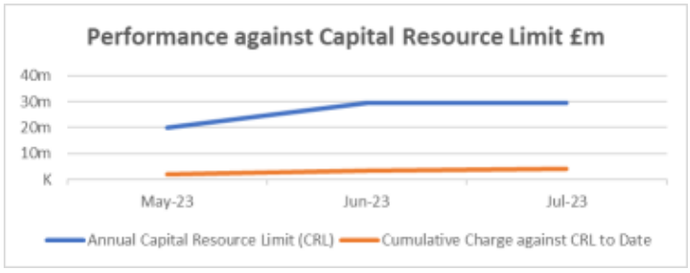
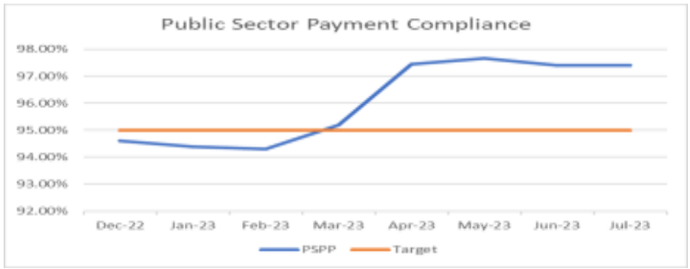
• Brought forward underlying deficit of £40.3m
• Local Covid Consequential costs of £34.2m
• Additional energy costs of £11.5m
• 23/24 Demand and cost growth and unavoidable investments of £48.8m
• Allocations and inflationary uplifts of £14.4m
• A £32m (4%) Savings programme

This results in a 2023-24 planning deficit of £88.4m.

The UHB is reporting a month 4 overspend of £34.353m. £29.467m of this being four months of the annual planned deficit. £4.055 deficit on the Savings Programme, being four months of red schemes and unidentified savings. 0.832m is an operational overspend in delegated and central positions.</td><td>Jul-23</td><td><table><tr><th></th><th>Forecast Month 4 Position £m</th><th>Forecast Year-End Position £m</th></tr><tr><td>Planned deficit</td><td>29.467</td><td>88.400</td></tr><tr><td>Savings Programme</td><td>4.055</td><td>0.000</td></tr><tr><td>Operational position (Surplus) / Deficit</td><td>0.832</td><td>0.000</td></tr><tr><td>Financial Position - Deficit £m</td><td>34.353</td><td>88.400</td></tr></table></td></tr>
<tr><td>Delivery of recurrent £32m savings target</td><td>At month 4, the UHB has identified £30.764m of green, amber and red savings against the £32m savings target leaving a further £1.236m (4%) schemes to be identified. The month 4 position includes a Savings Programme variance of £4.055m relating to a four month share of red and unidentified schemes.

Additional actions are progressing to recover the month 4 operational & CRP overspend to enable the UHB to deliver the planned £88.4m deficit

The UHB expects to be able to manage the balance of savings plans required to deliver the forecast deficit of £88.4m with the risk of non-delivery of savings shown in Graph 1 and the progress of reducing the risk via identification of schemes in Graph 2</td><td>Jul-23</td><td>Graph 1 – Profile of Savings Delivery and Unidentified Schemes
 
Graph 2 - Progress of Identification of Schemes
  </td></tr>
</table>

Priority	Performance Summary	Reported Period	Data
Remain within capital resource limits	The UHB forecasts to deliver within it's Capital Resource Limit.	July-23	
Creditor payments compliance 30 day Non-NHS	The UHB's public sector payment compliance performance is above the target of 95%. Performance for the month to the end of July was **97.42%** and improvements are illustrated in the graph to the right.	July-23	
Remain within Cash Limit	The UHB's working capital requirement assumes that Welsh Government will provide support to movements in working capital from the 2022-23 Balance Sheet and for the £88.4m planning deficit in the UHB 2023-24 Financial Plan. Discussion is ongoing with Welsh Government to provide cash support for these areas which will total approximately £100m.	July-23	
Maintain Positive Cash Balance	The closing cash balance at the end of July 2023, was £3.498m. A detailed monthly cashflow forecast is included in the monthly monitoring return submission to Welsh Government. The UHB's working cash assumption for 2023-24 is based on the following key assumptions :- • Movements in working capital from the 2022-23 Balance Sheet to be assessed as the year progresses. • Additional 1.5% consolidated pay award (£11.5m) for which Resource cover was received from Welsh Government in 2022-23 but has been paid out in 2023-24 and requires cash support. • Cash support for the £88.4m deficit of the UHB 2023-24 Financial Plan. Discussion is ongoing with Welsh Government to provide cash support for these three areas which will total approximately £100m.	July-23	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
40.	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Apr-23	Improvement trend	70%	Jan-23: 59%; Feb-23: 56%; Mar-23: 44%; Apr-23: 70%
41.	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following		90%	Work in progress	
42.	Percentage of calls ended following WAST telephone assessment (Hear and Treat)		17% or more	Work in progress	
43.	Number of Pathways of Care delayed discharges		12 month reduction trend	Work in progress	
44.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	Jul-23	90%	**90.2%**	Apr-23: 89.40%; May-23: 88.10%; Jun-23: 89.20%; Jul-23: 90.20%
45.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	Jul-23	90%	**46.7%**	Apr-23: 50.30%; May-23: 49.10%; Jun-23: 47.30%; Jul-23: 46.70%
46.	Number of patient experience surveys completed and recorded on CIVICA *(Total partial/full survey completions, including SMS, Bedside and bespoke)*	Jun/Jul-23	Month on month improvement	**3760**	

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
47.	Cumulative number of laboratory confirmed bacteraemia cases: *Klebsiella* sp and; *Pseudomonas aeruginosa*	Jul-23	*Klebsiella sp* - 23 *P. aeruginosa* – 8	**44** **6**	Work in progress
48.	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: *E-coli*; *S.aureus* (MRSA and MSSA)	Jul-23	*E. coli* - Tbc *S.aureus* – Tbc	**66.01** **33.30**	Work in progress
49.	Cumulative rate of laboratory confirmed *C.difficile* cases per 100,000 population	Jul-23	Work in progress	**22.60**	Work in progress
50.	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	May-23	Reduction against 22/23	Work in progress	Work in progress
51.	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Jul-23	95%	**58.12%**	Apr-23: 58.04%; May-23: 58.12%; Jun-23: 58.66%; Jul-23: 58.83%
52	Number of ambulance handovers over 1 hour	Sep-23	0 (Mar 24)	**1810**	Jun-23: 1558; Jul-23: 1473; Aug-23: 1728; Sep-23: 1810
53.	Number of patient safety incidents that remain open 90 days or more	Jul-23	12-month reduction trend	**4104**	Work in progress

Report Title:	Single Cancer Pathway Standard Performance			Agenda Item no.	2.4
Meeting:	Finance and Performance Committee	Public	✔	Meeting Date:	18th October
		Private			
Status *(please tick one only):*	Assurance	✔	Approval		Information
Lead Executive:	Chief Operating Officer				
Report Author (Title):	Director of Planned and Specialist care				

Main Report
Background and current situation:

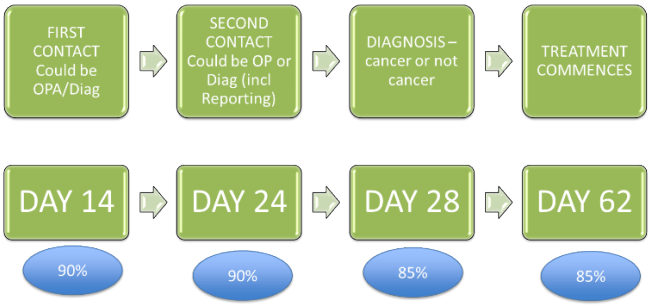
Background and current situation:

The purpose of this report is to provide an end of Quarter 2 update on the single cancer pathway standard. Within the planned Care improvement programme there has been increased scrutiny and focus on cancer delivered through the Cancer Delivery Group. The plan developed with Clinical Boards was to see continuous improvement in the percentage of patients treated within the standard and an aim to exceed 75% by the end of September.

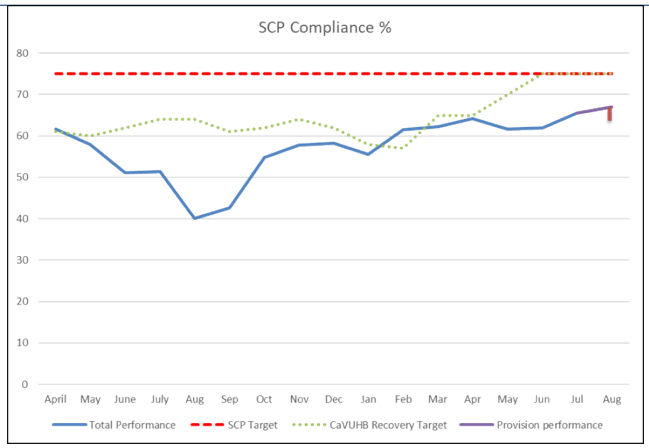
Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

Post pandemic the improvement of the cancer standard in Cardiff and Vale University Health Board has been slower than is acceptable for our patients. In January 2023 the performance remained at less than 57%. Through the planned care improvement programme there has been increased focus on the cancer standard which has been managed through the cancer delivery group. This group which has Director of Operations or deputy attendance meets weekly to ensure that there are robust improvement plans in place to both reduce the trajectory and attain at least 75% of patients receiving their treatment in less than 62 days.

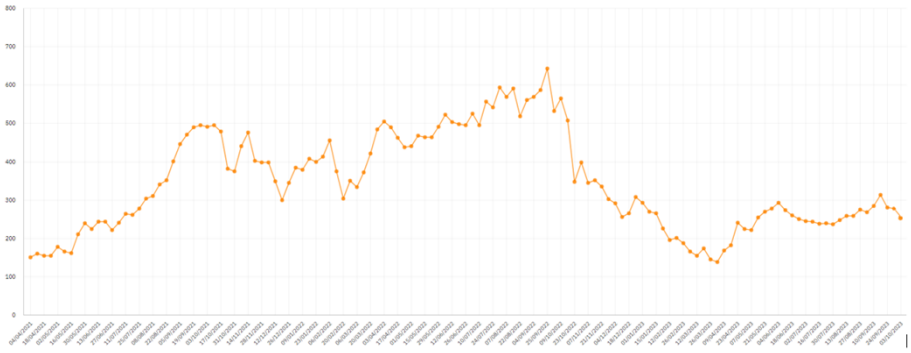
In the first quarter of this financial year each clinical board was tasked with creating both improvement plans, and backlog reductions in order to sustainably meet the standard. The cancer summit on January the 17th 2023 the ambitions of the cancer pathways were re stated and shared with all tumour sites. They were as follows:



This approach of improvement at each stage of the pathway should ensure a reduction in the overall waiting list for cancer and attainment of the standard. Each week for each tumour site the performance against the ambition is reviewed and improvement plans challenged in terms of implementation. The collective plan as a result of this work was to deliver at least 75% performance by the end of September 2023. As an organisation this improvement was not achieved. At the end of August, the confirmed cancer performance was 66.4%, and the September performance, which will be confirmed at the end of October, is likely to see a deterioration. The following graph demonstrates the progression in the standard to the end of August

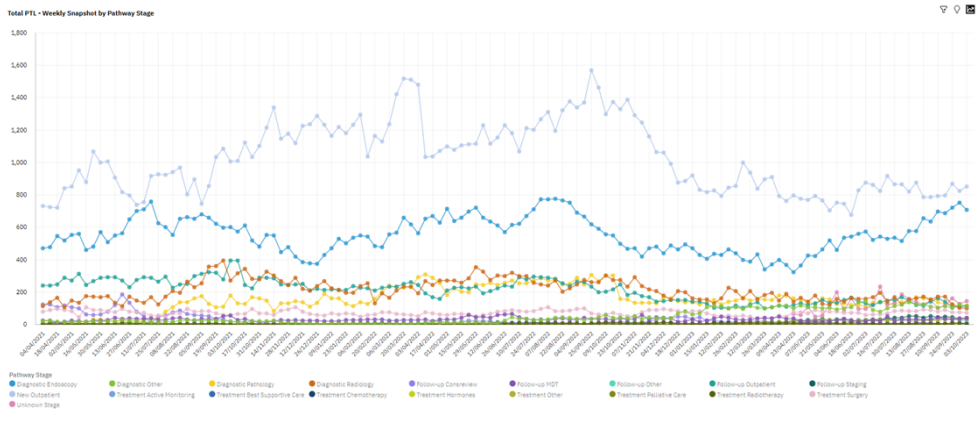


Whilst it is disappointing not to have had further progress in the standard it should be noted that this is the best performance attained by the organisation since the single cancer pathway was launched. In relation to the September performance the deterioration is anticipated due to the current position of the total waiting list and the backlog over 62 days. The cancer team has calculated that the sustainable backlog over 62 days to meet the standard is approximately 100 patients. The following graph shows the backlog as at the end of September.



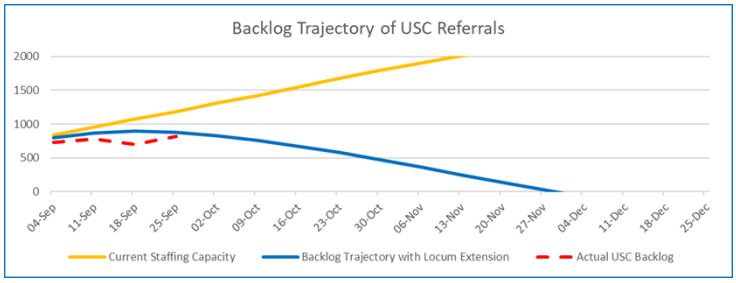
At the end of September there were 249 patients waiting longer than the 62-day standard. From this the cancer team has determined that the performance will worsen in September from 66.4% estimated to be c. 60%. This position will be validated through the month of October.

There are a number of factors that contribute to the continued challenges in relation to sustainable improvement. The Cancer team with Clincial boards have reviewed the contributory factors within the patient list in order to determine areas that require further focus. The graph below is a weekly snapshot of the total patient tracking list (PTL) by stage of pathway.

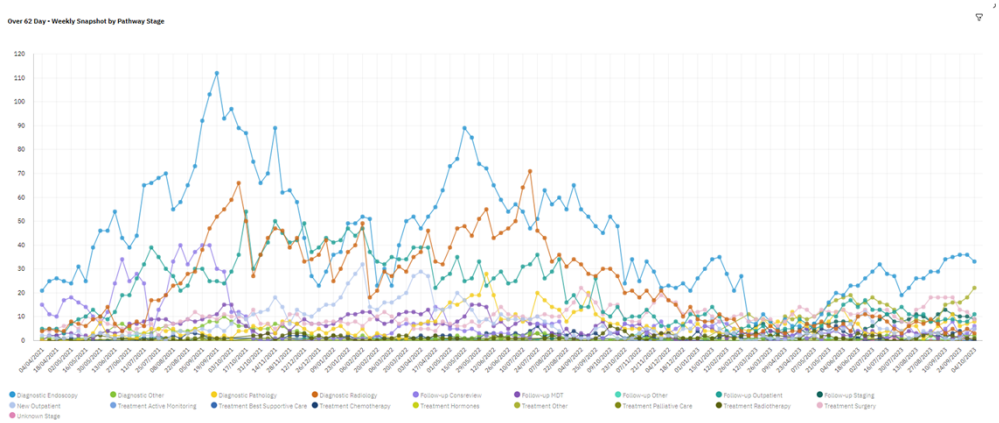


This graph demonstrates that the single biggest factor for the increase in the PTL is the growth in endoscopy. At the time of the report there were 706 patients awaiting an endoscopy out of the 2381 patients on the PTL or 29.6%. The agreed improvement plan for endoscopy was to utilise insourcing for a period of three months to manage the backlog in the cancer position. There were delays of at

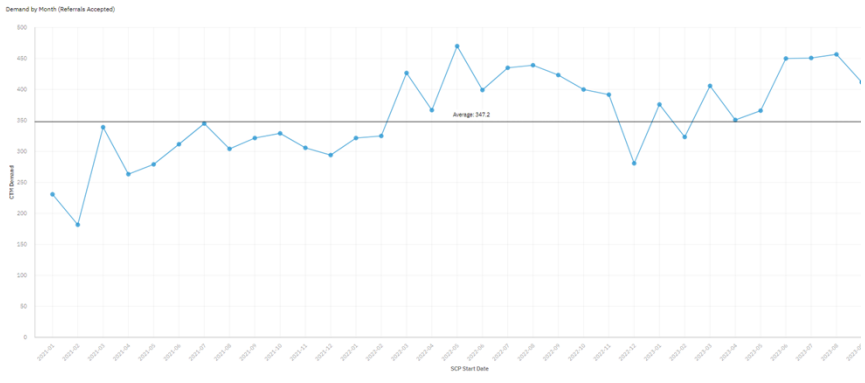
least 6 weeks due to a procurement challenge which has now been resolved. Without this delay there would have been a significantly improved performance in September. The endoscopy team have created the following trajectory for improvement in providing endoscopy within 10 days for cancer patients:



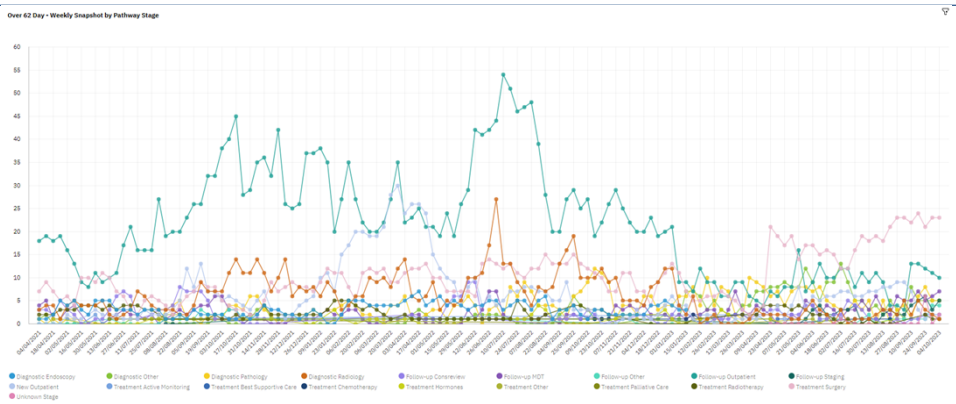
This trajectory will deliver a 10 day or less waiting time for cancer endoscopy patients by the end of the first week in December. Following this there is a clear plan to maintain the waiting times for endoscopy for cancer patients but there is likely to be a period of time for the patients that convert to requiring treatment. On the graph below the main cause of long waiting patients is endoscopy however a proportion of these are likely to need further intervention.



The cancer team is undertaking a review of the demand into our cnacer services in order to understand the impact that this may be having on our performance trajectory. The graph below demonstrates demand into the colorectal service. Demand has increased since the start of 2022, but importantly over the last 4 months the average demand has been in excess of 440 per month. These referrals directly impact on the demand for endoscopy.



The other key component contributing to the ongoing challenge in sustainable improvement is the urology pathway. Within this pathway the key contributing factor to prolonged waits is patients at the treatment stage of the pathway. This is shown in the graph below:



The urology team is currently working on improvements to the treatment backlog by working regionally on the utilisation of the robotic theatre lists. Once this work is completed, the clinical teams are considering the implementation of high intensity lists in order to manage the longest waiting patients.

Whilst it is disappointing that the improvement to the standard has not been achieved by the end of September the deep dive into the component parts of the challenge has enabled teams to develop improvement plans. For each Tumour site there has been an agreed upper limit set for the numbers of patients waiting longer than 62 days. This has been set based on current known challenges and the improvement plans that have been developed. The aim for the organisation is to reach a point where there are no more than 100 patients waiting longer than 62 days.

Each tumour site has set a trajectory for improvement to reach these limits. With the change in demand experienced and the improvements required there has been a need to reset our timeframe to achieve the 75% standard. It is now expected that it will take until March 2024 to meet this ambition.

Recommendation:

The Finance and Performance Committee is asked to **NOTE**:

1. The reasons for the performance not reaching the standard including endoscopy, demand increases and challenges within the urology pathway
2. The approach to setting upper limits for the longest waiting patients for each tumour site
3. The likely outcome of performance not reaching the standard before March 2024.

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	✔
2. Deliver outcomes that matter to people	✔	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	✔
4. Offer services that deliver the population health our citizens are entitled to expect	✔	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	✔	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered

Please tick as relevant

Prevention		Long term	✔	Integration	✔	Collaboration		Involvement	

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: No
Safety: No
Financial: No
Workforce: No
Legal: No
Reputational: No
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Committee/Group/Exec	Date:

Saunders,Nathan
13/10/2023 10:41:10

Cardiff and Vale University Health Board Business Case

For revenue investment proposals greater than £75,000

All business cases must be submitted in line with the timescales outlined in Annex f

Title	Electronic Prescribing and Medicine Administration (ePMA)
Clinical /Service Board or Department	Pharmacy
Expected funding source (highlight/delete as appropriate)	National Programme (e-Prescribing) for the implementation programme and UHB core funding for ongoing support requirements and capital device refresh funding.

Approval and scrutiny route	
Has this case been signed off by the Clinical Board / Corporate Departments senior team?	CD&T Clinical Board Digital & Health Intelligence
Has this case been signed off by the Clinical Board / Corporate Departments finance and workforce business partners?	Finance sign-off Digital & Health Intelligence
Clinical Boards: Has the COOs office signed off this document? **Corporate Departments:** Has the relevant Executive sponsor signed off this document?	Not yet approved by COO – DOp to arrange before IG meeting Medical Director

Table of Contents

1. Executive Summary

Key Points

The ePMA project is funded by Welsh Government's Digital Priorities Investment Fund (DPIF) for pre-implementation and implementation resources and supplier procurement. Once implemented the Health Board is expected to absorb ongoing business as usual (BAU) costs.

- **Patient Care:** Medication errors are a leading cause of injury and avoidable patient harm. ePMA will deliver a major advance in the safety and efficiency of medicines management across the organisation improving the quality of patient care.
- **Funding Source Revenue:**
  - **Project Funding** - Funding being requested of the Welsh Government is £4.46M over 2 years including ePMA solution and programme resourcing
  - **Health Board Funding** - The solution has been procured for 7 years. Once into business as usual, post the implementation period – September 2025/26, the Health Board is required to meet the ongoing costs. The current estimate is of recurrent revenue requirement is £919k. Although this will be offset by the anticipated cost benefits noted below.
- **Funding Source Capital**
  - **Project Funding -** Funding being requested of the Welsh Government is £843K capital over 2 years (2024/25 & 2025/26) for digital devices and computers on wheels (CoWs/carts).
  - **Health Board Funding -** It is anticipated that UHB will require an average of £170K capital per annum to cover the ongoing refresh of the associated digital devices. However, ePMA is one of numerous system developments will require mobile devices. It is therefore expected that the ongoing cost of digital devices should be considered more broadly and not only attributable to the ePMA system rollout.
- **Cost Benefits** - The cost-benefit analysis has identified over £230k p.a. cash releasing savings, alongside many significant non-cash releasing, patient safety, and quality improvement gains worth an estimated £3.34M per annum in productivity gains commencing in 2025/26.
- **Timeline** – The programme will be implemented over 2 years, with a structured delivery approach targeting key areas as agreed with clinical colleagues.
- **Key notes** –
  - Wi-Fi infrastructure improvements are not included in this business case. There are plans to improve the Wi-Fi capability in Q3 of 2023/4. An independent audit has been commissioned by Digital & Health Intelligence to identify any gaps. The results of this survey will be available in the next 2 months. Discussions with the Welsh Government are underway regarding the potential funding, this financial year, to increase the Wi-Fi capability of the organisation.

		Pre-Imp Funding		WG Funding Request		IG BAU Predicted Funding - *additional business case will follow, as more details will be available closer to programme completion*					
Revenue		**2022/23**	**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2030/31**	
	ePMA Solution (inc VAT)			£ 390,000	£ 390,000	£ 390,000	£ 390,000	£ 390,000	£ 390,000	£ 390,000	
	Pre-Implementation Resources	£ 538,254.0	£ 694,978								
	Implementation Resources			£ 1,818,620	£ 1,857,014						
	BAU Resources					£ 529,246	£ 529,246	£ 529,246	£ 529,246	£ 529,246	**BAU Revenue Total**
	Total		**£ 1,233,232**	**£ 2,208,620**	**£ 2,247,014**	**£ 919,246**	**£ 919,246**	**£ 919,246**	**£ 919,246**	**£ 919,246**	**£ 4,596,228**

		Pre-Imp Funding		WG Funding Request		IG BAU Predicted Funding - additional business case will follow, as more details will be available closer to programme completion					
Capital			**2023/24**	**2024/25**	**2025/26**	**2026/27**	**2027/28**	**2028/29**	**2029/30**	**2029/31**	
	Device Requirement			£ 421,220	£ 421,220	£ -	£ 285,608	£ 277,631	£ -	£ 285,608	**BAU Capital Total**
	Total		£ -	**£ 421,220**	**£ 421,220**	**£ -**	**£ 285,608**	**£ 277,631**	**£ -**	**£ 285,608**	**£ 848,848**

Overall		2026/27	2027/28	2028/29	2029/30	2030/31	**BAU Cap & Rev Total**
£ 2,629,840	£ 2,668,234	£ 919,246	£ 1,204,854	£ 1,196,877	£ 919,246	£ 1,204,854	£ 5,445,076
Total	**£ 5,298,074**				**Average PA**	**£ 1,089,015**	

Executive Summary

Medicines are the most common therapeutic intervention in healthcare, playing a significant role in managing chronic conditions and curing disease. Currently, the vast majority of inpatient prescribing within secondary care in CAVUHB is handwritten on paper charts and has remained broadly unchanged for many decades despite the continued detrimental impact of medication errors on patient care and safety. Human errors are an inherent risk of healthcare, however with paper-based processes there are limited systems in place to check and prevent medication errors. An Electronic Prescribing and Medicines Administration (ePMA) system is a Digital solution that allows medicines to be prescribed and recorded for administration digitally, both throughout a patient's inpatient stay, from admission to discharge, and across outpatient and day-case settings. The system also allows real time tracking and auditing of all prescriptions and adherence to them.

Over 80% of the hospitals in England already use ePMA, with a target for full coverage by 2024 that is on track to be met. Within Wales, Swansea Bay University Health Board (SBUHB) have utilised an ePMA solution since 2018 and the system is now in use at Neath Port Talbot, Singleton, and Morriston hospitals. The implementation of ePMA at SBUHB has been successful in improving patient safety and efficiency by reducing medication errors and has improved the timeliness of medication administration, freeing up nurses' time, allowing them to focus on other patient care activities.

A key component of A Healthier Wales policy is the investment, and use of the latest technology to improve the quality and safety of patient care whilst improving equity and efficiency. On the 20th of September 2021, Eluned Morgan MS, Minister for Health, and Social Services announced the e-Prescribing programme for Wales. One of the four parallel project workstreams of the programme is the implementation of ePMA in secondary care across all Health Boards and hospitals across Wales. The imperative aims to have digital prescribing available in every setting for all prescriptions by 2025; CAV UHB will be one of the first to go-live.

The ePMA project is funded by Welsh Government's Digital Priorities Investment Fund (DPIF) for pre-implementation and implementation resources and supplier procurement. DPIF is a priority for Welsh Government and funding identified to ensure that EPMA is live across all UHBs and Trust therefore a key priority to ensure digital advancement for the prescribing and administration of medicines within Wales. This is a key Welsh Government priority and there is an expectation that all Health Boards will implement the system. The

expectation is that the Health Board will take over the funding of this system when the project reaches the business as usual (BAU) phase.

A procurement framework was put in place in November 2022 for use by UHBs and Velindre Trust. Following this, an effective local procurement process has been undertaken and we have a preferred supplier that will support the delivery of the quality and safety benefits highlighted within this business case.

Welsh Government expectation is to receive a business case submission from CAVUHB in October 2023, with a plan to go-live in Q2 2024/5, and subsequent implementation over a 15-month period across all clinical areas. To achieve this, the contract must be awarded the contract to our preferred supplier before the end of December 2023.

What are the high-level benefits?

- Patient Safety - ePMA improves the legibility and safety of prescribing and administration of medicines, including a reduction in medicines errors and serious untoward incidents arising from paper-based processes.
- Clinical Quality Benefits - ePMA improves the consistency and quality of prescribing practice by providing clinical decision support to guide users to prescribe safely.
- Accuracy of medicines: ePMA provides barcode scanning functionality to support the administration of medicines to ensure that the right patient receives the right dose of the right medicine, via the right route.
- Service Quality Benefits - ePMA provides a complete data trail of medicines prescribing, and administration actions for improved governance, audit and access to data to support research and development opportunities.
- Value Based Healthcare - ePMA delivers a greater degree of equitable, sustainable, and transparent use of available resources to achieve better outcomes and experiences for every person.
- Time released to care - Currently, ward staff waste valuable time, searching for and re-writing paper drug charts. ePMA eliminates these problems, releasing a considerable amount of time for ward clinical staff to care for patients.
- Financial - ePMA, supports clinicians to align with the local formulary and local guidelines, enabling more efficient, economical and evidence-based prescribing. Guiding clinicians to prescribe efficiently from the onset of admission, will also reduce medicine waste by reducing any inadvertent prescribing variation.

2. Introduction and Background

The World Health Organisation has identified unsafe medication practices and medication errors[1] as a leading cause of injury and avoidable harm in health care systems across the world. Currently, most of the inpatient prescribing within secondary care in CAVUHB is handwritten on paper charts and has remained broadly unchanged for many decades despite the continued detrimental impact of medication errors on patient care and safety. Human errors are an inherent risk of healthcare, however with paper-based processes there are limited systems in place to check and prevent medication errors and patient harm.

We are one of the largest NHS organisations in the UK, with a workforce of around 16,000 staff who consistently deliver high quality services to all our patients. Our services include a broad range of emergency and planned care including medical, surgical, paediatric, and mental health. We also serve a wider population across Wales providing specialist and complex tertiary services.

An ePMA system is a Digital solution that allows medicines to be prescribed and administered digitally both throughout a patient's inpatient stay, from admission to discharge, and across outpatient and day-case settings. Unlike paper-based prescribing, ePMA provides a clear and legible record of medicines, with functionality to guide healthcare professionals to prescribe effectively and safely as well as providing robust systems to check that medicines are administered accurately to patients.

Within Wales, Swansea Bay University Health Board (SBUHB) have utilised an ePMA solution since 2018. The implementation of ePMA at SBUHB has been successful in improving patient safety and efficiency by reducing medication errors and improving the timeliness of medication administration, freeing up nurses' time, allowing them to focus on other patient care activities. In 2020, Welsh Government commissioned an independent review into e-Prescribing to review options and made recommendations on how to deliver a fully digital, multi-sectoral ePrescribing platform for Wales. A strategic review was commissioned and overseen by an expert panel, drawn from all areas within NHS Wales, chaired by Welsh Government's Chief Pharmaceutical Officer. The main recommendation from the review was a parallel delivery approach to digital change across four main areas being:

a) Seamless primary care e-prescribing capability
b) Seamless secondary care e-prescribing capability (ePMA)
c) Patient Access development (NHS Wales App)
d) Shared Medicines Record

Responding to the review[2], the Minister for Health and Social Services set out an ambition for a comprehensive digital medicines plan for Wales and asked Digital Health and Care Wales to establish the Digital Medicines Transformation Portfolio[3]. The national approach for the secondary care ePMA programme has seen the creation of a national procurement framework, allowing each Health Board and Trust to procure their own ePMA system. A

[1] Medication Safety Webinar series: WHO Global Patient Safety Challenge: Medication Without Harm & World Patient Safety Day 2022
[2] https://dhcw.nhs.wales/files/eprescribing/welsh-government-eprescribing-review/
[3] https://gov.wales/written-statement-statement-eprescribing-programme)

multi-vendor framework for e-prescribing in secondary care was awarded by Digital Health and Care Wales in July 2022, on behalf of NHS Wales.

The CAVUHB ePMA programme vision is to successfully implement, within all secondary care and some specific tertiary care areas, a modern ePMA system that facilitates the safe prescribing, supply, administration, and communication of medicines from and to primary care, helping to reduce medication errors and improve patient care through standardisation and the utilisation of improved data and decision support.

CAV UHB ePMA programme objectives are detailed below.

Objective	Desired outcome
Complete CAVUHB procurement specification for the secondary care procurement activity (Completed)	Ensure that the system procured will meet the specific local requirements of CAV UHB
Procure an ePMA solution from the framework provided by DMTP and award contract. (Contract award in November 2023)	
To work alongside chosen supplier and DHCW colleagues to ensure open standards and API compatibility with current architecture. (November 2023 to July 2024)	To achieve interoperability between NHS Wales organisations and NHS Wales digital systems.
Utilise dm+d as an initial drug library and build any additional unlicensed medicines. Configure the system to work seamlessly according to local and national guidance and local clinical protocols (to be completed by July 2024)	To deliver a system which improves the safety of medicines management and is built up on the needs of clinical users.
Engage with, support and train colleagues within the health board during pre-implementation activities (August 2024 – November 2025)	To have seamless electronic prescribing and medicines administration for all patients in CAVUHB secondary care settings, across hospital sites and outpatient settings.
Implement an ePMA system across CAVUHB secondary care settings (September 2024 – December 2025)	
Continue ongoing maintenance of the ePMA system following successful implementation. Including the optimisation of the system.	Ensure that the system continues to be utilised optimally within the organisation and develop service improvements in line with organisational requirements ongoing.

ePMA is a key enabler in raising the digital maturity of CAVUHB in line with our digital strategy and digital roadmap, including progressing against the Healthcare Information and Management Systems Society (HIMSS) digital maturity model, namely, the Electronic Medical Record Adoption Model (EMRAM). Implementing ePMA represents significant business change, moving from paper-based to digital medicines management processes across all clinical areas impacting many patient-facing staff, including nursing, medical and pharmacy, which will mean new ways of working, modernisation and the upskilling of workforce. CAVUHB currently has a very low level of digital maturity (HIMSS Level 1), therefore ePMA is breaking new ground for digital and for the health board.

In scope - The scope of the programme is to replace paper-based prescribing and administration processes across all clinical areas over the hospital sites, including inpatient, outpatient, day-case, and discharge settings.

Out of Scope - Electronic prescribing is already planned within the adult general intensive care setting and in use for chemotherapy within paediatric haematology and oncology and

adult haematology services. These areas are therefore outside the scope of the ePMA programme.

An essential aspect of the ePMA programme is that the ePMA system is built on open communication standards (such as FHIR, SNOMED CT and dm+d) and has at its core, the interoperability required to use and share information across the CAVUHB digital infrastructure and more widely across the health boards and trusts within Wales to facilitate consistent and joined up care nationally. The ePMA solution will integrate with existing key national systems such as the Welsh Clinical Portal (WCP) and Welsh Hospital Pharmacy Stock Management System (WHPSMS). Interoperability is key for the chosen solution to ensure key medicine information can be consumed and sent within the local and national digital architecture.

The national framework allows NHS Wales organisations, on a local basis to undertake a competitive tender process, setting their own detailed specification and cost model and select their solution provider. This is allowing CAVUHB to tailor it's specific digital and clinical requirements, whilst optimising ePMA implementation. Given the significance in undertaking a local ePMA procurement, CAVUHB designed a thorough specification in conjunction with the procurement department.

Following a thorough and effective local procurement process we have identified a preferred supplier that will help us deliver the quality and safety benefits highlighted within this business case.

3. Strategic Context – Alignment to UHB strategic direction

CAVUHB Strategy '*Our vision for 2035 – living well, caring well, working together*'

"Working together, we will help improve lives so that by 2035 people are healthier and unfair differences in health outcomes are reduced. The care we provide for people who need our services and those delivering services will be outstanding, with outcomes and experience for all that compare with the highest performing peer organisations. "

To achieve the inspiring aspiration of the board, we must look to our immediate requirements to deliver the objectives set out in the strategy. ePMA plays a key part in the development and delivery of these objectives providing a key step change in how care is provided for the better.

Objective 2 - PROVIDING OUTSTANDING QUALITY

"We will provide outstanding services which are equitable, timely and safe, where people are treated with kindness and are supported to achieve the outcomes that matter to them. By 2035 we intend to consistently benchmark in the top decile (10%) against key quality measures when compared with peer organisations and we will have reduced inequities in prevention, improved access to clinical services and clinical outcomes."

Key Priorities within objective 2 that will be impacted be the delivery of the ePMA project are:

Priorities	Key milestones		ePMA Impact
	2027	2035	
Deliver outstanding quality of care every time - care that is personalised, timely, safe, accessible, and effective – from the most complex care for the most critically ill through to routine care that prevents and protects against ill health and disease – addressing physical and mental health needs. Achieve the best outcomes for patients in line with what matters most to them, their families, and carers.	We intend to be in the top quartile for key quality indicators including patient experience, avoidable harm, and mortality.	We aspire to be in the top decile (10%) for key quality indicators including patient experience, avoidable harm, and mortality.	The ePMA system will reduce error and therefore significantly reduce harm and waste. It will also negate the need to waste time searching for paper drug charts. ePMA will utilise technologies such as barcode scanning at the point of medicine administration to improve patient safety. The system will allow timely and effective audit so that unwanted variations can be identified and addressed. Order set and decision support functionality will help improve the consistency of prescribing practice to reduce any unnecessary variation in clinical care.
Develop the Health Board's approach to continuous quality to improvement and make the best use of the health board's resources –	We will increase the proportion of the Health Board's resources to support people to live healthy	We will further increase the proportion of the Health Board's resources to support people to	ePMA will improve the availability and accessibilities of patient prescriptions to improve efficiency but also staff satisfaction. ePMA also

people, assets (buildings and equipment) and money.	lives and to reduce risk of ill health and to increase the services delivered in the community.	live healthy lives and to reduce risk of ill health and to increase the services delivered in the community.	provides a wealth of data that can be utilised for audits, quality improvement and research projects. Decision support will help guide prescribing practice to ensure consistent and evidence-based care. ePMA will improve patient safety and deliver seamless knowledge transfer.

Objective 3 - DELIVERING IN THE RIGHT PLACES
"By 2035 we will be using real time integrated data to inform joint decision making and multi-disciplinary team working, giving people access to and ownership of their data to enable them to manage their health and wellbeing. We will be well on our journey to provide care in the right place, in facilities that are fit for purpose, flexible and promote recovery."

Our hospitals will be 'digitally enabled hospitals' where health and care systems are fully connected across the patient pathway. We will be planning new acute hospital facilities to be 'smart hospitals' which combine patient and environmental data to enable the use of all the data available across the entire patient journey to deliver services in highly efficient ways. …. The Health Board's digital and data systems will be integrated and provide real time data to inform joint decision-making between the patient, their family and carers and the multidisciplinary team, and to provide insights needed for research and the management and future planning of services.

Key Priorities within objective 3 that will be impacted be the delivery of the ePMA project are:

Priorities	Key milestones		ePMA Impact
	2027	2035	
To achieve digital maturity enabling the Health Board's workforce, partners, patients and public to connect and communicate, supporting shared decision making in the planning and delivery of health care services.	We will have in place a digitised health and care system with integrated care records supporting decision making and service planning in real-time, and will have delivered 50% of the digital roadmap (stage 3 of the healthcare digital maturity model)	We will have a fully paperless environment with digital solutions supporting the entirety of the patient journey from beginning to end, spanning all care settings, including care at home. Full delivery of the entire digital roadmap, achieving full digital maturity across all the Health Board's services. Both environment and patient data will be combined to deliver digitally enabled healthcare premises.	ePMA will utilise open standards of computable communication to ensure that information can freely move to care settings and other systems, such as the NHS Wales patient app, to facilitate shared decision making across all care settings. ePMA will facilitate accurate and timely communication of discharge letters to primary care as a key enabler for safe transition of care.
With Cardiff University and NHS partners,	The Health Board's plans will be well progressed to replace or	We will be commissioning a new/redeveloped	ePMA will deliver benefits to our digital infrastructure and

develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future (Shaping Our Future Hospitals).	redevelop University Hospital of Wales and University Hospital of Llandough, so we provide 'smart hospitals' that enable delivery of our Shaping our Future Clinical Services plan.	University Hospital for Wales and have progressed the Health Board's redevelopment plans for University Hospital Llandough. The Health Board's facilities will meet standards of accrediting organisations.	collaboration processes as well as provide quality improvements opportunities. Being one of the initial building blocks of becoming a smart hospital, ePMA will improve medicines management and ensure practices are continuously improving to improve patient care and ensure care is fit for the future.

Objective 4 - ACTING FOR THE FUTURE

"We will work to ensure that what we do today does not compromise the wellbeing of our future generations. We will protect the environment and develop and use new technologies, treatments, and techniques to provide the best possible health outcomes and sustainable health care into the future. By 2030 we will have reduced the Health Board's carbon footprint by 34% (currently under review) and will have increased our research and clinical innovation activities."

Key Priorities within objective 4 that will be impacted be the delivery of the ePMA project are:

Priorities	**Key milestones**		**ePMA Impact**
	2027	**2035**	
Contribute to the development of and adopt cutting-edge and novel treatment, techniques, and technologies where they deliver improved patient outcomes and improved value.	Eligible patients have access to advanced therapies defined in the Welsh Policy Guidance	We will be a centre of excellence and all eligible patients will receive advanced therapy care within national standard timeframes.	ePMA will deliver key benefits to the patient and to the delivery of quality care. We will improve patient safety, deliver seamless knowledge transfer, and speed up time to discharge / length of stay. ePMA will utilise technologies such as barcode-scanning at the point of medicine administration to improve patient safety.
Deliver the Health Board's carbon emissions targets and fully support active and sustainable travel for staff and visitors to patients. Promote, reward, and embed successful waste reduction as part of our quality programme of continuous improvement.	We will continue to aim to achieve the targets for delivering our carbon emission-reduction (currently the target is 34%) and supporting active and sustainable travel	We aim to secure carbon neutral status by 2035	ePMA will deliver key benefits to staff in providing efficiencies the delivery of quality care. We will improve staff utilisation and improve our sustainability. Utilising a digital

	for staff and visitors to patients.		ePMA system for prescribing will significantly reduce the use of paper on secondary care wards.

4. Case of change

Current Performance

The use of medicines is the commonest therapeutic intervention used in healthcare and plays a significant role in managing chronic conditions and curing disease. Currently most of the prescribing within secondary care in CAV UHB is handwritten on paper charts. Over decades numerous projects and initiatives have looked to improve the safety and efficacy of prescribing and administration of medication locally and nationally, however there are inherent risks associated with paper-based medicines management processes which cannot be overcome. Over the last financial year 2023-24 alone, there were 1311 medicines related errors recorded within the organisation.

Medication related incidents have a negative impact on patient care and can lead to preventable adverse drug events (ADE). ADEs are linked to patient harm, increased mortality, an increase in hospital length of stay and have financial implications on the NHS organisations.

A 3-month report detailing documented medication related errors in the organisation between 01/05/23 – 31/07/23 was reviewed as part of ePMA pre-implementation business analysis work. During this period, 321 errors were documented related to the prescribing, administration and supply of medicines. 3 of these errors are categorised as 'never events' according to NHS Improvement [4], which means they are wholly preventable incidents with the potential to cause serious patient harm. ADE, particularly where patients have come to harm have significant financial implications for organisations through litigation. Every single medication error carries risk of causing harm or even death and the organisation is currently involved in 2 coroners inquests related to medicines.

31% of errors, from the 3month review, were related to prescribing. Documented prescribing errors included but were not limited to: prescribing a medication a patient is allergic to, prescribing the wrong dose, prescribing via the incorrect route, prescribing for the wrong patient and prescribing a dose without a medicine name. Human errors are an inherent risk of healthcare, however with paper-based processes there are limited systems in place to check and prevent errors being made at the point of prescribing.

Poor legibility of handwritten prescriptions also increases the risk of nursing staff making an administration error, due to the prescriber's handwriting being unclear, leading to miss-interpretation and ultimately an incorrect medicine or dose being administered to a patient which carries a large risk of preventable patient harm.

56% of medication errors, from the 3-month review, occurred at the point of administration. Documented administration errors included, but were not limited to, administering the incorrect medicine or incorrect dose, by the wrong route or to the wrong patient.

The largest reported medication administration error type is where the administration signature field has been left blank on the medication chart, meaning that either a medication has not been administered, or that it has been administered but not signed for. This carries the risk that an assumption would be made about whether the patient has received the dose or not either leading to double dosing or retrospectively signing the chart but not receiving a dose at all, both of which increase the risk of harm to the patient.

A significant proportion of medication administration errors are not known about within the organisation. This is either because the error was not noticed when it happened, was

resolved without documentation, or was not reported due to fears of any repercussion. Therefore, it is likely that error numbers produced from the datix system is a significant underestimate. A large systematic review estimated that errors occur in 18.64% of medications administered [5]. A contributing factor is the inherent risks of paper-based prescribing and the limited availability of checking processes that paper-processes provide at the point of administration. Medication administrations errors can have a significant detrimental impact on patient care and its prevalence has a significant clinical and financial burden on the NHS.

A large amount of healthcare professionals' time is taken on locating patient medication charts. Medication charts can be taken by other members of the multidisciplinary team to any area of the ward, taken to pharmacy due to a medication request or lost in the vast amount of paper documentation in clinical areas. The direct impact of this to patient care is that medications cannot be started, altered or given in a timely manner, which is particularly problematic for patients taking time critical medications. A significant amount of time is taken up by healthcare professionals trying to find the drug chart to complete a task, such as weekend cover doctors having to walk across a hospital site just to prescribe paracetamol. Frequently, medicines charts are completely lost, and a new chart must be prescribed by a doctor without an old chart to reference from, which risks losing any changes to medications that have happened in hospital. The ultimate impact of this inefficiency is causing potential harm to patients and distress for the patients and their families. Delays administering medications can result in poorer outcomes and the additional time taken by nurses to locate the medication chart results in time taken away from direct patient care.

Because there are limitations from prescribers not having access to a paper drug chart for example, if working on-call from home, verbal orders for medications are taken by nursing staff over the telephone. Not only does this introduce a risk of misinterpretation and potential harm but also impacts on nursing time as current protocols state that a second nurse needs to confirm the verbal order to allow administration to occur.

Another inherent issue with paper prescribing, is having to re-write drug charts once they have expired after 14 days. This is hugely time consuming for doctors and pharmacy staff as well as introducing a significant number of prescribing errors, which occur at the point of transcribing medication from an old chart to a new. Additionally, rewriting of medication charts is a low priority task for doctors resulting in charts not being re-written in a timely manner meaning medication cannot be administered, and therefore, patients are at risk of missing doses.

Auditing and data collection regarding medicines management across the organisation is currently very difficult, due to the reliance on manually extracting information from paper-based prescriptions and charts, this is incredibly time-consuming and in-efficient. This makes improving practice inherently difficult especially within the current financial climate. To improve patient care, we need to adapt and improve based on the best level of evidence and a deep understanding of our current practice, however paper-based processes do not provide the organisation with the foundation on which to do this.

Demand

There are clearly defined benefits of an ePMA system compared with paper-based medication charts. ePMA as a digital solution, will enable the organisation to eliminate many

of the inherent risks of paper-based prescribing, and has been shown to reduce both prescribing [6] and administration errors [7].

The clinical decision support provided by ePMA helps to guide prescribing to reduce the risk of medication errors for their patients: decision support identifies potential issues with allergies, therapeutic duplication, drug interactions and provides dosing calculators for complex medicines. The system will also help users to prescribe consistently and according to local and national guidelines with order sets or protocols, which enables more efficient, economical and evidence-based prescribing. Guiding clinicians to prescribe efficiently from the onset of admission, will also reduce medicine waste by reducing any inadvertent prescribing variation. Implementing ePMA systems has been shown to reduce overall medicines expenditure at other NHS sites, including Swansea Bay UHB [8]. As part of pre-implementation analysis and benchmarking research, it is estimated that CAVUHB can reduce total influenceable drugs expenditure by 0.5% from the successful implementation of ePMA.

Unlike paper-charts, there is no expiry, and therefore prescribed medicines do not need to be re-written, releasing a significant amount of time for doctors to care for patients and helping to reduce the risk of transcription errors. The ePMA system is also web-based, enabling users to access drug charts from any computer, saving significant amount of time searching for drug charts and negating the need to provide verbal orders when doctors are unable to come to the ward.

The high availability and accessibility of the ePMA drug chart as well as its administration scheduling functionality will support nursing staff to administer medication more efficiently. At a time where there are significant workforce pressures within the nursing profession any advances in digital systems that can be utilised, freeing up nursing time, must be embraced.

Medications prescribed digitally are clear and legible, reducing the risk of medicines administration errors. The ePMA system can ensure the delivery of improved outcomes for patients due to providing timely treatment, which in turn, promotes improved patient outcomes and experience, and reduces the risk of harm.

ePMA provides an additional level of patient safety by utilising barcode scanning technology to ensure that nursing staff are administering medication to the correct patient and that they are administering the correct medicinal product, as part of closed-loop administration. If utilised correctly, barcode scanning can eliminate the risks of administering medication to the incorrect patient as well as reducing the risk of administering the incorrect medicine via the incorrect route.

In addition, ePMA provides a wealth of data regarding all aspects of medicines management. This has the potential to drastically increase our understanding of current practice and provide a wealth of improvement opportunities for clinical boards and directorates. With data updated in near real-time, the reporting functionality has the potential to improve the efficiency of healthcare staff on the ground, providing them with information to help them prioritise their time and work in a smarter and more informed way.

Capacity

Moving from paper-based to digital-based medicines management processes will represent significant business change. ePMA will not be a simple “plug and play” implementation, and instead requires considered implementation, where healthcare staff are supported through

the change over a period of time and that medicines management process are optimised in line with the functionality and possibilities that ePMA provides.

To prepare the workforce for the change there will be several engagement sessions where staff will have the opportunity to view the system and watch demonstrations. The training for staff will be based on e-learning packages tailored to user access and clinical roles. In addition, face-to-face training and drop-in sessions will be provided to ensure that staff are prepared for the change.

On-site support will be provided for staff during the period of implementation with ePMA multi-disciplinary staff and non-clinical “floorwalkers” available to aid in the transition. Electronic resources, such as quick-guides and FAQs will be easily accessible via the organisation’s MicroGuide mobile application and SharePoint site. Super-users will be identified and trained to help provide support for all clinical areas as well as help garner a sense of ownership amongst staff.

There is no doubt that the transformational change of moving from paper charts to an electronic system will have its challenges, however the opportunity to reduce the risk of harm to our patients and improve workflows cannot be underestimated. The determination and flexibility demonstrated by the NHS workforce showed that our staff are resilient to change and are willing to do whatever it takes to improve patient care.

Benchmarking

Detailed discussions, interviews and site visits have been conducted as part of pre-implementation work to learn from other NHS hospitals that have implemented ePMA. This business case is informed by lessons learnt from these organisations. NHS sites include:

- Greater Glasgow and Clyde UHB
- Liverpool University Hospitals Foundation Trust
- NHS Plymouth
- Nottinghamshire Healthcare Foundation Trust
- Sheffield Teaching Hospitals Foundation Trust
- Somerset NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- Swansea Bay UHB
- University Hospitals of Leicester NHS Trust

From all benchmarking discussions with other NHS sites, it is clear that ePMA represents significant transformational change, but sites were unanimous in supporting the overwhelming benefit that ePMA provides both for patient care and practice efficiency.

4. Option Appraisal

This section of the business case explores and assesses a series of options for delivering the investment objectives, resulting in identification of the best value for money option that is subsequently carried forward.

Step 1 – Generate Critical Success Factors

The following set of critical success factors was generated through reference to the '5 case model' guidelines:

Critical success factors	How evaluate?
CSF1: strategic fit	• How well proposed option supports the UHB strategies. • How well proposed option supports the Welsh Government Strategies. • Degree to which proposed option is compatible with other NHS initiatives
CSF2: investment objectives	• Degree to which proposed option meets investment objectives
CSF3: value for money	• Extent to which lifetime costs and risks are minimised and benefits are maximised
CSF4: supplier feasibility	• Capability of suppliers to supply the service. • Capacity of suppliers to supply services within the agreed timescales
CSF5: potential affordability	• Ability of the WG to meet the project costs and for the UHB to meet the required BAU capital and revenue costs, including via any anticipated cash releasing benefits and new financial contributions.
CSF6: organisational achievability	• Capability and capacity of the UHB PM Board programme and project management to deliver the service to the allotted timescales • Extent to which the service users can assimilate, adapt and respond to the change brought on by the solution within the allotted timescales

Step 2 – identify and evaluate

The identification and evaluation of options was undertaken within CAVHUB.

The evaluation discussed several potential options but judged the following options to be key for our further evaluation:

No	Option	Details
1	Do Nothing	Continue handwritten prescribing and administration across inpatient and outpatient setting.

2	Procure a Commercial off the shelf solution via the WG Framework	Procure an ePMA solution that will deliver on the local aim of successfully implementing a modern ePMA capability that facilitates the safe prescribing, supply, administration, and communication of medicines to primary care, helping to reduce medication errors and improve patient care through standardisation and the utilisation of improved data and decision support.

A partial implementation was initially reviewed, however this was dismissed due to:

- an increased risk profile resulting from increased transcribing from paper to digital and back again for those patients moving between ePMA services and those remaining on paper
- negative benefits realisation associated to the increased time taken to perform the required transcribing
- Increased staff dissatisfaction with the mixed prescribing model, leading to the development of negative behaviour

Step 3 - Create and Review Shortlist

On further review of the initial evaluation further risk/benefits analysis was performed resulting in the following table:

No	Option	Details	High-Level Benefits	Risk
1	Do Nothing	Continue handwritten prescribing and administration.	• Lack of change for staff who do not want to move to digital processes	• Continuation of medication errors burden, which is increasing with the use of new and more complex medicines • Continued inefficiency • Sub-optimal patient care • Continuation of patient harm risk • Increased risk of legal liability and associated higher costs • Continuing risk of digital immaturity • Loss of patient trust • Reputational damage from not delivering WG ambition with other health boards progressing onto ePMA solutions • With the possibility of a new hospital build, we would need to ensure digital maturity of which ePMA is a key step.
2	Procure a Commercial off the Shelf solution for e PMA via the	Procure and implement an electronic Prescribing and Medicines	• Patient safety Improvements • Clinical Benefits • Security and Service Benefits	• Staff change fatigue. • Enabling infrastructure • The implementation programme is reliant upon staff availability for training

	WG Framework	Administration (ePMA) solution that will integrate with existing key national systems such as Welsh Patient Administration System (WPAS) and the Welsh Clinical Portal (WCP).	• Financial and Compliance Benefits • Staff Development • Sustainability • Fulfill the WG ambition for ePMA and increase our digital maturity	• Financial consequences for both revenue and capital budget

5. The Preferred option

As the 'Do-nothing' option would have many adverse risks and very low benefits realisation, the preferred option is to Procure a Commercial of the Shelf solution via the WG Framework.

Deliverables

To secure the funding from Welsh Government for the ePMA implementation stages, there will be key outcomes that CAV UHB will be expected to achieve. These can be broken down as follows:

Stage	Deliverables	Estimated timescale	Owner
Implementation (readiness)	• Develop implementation plan • User Acceptance Training (UAT) plan • User evaluation plan (meaningful tasks) • Clinical safety workshops and hazard log • Change management plan • Training plan • Readiness checklist • Integration and configuration • Supplier engagement • Service management • Hardware installation Disaster Recovery planning • Support model	9 Months	CAV UHB implementation team, health board wider technical teams and DHCW technical teams
Implementation Go live	• Operational support model Service management support model • Supplier/contract management Training •	15 Months	CAV UHB implementation team and wider DHCW teams (national support)
Post Implementation	• Benefit realisation • Supplier management • Change management • Staff training • Drug library configuration • User access • Reporting and monitoring	On-going	BAU teams

Implementation scope

The ePMA solutions are intended to be implemented across every clinical area in every hospital in secondary care where drugs are prescribed or administered, including inpatients and outpatient settings. This is intended to cover medical, surgical (including theatres), paediatrics, community hospitals, special schools and CMHTS.

The following are considered out of scope for CAV ePMA;

- Primary care e-prescribing: This is being managed as part of the Primary Care Electronic Prescriptions Service Programme within the DMTP. It is anticipated that

the ePMA solution will integrate with these applications on a phased basis, however a timeline for this is yet to be determined.
- General Adult Critical Care setting: There is an existing national project which is seeking to implement an all-Wales Critical Care system which includes e-prescribing capabilities (Welsh Intensive Care Information System - WICIS).
- Chemotherapy and Radiotherapy
- Outpatient dialysis prescribing: Vitaldata is a national system, currently in use across dialysis services

Supporting the Operational Service

The successful implementation and continued use of an ePMA system is essential to:

- Assure the forecast financial benefits occur annually
- Ensure potential or new hazards from the new ways of working do not materialise
- Secure ongoing patient safety and quality improvements

This requires some additional investment in staff resources including 24/7 support. A multi-disciplinary approach is necessary to help tailor the support and training provided to different professional groups and encourages engagement and ownership from each healthcare profession.

The implementation team will:

- Manage large-scale business change.
- Test the ePMA system for it to be safely piloted and implemented.
- Provide robust processes and training to manage system downtime.
- Work alongside the system supplier and DHCW to provide integration with other systems used locally and nationally.
- Configure the ePMA system to suit current practices
- Create and provide training for all staffing groups who will be using the ePMA system; approximately 9,000.
- Provide configuration, planning and support for each hospital and clinical area during implementation
- Transcribe and check medications prescribed on paper drug charts to ePMA as part of the implementation.
- Provide hands-on technical and clinical support to help each ward with implementation.
- Support additional Digital problem solving and support
- Respond to feedback from staff
- Support the utilisation and storage of data provided as part of the reporting functionality of ePMA.
- Provide ongoing communication to staff on implementation.
- Provide governance accountability of the ePMA implementation.
- Report to nursing, medical and pharmacy directors on the implementation
- Provide support and communication to help implement ePMA systems to other health boards in Wales

Following the 2–3-year implementation period, the staffing resource will need to be altered to provide a business-as-usual team for:

- Continuing configuration of the system to allow prescribing and administration of new and complex medicines (e.g. unfractionated heparin and anaesthetics)
- Help with the integration of the ePMA system with an electronic patient record (EPR)

- Support the utilisation of the substantial amount of data that will be provided by the ePMA system, including the need to support clinical directorates, departments and clinical boards with their ePMA data requests and requirements.
- Provide ongoing training and support for users.
- Support optimisation of system use and functionality within each clinical area.
- Provide upkeep of formulary, dosing recommendations, linked documents, and order sets.
- Provide ongoing clinical governance accountability of the system
- Managing and communicating upgrades to the system
- Responding to planned and unplanned system downtime
- Providing support for integration with new local or national Digital systems.
- Responding to incidents and user feedback
- Provide support and communication to help implement ePMA systems to other health boards in Wales
- Reporting to nursing, medical and pharmacy directors on incidents and improvements
- Producing new performance monitoring and statistical guidance
- Evidencing the benefits realisation of the programme in line with those detailed within this document

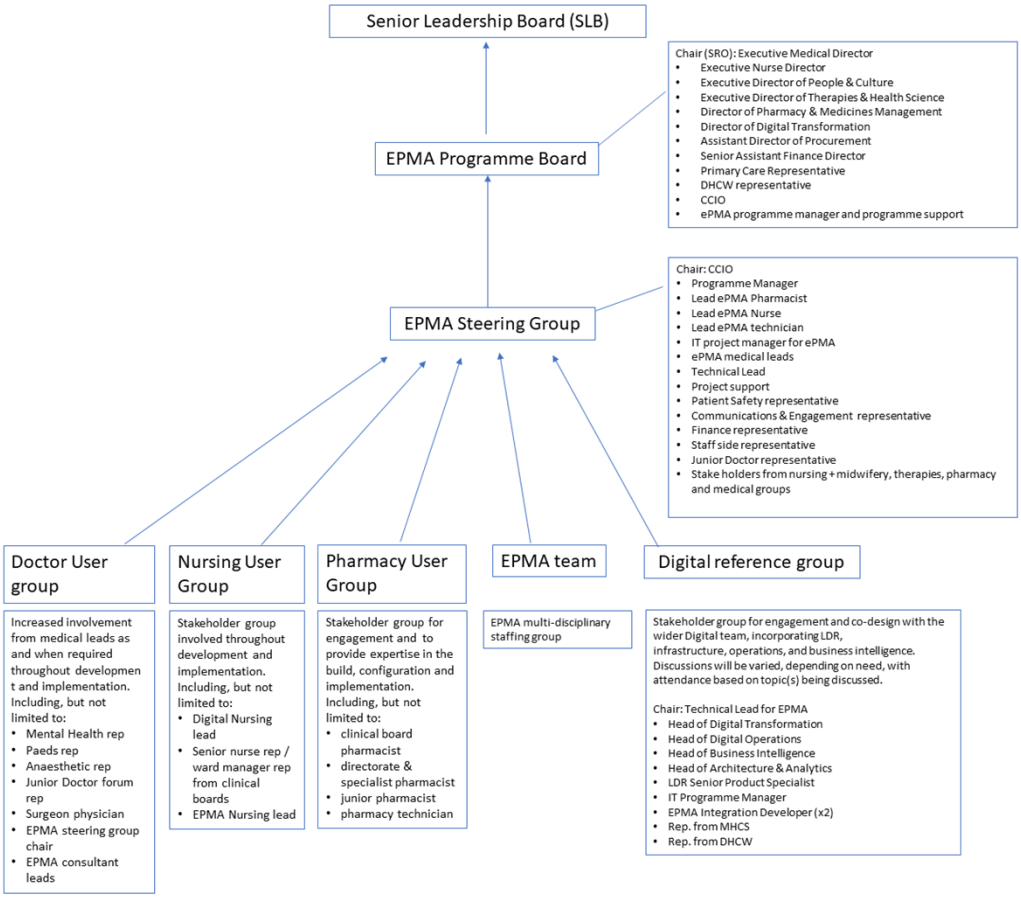
Governance Procedures

This governance structure is an internal breakdown of local governance channels within CAVUHB. To ensure collaboration and appropriate escalation of issues raised, representatives from the DMTP team within DHCW will be present at CAVUHB ePMA Programme Board and the CAVUHB ePMA Programme Manager will attend the national All Wales ePMA Programme Board. The ePMA programme board and steering group will link to existing governance groups and boards where appropriate.

Progress reporting within this structure will follow an established process of escalation through regular meetings noting items for discussion, decisions, and approval to ensure clear decision-making. Actions and decisions will be logged in a register and noted in the published minutes. In addition to this, information will also be distributed via shared documents on both MS SharePoint and MS Teams. This will enable collaborative working in escalating issues and obtaining approvals.

Please refer to the below Governance Structure Diagram.

CAV UHB ePMA Governance Structure



Hardware scope

The funding provided by the DPIF via Welsh Government will include hardware costs for the initial implementation of the ePMA solution. The specifications of device type (i.e. mobile device, handheld etc) can be found in Annex b. Consideration have been given to the clinical locations' individual requirements for equipment, particularly space available to store and charge equipment. The ongoing costs of replacement and repairs of hardware will be the responsibility of CAVUHB.

Training

The objective of the ePMA implementation is to facilitate a significant transformation in clinical processes, optimising medication management and patient care. To achieve this, we will deploy subject matter experts (SMEs) across different professions. These capabilities will seamlessly integrate with existing clinical teams, bolstering the quality and expediency of medication delivery while adhering to clinical best practices. Emphasising continuous improvement, we will leverage the expertise of these leads to drive the success of the e-prescribing programme. Utilisation of subject matter experts will ensure all resources are highly skilled and seasoned within programmes of this nature and will support rapid deployment across 15 months, with the ability to flex to the programmes demands. A team of specialist provision will be available for the implementation period, with 24/7 floor walkers over the implementation period.

Business as Usual (BAU)

ePMA will be a corporate system, The Pharmacy Directorate will operationally manage the clinical system in BAU. The digital team will provide support to the ePMA solution and its enabling infrastructure. To fully understand the resource requirements, the below table lists an overview of roles and responsibilities for ePMA BAU and the related disciplines/directorates that would undertake those roles. This list assumes that implementation across all clinical areas has been completed.

Discipline / Directorate	Role	BAU Roles and Responsibilities
Pharmacy	ePMA Senior Pharmacist (1 WTE) Pharmacy Technician (1 WTE) Data Analysts (2 WTE)	• Provide Pharmacy leadership - engagement with end-users • Link to MD and CCIO regarding ePMA • Help manage changes to practice/ misuse of system in certain areas • Provide pharmacy leadership – engagement with end-users • Manage medicines-related interface with ePMA. • Provide strategic direction for optimisation. • Manage requests for change related to medicines management/ manage clinical optimisation of the system • National support within DMTP • Manage improvements in ePMA system/ practice (ETP, barcode scanning etc) • Managing system upgrades and implementation • Manage updates to relevant SOPs • Close relationship/ link to supplier and other supplier sites for clinical developments • Updating drug files • Updating configuration of decision support/ order sets • Support / ongoing training • Optimising medicines management workflows related to ePMA • ePMA interface support (Omnicell, CMM, WCP, etc) • Communication of updates/ changes • Out of hours support for ePMA requests • Data Reporting • Creation and management of data dashboards to help healthcare staff prioritise their time and for management staff to optimally manage their services. • Support research, audit and quality improvement data requirements of the organisation related to medicines use.
Nursing	Senior Nurse (1 WTE)	• Provide nurse leadership for ePMA - engagement with end-users • Medicines safety and improvement link • Support ongoing training including agency staff • Ward staff/ nursing clinical governance link for ePMA-related issues • Communication of updates/ changes

Digital	IT Project Manager (1WTE)	• Provide Digital Management - Engagement with end-users • Co-Ordinate change control and requirements/specifications for system digital implementations, interface specification and development management, and digital service management. • Manage Problem management, Change Management, Upgrade Management and Configuration Management over the Digital estate supporting the successful use of EPMS (Interfaces, User Privileges, Clinical Safety Reviews.) • Provide strategic direction for optimization (Digital perspective). • Engage with National ePMA operational and Digital groups as necessary to maintain optimum service. • Digital management over improvements in ePMA system/ practice (ETP, barcode scanning etc.) • Management of Digital resources required for ePMA (demand and prioritization, knowledge transfer and standard procedures). • Digital Management for system upgrades and implementation • Lead Digital input to updates to relevant SOPs • Close relationship/ link to supplier and other supplier sites for digital developments • Updating configuration of decision support/ order sets • Management of Digital Support staff (initial onboard, and implementation support, then ongoing Digital SOP delivery) • ePMA interface support (Omnicell, CMM, WCP, etc) • Communication of updates/ changes • Manage Out of hours Digital support for ePMA

6. Benefits

This section outlines both the quantifiable and non-quantifiable benefits associated with the proposal.

Quantifiable benefits	*Non-quantifiable benefits*
• Reduced stationery costs in the use of Drug Charts • Reduction in costs of influenceable drugs • Reducing (or eliminating) the time spent rewriting drug charts • Reducing (or eliminating) the time spent looking for drug charts or lost drug charts • Decreased nurse drug round time by 2% • Reduce the time taken by clinicians/nurses queuing in pharmacy to drop prescription off • Reduce the time taken by clinicians/nurses walking to the pharmacy • Removal of MTeD transcribing • Increased allergy documentation - Drug Chart • Increased allergy documentation - WCP • Improved mandatory thromboprophylaxis screening • Improved mandatory thromboprophylaxis treatment where “clinically indicated” • Ensuring clear accountability for prescribing • Elimination of illegible Prescriptions • Elimination of incomplete Prescriptions • Improve the documentation of patient weight on drug charts • Removal of handwritten medicines supply orders • Eliminate blank administration records • Improved patient experience/satisfaction – through less time waiting for beds, and better information for patients on medication from clinicians which will all have a positive impact on patient satisfaction. • Reduction in litigation risks through full availability of good quality records and improved audit trails • Reduced prescribing errors • Reduced administration errors	• Improved pharmacist efficiency due to the ability to target clinical pharmacist activity to patients with greatest need and application of LEAN principles • The incoming supplier has committed to strengthening the local supply chain, focussing on the development of software infrastructure provided by third party providers within Wales. • Commitment to increase the number of Welsh employees at the ePMA supplier organisation, emphasising further investment in supporting local communities and building robust foundations for key engagement infrastructure. • A prosperous Wales will be achieved through technological improvement in the Cardiff & Vale digital infrastructure via EPMA. Continually developing and innovating the EPMA system to establish the Health Board as a pivotal leader in advancement of improved Healthcare Technology. • A resilient Wales will be established through sustained reliability and robust healthcare services provided by the Health Board to key stakeholders. Ensuring that the safe storage of patient and pharmaceutical data is maintained for the duration of the contact. • A more equal Wales will be strived for through the implementation of EPMA, developing a system that is non-discriminatory and maximises the benefit of the individual stakeholder/patient.

6.1 Benefits tracker					
Benefit	Metric	Baseline	Target	Savings per annum	Timeline / Ambition
Reduced stationery costs in the use of Drug Charts	Cost of paper charts procured and utilised	Current expenditure on Drug charts per annum is £30k	£0	£30,000 (CR)	Yr3
Reduction in costs of influenceable drugs	Reduction in costs of influenceable drugs	Current expenditure on 'influenceable drugs' is £40m	0.50%	£200,000 (CR)	Yr3
Reducing (or eliminating) the time spent rewriting drug charts	Effort spent rewriting drug charts	Drug charts will not need to be rewritten with ePMA	0hrs spent	£190,851 (NCR)	Yr3
Reducing (or eliminating) the time spent looking for drug charts or lost drug charts	Effort spent looking for drug charts or lost drug charts	Effort spent looking for lost drug charts	0hrs spent	£2,450,975 (NCR)	Yr3
Decreased nurse drug round time by 2%	Audit drug round times pre and post-implementation	Average time taken to do a morning drugs round per patient = 11.47 minutes	2% reduction	£220,491 (NCR)	Yr3
Reduce the time taken by clinicians/nurses queuing in pharmacy to drop prescription off	Number of prescriptions dropped off per day multiplied by the average time to wait in the pharmacy	Average waiting time 303 seconds	95% reduction	£34,233 (NCR)	Yr3
Reduce the time taken by clinicians/nurses walking to the pharmacy	Number of prescriptions dropped off per day multiplied by average time to walk to the pharmacy	Average of 161 seconds to walk to Pharmacy	95% reduction	£18,371 (NCR)	Yr3
Removal of MTeD transcribing	Time taken to perform MTeD transcribing per annum	Time taken to perform MTeD transcribing is 150 mins per pharmacist technician and pharmacist 30 per working day	0 minutes	£192,725 (NCR)	Yr3

6.1 Benefits tracker					
Benefit	Metric	Baseline	Target	Savings per annum	Timeline / Ambition
Increased allergy documentation - Drug Chart	% of prescription records with allergy information recorded on Drug chart	Baseline sample of 200 Drug Charts: 99% of drug charts with allergy information documented	100% of ePMA records with allergy information documented	N/A	Yr3
Increased allergy documentation - WCP	% of prescription records with allergy information recorded on Discharge Letters	Baseline sample of 200 Drug Charts: 5% of prescriptions within WCP with allergy information documented	100% of ePMA records with allergy information documented	N/A	Yr3
Improved mandatory thromboprophylaxis screening	%VTE Risk Assessment Completed (audit)	Baseline sample: 30% VTE Risk Assessment Completed	100%	N/A	Yr3
Improved mandatory thromboprophylaxis treatment where “clinically indicated”	%VTE Prophylaxis prescribed (audit)	Baseline sample: 76% VTE Phophylaxis prescribed	100%	N/A	Yr3
Ensuring clear accountability for prescribing	% of drug charts currently missing a doctor’s signature	Baseline sample of 200 Drug Charts: 17% of drug charts missing a doctor’s signature	0%	N/A	Yr3
Elimination of illegible Prescriptions	% of current drug charts with illegible prescriptions	Baseline sample of 200 Drug Charts: 59% of drug charts incorporate illegible prescriptions	0%	N/A	Yr3
Elimination of incomplete Prescriptions	% of current drug charts with incomplete prescriptions	Baseline sample of 200 Drug Charts: 20% of drug charts incorporate incomplete prescriptions	0%	N/A	Yr3

6.1 Benefits tracker					
Benefit	Metric	Baseline	Target	Savings per annum	Timeline / Ambition
Improve the documentation of patient weight on drug charts	% of weights recorded on Drug Chart	Baseline sample of 200 Drug Charts: **64**% of drug charts had weights recorded on them	95%	N/A	Yr3
Removal of handwritten medicines supply orders	Number of handwritten medicines supply orders performed	**72**% of Prescriptions where dispensed handwritten	0%	N/A	Yr3
Eliminate blank administration records	National - (Number of Blank Boxes in previous 24 hours) BASELINE: No. Blank Boxes per No. Medication Charts then percentage*% out of X number of medicines charted.	% Medicines Administration Boxes not Completed. A recent audit of a 200-drug chart sample found that 33% of these drug charts had a blank administration on them	<2%	N/A	Yr3
Improved patient experience/satisfaction – through less time waiting for beds, better information for patients on medication from clinicians which will all have a positive impact on patient satisfaction.	Improved patient survey ii. Reduction in the number of complaints		Improved patient satisfaction	N/A	Yr3
Reduction in litigation risks through full availability of good quality records and improved audit trails	Current litigation risk level to be reduced following ePMA implementation		Reduction in the risk level associated to litigation.	N/A	Yr3
Reduced prescribing errors	The number of prescribing errors recorded on inpatient chart in relation to drug, dosage and frequency.	16.9% were in error	50% reduction of errors recorded	N/A	Yr3

6.2 Benefits Realisation

Delivering the benefits of the ePMA project will require a benefits realisation register detailing who is responsible for the delivery and monitoring of benefits. Due to the considerable transformational change, project benefits may not be realised until after the programme has transitioned to operational service. Therefore, it is important for CAV UHB business change leads to continue to track and realise benefits following programme closure. The main stages for the benefits realisation process are:

- Before implementation:
  - Identify the key benefits to be tracked and quantify these
  - Baseline what happens now
  - Define the target position
  - Assign responsibility for delivery
  - Identify assumptions / issues
- During / after implementation:
  - Measure the expected benefits against the baseline
  - Take action to rectify if benefit not achieved

All cash-releasing benefits identified within the financial case will be treated as project deliverables.

Over and above these, the non-cash releasing financial, and the qualitative benefits will be prioritised, and their delivery tracked by the Project Group. For these, the following will be defined:

- Value
- When the benefit is expected to be realised
- The tasks to be undertaken, and by whom, to enable the benefit to be realised
- The individual responsible for its delivery

The Economic Case presented several benefits that have been reviewed and revised. It has also described how the transformation of processes is essential to ensure that these benefits can be realised. A full benefits strategy and transformation plan will need to be developed considering the selected preferred bidder and their proposed solution.

Leads will be identified for all benefits, including executive level sponsorship, with benefits aligned to divisions and appropriate operational leadership assigned. The Programme governance structure will include a benefit steering group. This will oversee benefits delivery, and will include consideration of failing benefits processes, disbenefits or emergent benefits. The benefits process will also need to review other programmes that may cross over with the ePMA deployment to ensure benefits are not double counted.

In addition, DHCW have been asked by Welsh Government to provide an All-Wales national benefits realisation work. Local benefits match an agreed but smaller list of national benefits and as such, CAVUHB BAU team will support DHCW with this piece of work and provide all the necessary data for this.

7 Risks

This section outlines the risks associated with the successful implementation (should the case be approved) and plans for mitigation. On-going risk reviews are being held during the development of this business case to identify, review, and score the nature of individual risks. The responsibility for identifying risks is shared across the project team and governance structure in section 5. The primary tool for identifying, assessing, controlling, and communicating risks within the project will be the Risk Register.

The ePMA Programme Lead has the authority to manage risk within tolerance and escalate where the tolerance is breached. The SRO for the ePMA project and Programme Board are accountable for ensuring risks are escalated via the appropriate route. The Programme Board will also be required to hand over any open risks to the respective governance meeting at the point of the project's closure.

The Risk Register record risks and any mitigating actions, with the party responsible for these actions documented. The Risk Register is hosted on Microsoft Teams and available to all members of the project team. This register will be regularly reviewed at both the Steering Group and Programme Board for discussion and decisions. This will also feed into the monthly RAG Report to DHCW.

The weighting of risks will be based on the multiplication of probability and impact of risk occurring. This will provide an overall risk rating to prioritise risk. Responsibility for assigning the likelihood and impact of risks will sit with the Steering Group.

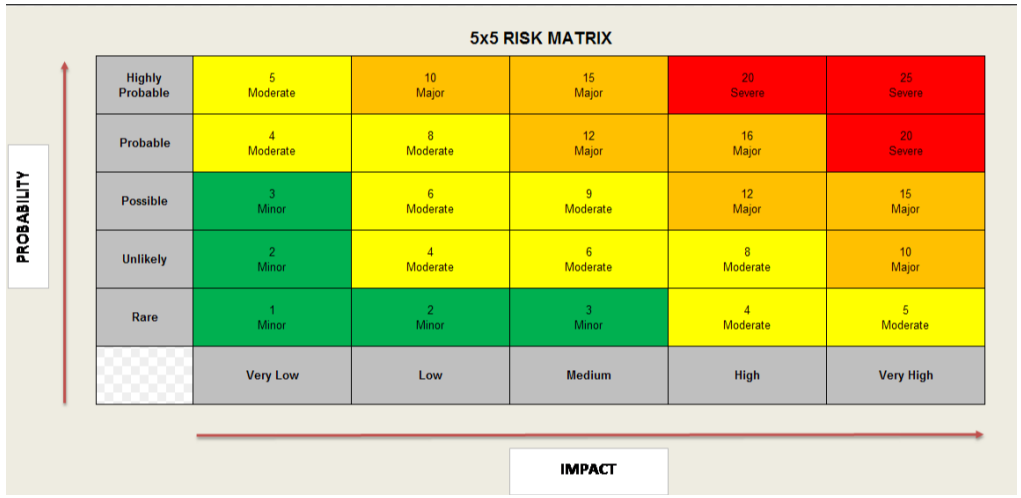
The Risk Escalation Procedure sets out the standards which are to be applied to risk management and codifies the responsibilities to provide adequate risk management and consistency in procedure. The assessment of risks will depend on which stage of the escalation procedure the risk has progressed to, and mitigating actions decided at this stage.

Risk Title	Descriptor	Probability (1-5)	Impact (1-5)	Total risk score (PxI)	Mitigating Action	Owner
Capacity and receptiveness to ePMA training	The risk is that there has been a Welsh Nursing Care Record (WNCR) implementation delay and there are currently 3000 nurses awaiting training for WNCR which will likely impact capacity and receptiveness to ePMA training.	1	2	**2**	Awaiting more information on WNCR implementation following discussions. High level plan indicates that go live for ePMA should come after WNCR implementation	Nursing Informatics Lead
ePMA Record Sharing	The risk is that an audit by DHCW identified that 10-20% of drug files on the pharmacy stock control system (i.e. the medicines we use in C&V) will be uncoded on Dictionary of medicines and devices (dm+d). This could mean that ePMA system would not be able to send electronic orders for these items that are not Dictionary of medicines and devices (dm+d) and the medicine information is not interoperable with other ePMA systems nationally .	1	3	**3**	Needs highlighting to DHCW to reduce any pushback against setting up of Welsh medicines library (or other editorial policy) to ensure interoperability of medicines. This was discussed with DHCW and emailed in January 2023. Additional pharmacist funding was requested to look at drug file built locally	DHCW
Interdependencies	The risk is that there are numerous interdependencies between ePMA and both local and national systems, and these interdependencies are not yet well known or understood.	2	3	**6**	Prioritise development of local SAD & SRS to fully understand the requirements and dependencies of the system once procurement activities have been concluded. We are aware and prioritising this work accordingly. 21/07/23	Informatics Lead

ePMA API Usage	The risk is that the Application programming interface (API) roadmap is unknown, and we are dependent on DHCW for the numerous interdependencies between current DHCW systems and the proposed ePMA solution. We don't know which API will be available when and whether this will be ready for CAV proposed go-live.	1	4	**4**	Issue has been raised and escalated to Programme Board. Update at PB 11/01/2023 from JP (DHCW): An executive Director for API Delivery has been appointed – Ifan Evans DHCW Executive Director of Strategy. Work is underway at DHCW and DMTP and ePMA are a huge priority, when there is a formal response, it will be shared. No timeframe yet. CAV team are in ongoing discussion with DHCW - Meeting on 10/01/23 to discuss dependencies on National Architecture with DHCW team API roadmap has been published and is being updated at national programme board meetings	Programme Board/DHCW
Increased Supplier Demand	The risk is that the more UHBs & Trusts that progress through the ePMA procurement the greater the demand for supplier attention will be. If multiple trusts procure the same supplier and they are running back-to-back procurements whilst we are trying to develop and implement, then attention will be divided.	1	3	**3**	Issue was raised with National Programme team – they are reviewing HBs ITT dates and will stagger ITTs to provide all vendors on the framework with the opportunity to reply to all tenders	DHCW

WICIS Conflict	The risk is that the WICIS programme is due to go live in CAV in Q3-Q4 2024/25 which will clash with the planned implementation of the pilot sites for ePMA	1	3	**3**	The project team for WICIS are requesting to move CAV to be the last UHB to implement WICIS, this would mean that the go-live would move back to December 2024. Lines of communication are clear between the two project teams, and both are working together to ensure clarity on go-live conflict dates and update any changes to go-live. HW will monitor the situation and update if necessary.	ePMA Project Manager
Wi-Fi Coverage	There is a risk that the lack of coverage of Wi-Fi within CAV sites may impact the effective implementation of an ePMA system as staff will not engage with the process if the infrastructure is not working effectively.	4	3	**12**	Funding has been secured to investigate the Wi-Fi coverage across the UHB, with a priority focus on UHW. Improved Wi-Fi coverage will be essential for the Testing stage of the programme in July 2024. An independent audit has been commissioned by Digital & Health Intelligence to identify any gaps. The results of this survey will be available in the next 2 months. On-going discussions with the Welsh Government regarding future funding in this financial year to increase the Wi-Fi capability of the organisation.	Informatics Lead

Key: 5x5 risk matrix



7.1 Critical Milestones

To ensure the effective delivery of the project several critical milestones have been identified below and place as a high risk to the project:

- **Contract Award –** The implementation timeline is only achieved by ensuring a commencement date for Implementation of January 2024. To achieve this Business Case approvals, funding approvals, procurement award and contract negotiation must be completed before this date.
- **Microsoft O365 licences & Nadex accounts** - There may not be enough for the full implementation of ePMA across the UHB. We will require all nursing, medical, dental and AHP staff, as well as a large proportion of therapies staff, training staff and administrative staff to have individual Nadex accounts with email access to be able to access the ePMA system. These accounts will need to be enabled for the Pilot stage of the programme in July 2024.
- **Wi-Fi Coverage** - Funding has been secured to investigate the Wi-Fi coverage across the UHB, with priority focus on UHW. Wi-Fi is crucial to the effective implementation of an ePMA system as staff will not engage with the process if the infrastructure is not working effectively. Improved Wi-Fi coverage will be essential for the Testing stage of the programme in July 2024.
- **Device Rollout** – With the project funding, and using, more than 900 devices, we require an effective implementation schedule to ensure these can be delivered in line with our pilot and implementation phases. Therefore we require the first phases of these devices to ready for the Testing in July 2024.
- **Local Data Repository –** Data integration and feeds are to be established including the Management of ADT. To ensure coverage the expectation is that the LDR will be available by the end of April 2024.

7.2 Assumptions

- All critical milestones are achieved as detailed above.
- Wi-Fi Costs are excluded from this business case.
- VAT is included in the Software and Licencing costs
- The product continues to receive improvements and upgrade cycles for the lifetime of the contract
- A correct mix of mobile devices including laptops with COWs and digital tablets have been effectively scoped.
- ePMA is a change programme. Robust implementation support is critical to its success. Resource costs are informed by the experiences of others and include governance, business programme change management, training, and education on the application as well as user devices.
- Implementation staffing concludes at end of Year 2

7.3 Information Governance (IG)

All foreseen issues of security and confidentiality were addressed in the procurement specification and follow Caldicott principles. The issues of patient confidentiality have been taken into consideration when outlining requirements for the solution. This includes the requirement for system security that ensures that all those who access, and change patient information can be clearly identified through an audit trail. The specification also addressed controls relating to providing access to appropriate persons.

Compliance with relevant legislation (GDPR and DPA) and with relevant NHS was added to the requirements defined in the specification.

A Data Protection Impact Assessment (DPIA) and System Level Security Policy (SLSP) will be included as project deliverables from the appropriate IG workstream. Testing of the security features will be included in the testing workstream activities.

7.4 Total Cost - Resource Implications and Affordability

The project is funded by Welsh Government's Digital Priorities Investment Fund (DPIF) for pre-implementation and implementation resources and supplier procurement. The expectation is that the Health Board will take over the funding of this system when the project reaches the business as usual (BAU) phase in **September 2025/26**.

Total Costs

The following table summarises how the costs are allocated. All costs are in £. Blue highlights the funding being requested of WG and Amber reflects the predicted BAU requirements going forward in 2025/26 we are requesting of the Investment Group.

		Pre-Imp Funding		WG Funding Request		IG BAU Predicted Funding - *additional business case will follow, as more details will be available closer to programme completion*					
Revenue		2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	
	ePMA Solution (inc VAT)			£ 390,000	£ 390,000	£ 390,000	£ 390,000	£ 390,000	£ 390,000	£ 390,000	
	Pre-Implementation Resources	£ 538,254.0	£ 694,978								
	Implementation Resources			£ 1,818,620	£ 1,857,014						
	BAU Resources					£ 529,246	£ 529,246	£ 529,246	£ 529,246	£ 529,246	BAU Revenue Total
	Total		£ 1,233,232	£ 2,208,620	£ 2,247,014	£ 919,246	£ 919,246	£ 919,246	£ 919,246	£ 919,246	£ 4,596,228

		Pre-Imp Funding	WG Funding Request		IG BAU Predicted Funding - additional business case will follow, as more details will be available closer to programme completion					
Capital		2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2029/31	
	Device Requirement		£ 421,220	£ 421,220	£ -	£ 285,608	£ 277,631	£ -	£ 285,608	BAU Capital Total
	Total	£ -	£ 421,220	£ 421,220	£ -	£ 285,608	£ 277,631	£ -	£ 285,608	£ 848,848

Overall		2026/27	2027/28	2028/29	2029/30	2030/31	BAU Cap & Rev Total
£ 2,629,840	£ 2,668,234	£ 919,246	£ 1,204,854	£ 1,196,877	£ 919,246	£ 1,204,854	£ 5,445,076
Total	£ 5,298,074				Average PA	£ 1,089,015	

Total Benefits

The following table summarises the benefits to be realised as part of this programme. All costs are in £.

		2025/26 Q3&Q4	2026/27	2027/28	2028/29	2029/30	2030/31	
Benefits	Cash releasing	£ 115,000	£ 230,000	£ 230,000	£ 230,000	£ 230,000	£ 230,000	
	Non-cash releasing	£ 1,553,824	£ 3,107,648	£ 3,107,648	£ 3,107,648	£ 3,107,648	£ 3,107,648	Total CR & NCR
		£ 1,668,824	£ 3,337,648	£ 3,337,648	£ 3,337,648	£ 3,337,648	£ 3,337,648	£ 18,357,062

Affordability Analysis Assumptions

The following assumptions have been made when considering the affordability of this investment.

- VAT - Due to the nature of the software procurement we are required to include VAT as it will be unrecoverable.
- Inflation – all figures are shown excluding inflation.

Assumed start date:	April 2024
Funding Source Revenue:	• Implementation - Funding being requested of the Welsh Government is £4.46M over 2 years including ePMA solution and programme resourcing • Investment Group Approval - Once into BAU funding (post the implementation period – September 2025/26), a further business case will be submitted at that point to confirm the detailed requirements. We are currently predicting UHB will require an average of £919K revenue per annum to cover the ePMA solution and ongoing resourcing.
Funding Source Capital:	• Implementation - Funding being requested of the Welsh Government is £843K capital over 2 years for digital devices • Investment Group Approval - Once into BAU funding (post the implementation period – September 2025/26), a further business case will be submitted at that point to confirm the detailed requirements. We

	are currently predicting UHB will require an average of £170K capital per annum to cover the ongoing refresh of the associated digital devices. However, this will be dependent on the Digital strategies position at the point of device refresh.

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5. Keers RN et al. Prevalence and nature of medication administration errors in health care settings: a systematic review of direct observational evidence. Ann Pharmacother 2013;47(2):237-56. doi: 10.1345/aph.1R147
6. Westbrook JI et al. Effects of Two Commercial Electronic Prescribing Systems on Prescribing Error Rates in Hospital In-Patients: A Before and After Study. PLoS Med 2012;9(1):e1001164
7. Poon EG, Keohane CA, Yoon CS, Ditmore M, Bane A et al. Effect of Bar-Code Technology on the Safety of Medication Administration. N Engl J Med 2010;362:1698–707.
8. Swansea Bay University Health Board. Hospital E-Prescribing and Medicines Administration (HEPMA) Evaluation. 2022.

Annex a: Workforce Implications

The full details of the associated project and BAU resources can be found below:

CAV%20Resource%20Profile%20and%2

Annex b: Capital requirements - Digital Device Profile and Cost Model

CAV%20Device%20Breakdown%20v0.33.

Annex c: Medical incidents Reporting

Appendix d (1) - datix_medication_in

Appendix d (2) - Medicines related in

Annex d: Alignment to previously identified 'Outcome and Priority'

Outcome and Priority	How does this proposal support any of these outcomes
Outcome 1: Home first	ePMA will utilise open standards of computable communication to ensure that information can freely move to care settings and other systems, such as the NHS Wales patient app, to facilitate shared decision making across all care settings. ePMA will facilitate accurate and timely communication of discharge letters to primary care as a key enabler for safe transition of care.
Outcome 2: Outcomes that matter to people	ePMA will deliver benefits to our digital infrastructure and collaboration processes as well as provide quality improvements opportunities. Being one of the initial building blocks of becoming a smart hospital, ePMA will improve medicines management and ensure practices are continuously improving to improve patient care and ensure care is fit for the future.
Outcome 3: Empower the person	ePMA will improve the availability and accessibilities of patient prescriptions to improve efficiency but also staff satisfaction. ePMA also provides a wealth of data that can be utilised for audits, quality improvement and research projects. Decision support will help guide prescribing practice to ensure consistent and evidence-based care. ePMA will improve patient safety and deliver seamless knowledge transfer.
Outcome 4: Waste, harm and variation	The ePMA system will reduce error and therefore significantly reduce harm and waste. It will also negate the need to waste time searching for paper drug charts. ePMA will utilise technologies such as barcode-scanning at the point of medicine administration to improve patient safety. The system will allow timely and effective audit so that unwanted variation can be identified and addressed. Order set and decision support functionality will help improve

	consistency of prescribing practice to reduce any unnecessary variation in clinical care.

Annex e: Implementation plan

Implementation%20
plan%20-%20Gannt'

Annex f: IG submission deadlines

IG meets on the first Wednesday of every month. In order for cases to be considered at a meeting they must be with the secretariat in Strategy and Planning **by close of play two weeks beforehand.**

For 2023 this means:

Business Case Submission Deadline	Circulation of Papers to Investment Group	Date of Investment Group Meeting
18 January 2023	25 January 2023	1 February 2023
15 February 2023	22 February 2023	1 March 2023
4 April 2023	11 April 2023	18 April 2023
26 April 2023	3 May 2023	10 May 2023
24 May 2023	31 May 2023	7 June 2023
21 June 2023	28 June 2023	5 July 2023
19 July 2023	26 July 2023	2 August 2023
23 August 2023	30 August 2023	6 September 2023
20 September 2023	27 September 2023	4 October 2023
18 October 2023	25 October 2023	1 November 2023
22 November 2023	29 November 2023	6 December 2023

There is no flexibility without the express permission of the Director of Finance

For 2024 this means:

Business Case Submission Deadline	Circulation of Papers to Investment Group	Date of Investment Group Meeting
13 December 2023	20 December 2023	03 January 2024
24 January 2024	31 January 2024	07 February 2024
21 February 2024	28 February 2024	06 March 2024
20 March 2024	27 March 2024	03 April 2024
17 April 2024	24 April 2024	01 May 2024
22 May 2024	29 May 2024	05 June 2024
19 June 2024	26 June 2024	03 July 2024
24 July 2024	31 July 2024	07 August 2024
21 August 2024	28 August 2024	04 September 2024
18 September 2024	25 September 2024	02 October 2024
23 October 2024	30 October 2024	06 November 2024
20 November 2024	27 November 2024	04 December 2024

Implementation of Paediatric Infectious Diseases Service – WHSSC Tertiary Paediatric Strategy – Women and Childrens Clinical Board

A Business Case for implementation of a Paediatric Infectious Diseases Service within Cardiff and Vale University Health Board was invited by WHSSC in 2022-23 as part of the 2023-24 annual planning round linked to the 5-year Commissioning Strategy for Specialised Paediatric Services.

This case was originally reviewed and approved by Cardiff and Vale Health Board's Investment Group at the start of 2023/24 and was submitted to WHSSC.

Since submission of this original case, due to the current financial climate and to reduce the level of Health Board investment required in 2023/24, a rationalised version of the original Paediatric Infectious Diseases case has been invited and is attached for consideration. This has been discussed with WHSSC.

The original case detailed required investment of £0.900m in 2023-24 with full year recurrent impact £1.160m. The rationalised case reduces full year investment from £1.160m to £0.678m and assumes further year 1 slippage in terms of recruitment and implementation.

Table 1: original to rationalised case WTE and £ investment by staff type:

		Original Case			Rationalised Case			Variance		
Resource Requirement/Role	WTE	PYE 23/24	FYE 24/25	WTE	PYE 23/24	FYE 24/25	WTE	PYE 23/24	FYE 24/25
		£'000	£'000		£'000	£'000		£'000	£'000
Consultant PIID	2.60	306	371	2.10	150	299	-0.50	-156	-72
Consultant Microbiology	0.60	72	86	0.00	75	0	-0.60	4	-86
Senior Clinical Fellow	1.20	96	128	1.20	0	128	0.00	-96	0
Clinical Nurse Specialist	1.80	81	108	0.80	30	0	-1.00	-51	-108
Advanced Nurse Practitioner	1.00	52	69	0.00	0	51	-1.00	-52	-18
HCSW	0.30	6	8	0.00	0	0	-0.30	-6	-8
Psychology	0.20	8	17	0.20	4	18	0.00	-4	1
Antimicrobial Pharmacist	0.50	23	30	0.00	0	0	-0.50	-23	-30
MDT Team Coordinator	1.00	31	41	0.00	0	0	-1.00	-31	-41
Clinic Coordinator	0.60	13	17	0.60	11	19	0.00	-2	2
Medical Secretary	1.30	32	42	1.00	20	35	-0.30	-12	-7
Staff Set up		11	0		6	0		-5	0
Non Pay		72	92		31	55		-41	-37
Micro/Vir/Mycology		18	23		7	14		-11	-9
PIC Line Service		0	25		0	0		0	-25
Overheads		81	105		35	60		-46	-45
	11.10	**900**	**1,160**	**5.90**	**369**	**678**	**-5.20**	**-531**	**-482**

This rationalised case proposes a phased approach in implementation, delaying the initial planned implementation of an **antimicrobial stewardship programme (AMS**)* and **paediatric out-patient antimicrobial therapy (pOPAT).**

Both AMS and a pOPAT service are recognised as a vital component of a paediatric ID services. However, it is recognised that current challenges require a prioritised and phased approach whilst ensuring benefits are realised at pace.

Antimicrobial stewardship (AMS). Introduction of this service would look to combat the rising rates of antimicrobial resistance (AMR) thought optimisation of antibiotic use and reducing ineffective prescribing. This is in line with the World Health Organisation (WHO) Global Action Plan. AMR must become an integral part of all health services but becomes more important in a tertiary setting where antibiotic prescribing involving a variety of drugs and those used as a last resort is becoming more frequent. Progress on this element of the case will be delayed until further ICP planning rounds with WHSSC.

pOPAT is part of a strategy to promote ambulatory care (early discharge or admission avoidance) which can lead to significant benefit in terms of length of stay.

It is proposed that once this initial service (as outlined in the rationalised case) is established a Phase 2 case to establish AMS and pOPAT services is considered by WHSSC in future planning cycles.

Cardiff and Vale University Health Board Business Case

For revenue investment proposals greater than £75,000

All business cases must be submitted in line with the timescales outlined in Annex d

Title	
Clinical /Service Board or Department	Implementation of Paediatric Infectious Diseases Service – WHSSC Tertiary Paediatric Strategy – Women and Childrens Clinical Board

Expected funding source (highlight/delete as appropriate)	Welsh Health Specialised Services
Where a business case is in regards to external funding sources this template **must** be used unless the source of funding requires their own template to be used.	

Approval and scrutiny route	
Has this case been signed off by the Clinical Board / Corporate Departments senior team?	Women and Children Core Board Meeting 13th of January 2023 Revised version agreed August 2023.
Has this case been signed off by the Clinical Board / Corporate Departments finance and workforce business partners?	Cath David / workforce business partner
Clinical Boards: Has the COOs office signed off this document? **Corporate Departments:** Has the relevant Executive sponsor signed of this document?	yes/no

Contents

1. Executive Summary

Currently there is no commissioned or funded tertiary Paediatric Infectious Diseases service for South Wales.

Recognising increasing complexity and globalisation, and the importance of emerging new infections and antimicrobial resistance, the provision of a tertiary paediatric infectious diseases service has long been a requirement of a Regional Children's Hospital in England, as detailed in the NHSE 2013/14 service specification for Paediatric Immunology and Infectious Disease (PIID), and by DOH England (2008) and the NHS constitution (2009).

The absence of a resourced regional clinical PIID network, carries significant postcode related inequity of access to care as well as adverse public health outcomes, that this case seeks to address.

Over the past 10 years, some of the most urgent components of a PIID service have been provided by 2 consultants with dual accreditation in General Paediatrics and Tertiary Paediatric Immunology and Infectious diseases, training and research expertise. The infectious disease work is delivered largely in addition to their core job plans that require them to deliver a tertiary immunology service as well as secondary care general paediatrics. With ever increasing demand for infectious disease expertise in the past few years, the situation has reached breaking point with the directorate of Acute Child Health no longer being in a position to deliver tertiary infectious disease expertise in a safe and sustainable way. Both consultants are senior, and unless support and resource are now put in place, they will seek retirement or alternative employment by September 2023.

These consultants provide the Paediatric Immunology service, which is part of the WHSSC funded Immunodeficiency Service for Wales and which is aligned with services in other nations. Their departure would precipitate collapse of this service (loss of 6 of 8 paediatric sessions).

There is an urgent need for sustainable continuation of regional direct clinical services and provision of training for succession planning. Furthermore, this business case includes consolidation of regional clinical leadership towards Welsh Public Health activity, notably prevention, enhanced surveillance, screening, eradication programs and outbreak management.
It is anticipated that the team would work towards the development of a regional paediatric antibiotic stewardship and a paediatric outpatient parenteral antibiotic service (OPAT) program as part of hospital from home strategies and while not part of phase 1 of the service would welcome the opportunity of working with WHSCC over the next three years to develop a further proposal to establish this service across Wales.

The proposal is that 21 dedicated paediatric consultant ID sessions are commissioned to enable the delivery of a paediatric infectious diseases service alongside the current paediatric immunology service. This in total would amount to 2.7 WTE paediatric consultants to deliver both paediatric immunology and paediatric ID services, with 3 further Paediatric Immunology sessions remaining with the adult immunology lead and the immunology laboratory. The consultant team would be supported by nursing, junior doctors, and administration and other supporting therapy input.

The creation of a sustainable tertiary PID service is an integral part of the WHSSC Paediatric Strategy for tertiary services and as such has an associated source of revenue assumed recurrently within WHSSCs financial plans from 2023 onwards.

Annual Revenue Requirement	Current Year (£)	Recurrent (£)
	369,000	678,000
Capital Requirement (£)	0	

2. Introduction and Background

Paediatric Immunology and Paediatric Infectious Diseases (PIID) is classed as a single tertiary sub-speciality made up of the two component parts throughout the UK.

In the contemporary global context PIID specialists provide a key clinical link between Public Health, Microbiology/Virology and all tertiary and secondary paediatric clinical services, typically in the form of a regional managed clinical MDT network.

Tertiary paediatric immunology is a WHSSC commissioned service within Wales. However, there is no commissioned paediatric infectious diseases (ID) service in South Wales.

Children and young people in North Wales have access to the tertiary Infectious Diseases services in Alder Hey hospital in Liverpool, which is an established centre of excellence. This represents inequity of access to this service across Wales and compared with the wider UK, particularly to the detriment of the paediatric population of South Wales.

Indeed, as early as 2008, the Department of Health in England made the following statements:

"*With the emergence of new infections, new diagnostic tools, new antimicrobial treatments, increasing resistance to antibiotics, increased immunosuppressive treatments, the complexity of modern tertiary care and increased global travel, it has been recognised that* ***paediatric specialist centres should have access to and support from a specialist in PIID***"

In 2013, NHS England produced a detailed service specification for Paediatric Immunology and Infectious Diseases, based on over 15 standards of care. An equivalent set of documents does not exist for PIID within Wales.

"In addition, PIID clinical and academic researchers provide NHS patients with access to the latest new diagnosis/treatments for immune problems, infections and vaccines to prevent new and emerging infections (NHS Constitution (2009) and seek to ensure that patients from every part of England are made aware of research that is of particular relevance to them"

Importantly, infectious diseases form a top burden of acute morbidity and mortality and health care use in infants and children. The incidence of infection in children is strongly correlated with social deprivation. Many of the children admitted to paediatric intensive care facilities will either have presented with an infection or will have had an infectious complication of another health care problem for example, cancer, immunodeficiency etc. Although COVID 19 infection in children rarely resulted in serious respiratory disease as it did in adults, we did see the emergence of a life-threatening inflammatory disorder known as PIMS-TS that affected a small minority of children as a consequence of infection by COVID 19. South Wales saw 71 cases of PIMS-TS between May 2020 and April 2022, which is proportionally very high and due to the high incidence of COVID 19 in our population. In the

later waves, with changes in variants, severe respiratory COVID-19 also emerged in children and young people in South Wales (16 cases). Management of these children, as well as diagnostic work up of a ~20 further suspected PIMS-TS cases for other causes (e.g. systemic JIA or post-COVID recurrent fevers), was coordinated by the paediatric immunology consultants in Cardiff who established a guideline and management pathway alongside paediatric infectious diseases colleagues in England. The vulnerability posed by a lack of a commissioned paediatric ID service was brought into sharp focus by the PIMS-TS outbreak as, without the skill of our immunology colleagues in the management of infectious diseases and consequent inflammatory syndromes, we would not have been able to manage this outbreak within south Wales.

COVID 19 was not the first new infection to affect children in recent years. The HIV pandemic of last century has left an ongoing legacy of children infected by vertical transmission (mother to baby). The paediatric HIV service is currently the only funded paediatric ID service within south Wales, but that provides only 0.4 WTE clinical nurse specialist time and none of the necessary consultant time. Similar services are required for children affected by hepatitis, again spread by vertical transmission, tuberculosis (particularly prevalent in the recent Afghan and Ukrainian refugee population), tropical diseases etc. We also need to be prepared for future outbreaks of infections yet uncharacterised.

There has been a profound impact on the immunity of our population to common infections as a consequence of our lock down strategy during the COVID 19 pandemic in 2020 -21. As a consequence we have seen a cohort of children with no immunity to common seasonal viruses such as RSV. This 'immune debt' has led to recent outbreaks of severe RSV, invasive group A strep and flu, all of which have resulted in high numbers of children requiring secondary and tertiary paediatric services. We do not know what the long term impact of this immune debt will be on the incidence of infections going forwards.

During the winter of 2022-23 there was an unprecedented regional outbreak of cases of myocarditis in very young children infected with enterovirus. This is a common virus that normally causes a self-limiting illness in children, but can sporadically be very serious in young babies. Over a period of a 2 months, 9 babies from south Wales (5) and south west England (4) were diagnosed with rare condition that sadly carries a very high mortality. Indeed, 2 further babies are highly likely to have died from the same condition prior to reaching PCCU (full post mortems awaited).

Our paediatric immunology consultants set up a collaborative MDT with colleagues from Bristol in order to manage these children. They wrote a pathway that included providing a novel antiviral drug to all the children alongside anti-inflammatory therapy. It would have not been possible to manage these very sick children in a coordinated and collaborative way if we had not had the expertise required within south Wales.

Given the rapidly changing landscape of infections affecting children it is going to be essential that south Wales has a paediatric ID service that can work alongside colleagues in microbiology, virology, public health, primary care etc to plan for infection outbreaks in children in the future, enabling our service to be reactive to changes as they occur.

Children and young people (CYP) are our future. Their rights to equitable access to clinical care and clinical research are further underlined in many strategic documents, notably the UN Convention and Committee on the rights of CYP, UNICEF Sustainable Development Goals (SDG 3), The Rights of CYP Wales art 24 (2011), Turning the Tide by RCPCH (2012, 2018), and A healthier Wales (2019). NIHR INCLUDE calls for an improvement in the inclusion of under-

served groups in research. This study regards children as an under-served group, as well as those people from socio-economically disadvantaged groups.

This case describes the component parts that will provide a contemporary Paediatric Infectious Diseases service for South Wales, aligning this with the services provided to children in North Wales and the rest of the UK.

3. Strategic Context – Alignment to UHB strategic direction

Getting things right early in life lays the foundations for lasting population wellbeing, health and resilience. The UK strategy documents for Child Health emphasise prevention and health promotion, and a holistic bio-psychosocial model of care, (Facing the Future, Together for Child Health Standards, Paediatrician of the Future RCPCH 2018-21). The proposed PIID service model supports this approach.

The managed clinical network is aligned with the principles of Shaping our Future Wellbeing, Prudent Health Care, A Healthier Wales, Value in Healthcare, and wider national strategies, in particular the National Clinical Framework for a learning health and care system.

Outcome and Priority	How does this proposal support any of these outcomes
Outcome 1: Home first ❖	The managed clinical PIID service network brings equitable access to expertise as close to home as possible, irrespective of post code. Furthermore, it supports development of All Wales integrated care pathways connecting Public Health, community, primary, secondary, tertiary services. The initial funding of the PID service will enable the development of a further funding proposal to provide a south Wales wide program of paediatric antimicrobial stewardship (PAS) and Outpatient Parenteral Antimicrobial Therapy (p-OPAT) integrated in community-based hospital at home services. Close collaboration with Public Health Wales on outbreaks, emerging diseases, surveillance, screening, transmission prevention and eradication bolsters this also. Reducing hospital admissions and visits also avoids major negative collateral social, educational, employment and financial impact on CYP and families (siblings, parents/carers).
Outcome 2: Outcomes that matter to people ❖	Getting things right first time through early appropriate diagnostics and correct management, improves outcomes, reduces complications, stigma and harm. Experiencing seamless care **(re)builds TRUST** in our system, enhances partnership working and

	improves the experience of CYP, families and professionals alike. Our model represents cross-silo system redesign. It frees up scarce hospital infrastructure and enables continued covid-19 response and post-pandemic recovery. Use of **Value Based Health Care** methodology for ongoing multisource evaluation and system learning will support this further.
Outcome 3: Empower the person ❖	A PIID network leadership empowers professionals in all tiers to function 'at the top of their pay grade'. Our emphasis on self-care empowers families and reduces reliance on services and over-medicalisation. During the **Covid-19 pandemic and emergence of PIMS-TS** strong Paediatric ID leadership for Wales, jointly with the Clinical Research facility, from CHfW, demonstrated this is achievable and there is keen support and momentum from colleagues across South Wales for a collaborative clinical network. Our regional capacity building plan will future proof the PIID service, and reputational benefits will enhance recruitment of high calibre trainees and staff to Wales.
Outcome 4: Waste, harm and variation	A regional PIID service supports prevention and screening programs and effective local clinical care, including recognition and management of rare and serious infections. The proposed network model addresses current postcode related inequity of access within South Wales, between North and South Wales, and between Wales and England/UK. Without funded PIID service for South Wales, acute support and scheduled care will have to be sourced from England (e.g. Bristol, Birmingham Liver Unit, GOSH, King's and St Mary's in London). This is unrealistic and will cause waste and harm and variation from delayed/missed diagnoses and treatment, poor clinical oversight and governance, increased acute out of Wales transfers and excessive travel for families, with associated environmental impact

	and inevitable disengagement of those who need it most. Telemedicine and the wider digital strategy for Wales enable our remote support to patients and professionals (e.g. WCP, Attend Anywhere, TEAMS MDTs, consultant connect, e-advice) and reduce our carbon footprint. Antibiotic stewardship reduces harm, waste, and environmental impact from inappropriate use of antimicrobials.

4. Summary current service provision and case for change

4.1.1 PIID service specification, MDT requirement and UK benchmarking

In the contemporary global context **PIID** specialists provide a **key clinical link** between Public Health, Microbiology/Virology/Mycology and all tertiary and secondary paediatric clinical services, typically in the form of a regional managed clinical MDT network.

In 2013 NHS England produced a detailed service specification for Paediatric Immunology and Infectious Diseases (PIID), based on over 15 standards of care (https//:www.england.nhs.uk/specialised-commissioning-document-library/service-specifications/). Condition specific standards can be provided on request.

The first column of Table 1 lists the key conditions which should be managed by the specialist PIID centre or by a general paediatrician in a local hospital under a network/shared care arrangement with support from the specialist centre. This is based on the NHSE Service Specification (2013), and adjusted to reflect new clinical advances and insights (not exhaustive). Column 2 and 3 will be discussed in section 4.2.

	Conditions requiring Paediatric Immunology and Infectious Disease expertise	Existing funding	Unfunded Paediatric Infectious Diseases expertise
1	Immunodeficiency syndromes - primary and secondary e.g. due to immune suppression or late effects of cancer treatment; clinical management and diagnostic laboratory support. Includes HSCT care pathway with Newcastle BMT unit, all Wales 22Q MDT, Immunology-Genetics MDT	Immunodeficiency Centre for Wales	integral to Immunology service
2	Immunedysregulation MDT clinic for autoinflammation including periodic fevers, complex autoimmunity sndromes	Immunodeficiency Centre for Wales	integral to Immunology service
3	opportunistic infections in immune compromised hosts	Immunodeficiency Centre for Wales	integral to Immunology service
4	common infections in immune-compromised host	Immunodeficiency Centre for Wales	integral to Immunology service
5	recurrent infections - work up for immune deficiency	Immunodeficiency Centre for Wales	integral to Immunology service
6	Kawasaki's syndrome, PIMS-TS and similar		Ad hoc CHfW & regional
7	severe, invasive and complicated infections		Ad hoc CHfW & regional
8	viral hepatitis		regional service lead & delivery - linked with B'ham & Kings liver centres
9	HIV	HIV funding	
10	fever of unknown origin (PUO)		Ad hoc CHfW & regional
11	nosocomial infections, health care associated infections		Ad hoc CHfW & regional
12	multiresistant infections (bacterial, fungal and viral)		Ad hoc CHfW & regional
13	postoperative and post traumatic infections		Ad hoc CHfW & regional
14	complex or multidrug resistant TB and mycobacterial infections		Ad hoc CHfW & regional
15	supporting sec care TB services		regional service lead & delivery
16	complex and unusual neonatal infections		Ad hoc CHfW & regional
17	prevention and treatment of congenital infections (HIV, hepatitis, toxoplasmosis, CMV, syphilis, rubella, herpes simplex, varicella, chlamydia)		Ad hoc CHfW & regional
18	persistent lymphadenopathy - cervical and other		Ad hoc CHfW & regional
19	sexually transmitted infections in CYP		Ad hoc, joint with Adult Integrated Sexual Health Clinics
20	complex vaccine advice for passive and active immunisation		joint immunisation coordinator PHW
21	rare, travel imported and emerging infections and outbreaks, e.g. Lyme, Malaria, Typhoid, MERS, SARS-COV-1, Ebola, Monkey pox, SARS-COV-2, severe hepatitis , neonatal enterovirus mycocarditis outbreak, iGAS		Ad hoc CHfW & regional

Table 1 PIID conditions

The NHSE service specification also summarises the PIID MDT staff and resource requirements as per Table 2.

PIID MDT staff and resource requirements as per NHSE service spec 2013
Consultants (GRID PIID trained
Paediatric Specialist Nursing support (ANP, CNS)
access to clinical Paediatric Micro/Vir/Mycology and laboratory support
Immunology laboratory support
antimicrobial pharmacy support
clinical psychology and play therapy support
access to clinical geneticist
access to safeguarding liaison, social worker and community support workers
access to anaesthetist or PICU based PIC line service

Table 2 PIID MDT requirements

In Table 3 below, we provide benchmarking data for PIID consultants in regional Children's Hospitals in England, which illustrates the stark contrast with the Children's Hospital for Wales.

PID Centre	Consultants	Inpatient Beds	Beds per 1WTE (10PA) PID Consultant
Children's Hospital for Wales (CHFW)	0.8WTE funded sessions and provided by x2 consultants approaching retirement	133 – Including PICU – 7 ITU 4 HDU NICU - 33	133
Evelina	6 consultants 36 PA's (4 IPC PA's)	200 Beds (33 ICU)	56
Bristol	4 consultants 30.75 clinical PA	189 + 47 neonate beds = 236 (20 ICU)	76
St George's	7 consultants 34 PA	160 (15 ICU/step down) 43 NICU/SCBU	47
Alder Hey	5 consultants 33 PA	310 beds (24 ICU)	93
GOSH (no immunology)	5 consultants 36 PA	389 beds? (20 CICU; 15 PICU; 9 NICU)?	105
St Mary's (no immunology)	9 consultants 35 clinical PA's supported by additional PA's from academic working 1:6 on call	130 beds (70 paeds, 15 ICU, 45 NICU)	37
Southampton (consult only)	3 consultants 15 PA	168 (14 ICU, NNU 38)	112
Sheffield (also do immunology)	4 consultants 33.5 PA's	154 beds? From CQC 10 PICU 10 HDU	45

Table 3 Benchmarking of PIID services in England (not all centres have submitted data) Courtesy to CSAC Chair PIID 2021

4.1.2 Antimicrobial stewardship and p-OPAT services – further background

Paediatric Antimicrobial Stewardship (PAS)

The prudent use of antimicrobial agents is essential to maintain the effectiveness of our antimicrobial armoury against increasing global antimicrobial resistance. There is compelling evidence to support the introduction of antimicrobial stewardship programmes in both community and hospital settings, in terms of reduced antibiotic use, improved quality of prescribing and cost-savings (ref British Society for Antimicrobial chemotherapy www.bsac.org.uk).

However, the introduction of paediatric programs lags behind. Furthermore, a recent survey of 17 regional children's hospitals in the UK also highlighted wide variation in program set-up (ref Paediatric antimicrobial stewardship programs in the UK's regional children's hospitals, Vergano et al, Journal of Hospital Infection, June 2020).

This has since prompted the formation of the UK-PAS network, which aims to collaborate with local and international stakeholders, collect and share benchmarking data on antimicrobial use, resistance and clinical outcomes, share information, engage patients and public and contribute to policy through research findings and advocacy. (ref UK Paediatric Antimicrobial Stewardship https//:uk-pas.co.uk)

Paediatric Outpatient Parenteral Antibiotic Therapy (p-OPAT)

OPAT, when governed and delivered well, is an important component of antimicrobial stewardship. Development, delivery and governance of outpatient parenteral (IV) antibiotic therapy (OPAT) programmes enables early discharge of patients to home. This carries significant well-being, resource and environmental benefits. Again, programs and studies have initially focused on adult practice (ref British Society for Antimicrobial Chemotherapy www.bsac.org.uk).

Paediatric programs (p-OPAT) lag behind, but are clearly of vital importance for children and young people themselves. In addition, hospital admissions heavily affect siblings, parents, family life, school attendance, parental work and family finance through additional costs (travel, food) and loss of income. This burden is disproportionately carried by socially deprived populations with unstable low incomes (e.g. zero hours contracts).

As p-OPAT programs are being introduced across the UK, they demonstrate significant positive impact on inpatient services, e.g. in Southampton 130 p-OPAT episodes saved 1683 bed days (ref. The impact of p-OPAT implementation at a Tertiary Children's Hospital in the UK, Patel et al, Paediatric Infectious Disease Journal Dec 2018).

Clinical Governance and p-OPAT staffing

Updated good practice recommendations for outpatient parenteral antimicrobial therapy (OPAT) in adults and children in the UK, were recently published and in addition to the above, highlight the following key points (Ref Updated good practice recommendations for outpatient parenteral antimicrobial therapy (OPAT) in adults and children in the UK, A Chapman et al, JAC Antimicrobial resistance Dec 2020).

Strong clinical governance and clear care bundles are an essential part for both PAS and p-OPAT programs to ensure regular clinical review to:

- reduce overall antibiotic prescribing
- ascertain infection source control
- monitor for clinical and pharmacological complications (including level monitoring)
- initiate prompt IV to oral switch
- make the correct choice of antimicrobial agent balancing effectiveness, ease of administration and development of resistance.

As such programs are being introduced across the UK studies repeatedly demonstrate the importance of a paediatric infectious disease clinician alongside microbiology and specialist pharmacist as key to the success and sustainability of such programmes.

The implementation of a AMS and OPAT programme for South and West Wales will not be part of phase 1 of the PID service but the development of a proposal, working alongside WHSCC, will be a major part of the work undertaken in this first phase, with the aim of having a service in the next 3-5 years.

Telemedicine

This is increasingly used successfully and should be incorporated into programs systematically with appropriate safety netting and plans for escalation.

4.2 PIID service – current position in South Wales

Column 2 and 3 from Table 1 illustrate that only Paediatric Immunology and HIV services (see appendix 1) are currently funded in South Wales.

4.2.1 Paediatric Immunology service

The WHSCC funded Immunodeficiency Centre for Wales provides adult and paediatric immunodeficiency clinical services and diagnostic laboratory support.

The service also includes adult and paediatric PID HSCT clinics, Autoinflammatory clinics, the All Wales 22q11 MDT clinic, a Paediatric Immunology-Genetics MDT and membership of the Syndrome Without A Name (SWAN) MDT clinic. In addition, adult and paediatric immunoglobulin replacement therapy (IgRT) and home therapy is a key component (Table 1 conditions 1-5).

This is a high-profile service with extensive laboratory and research expertise, a strong academic track record and large global collaborative network. The service hosts the TPD for adult immunology training in Wales and has a proved record of trainees passing FRCPath.
The Immunodeficiency Centre for Wales will be seeking Quality in Primary Immunodeficiency Services accreditation in Paediatric Immunology in the near future (https://www.qpids.org.uk). Of note, access to Clinical Infectious Diseases is a requirement of the Immunodeficiency service specification.

The Paediatric Immunology service is provided by 1 Adult trained Immunology consultant (Prof S Jolles, service lead, TPD), and two tertiary-trained PIID consultants (3 sessions each).

Current Paediatric Infectious Disease support to Paediatric Immunology: the PIID consultants are dual trained and thus have the expertise to provide the (unfunded) Paediatric Infectious Disease component of care to Paediatric Immunology patients.

4.2.2 Paediatric Infectious Diseases service – description of scope

Paediatric Infectious Disease specialists also provide an extensive portfolio of services.

- Their clinical workload is heavily biased towards acute consultation to all tertiary and secondary care services (infections can affect all organs) and involves extensive onward liaison with diagnostic services, notably microbiology and imaging.
- The numbers of CYP requiring tertiary beds directly under PIID are small, but carry high complexity and often long lengths of stay.
- Specialist outpatient services, in particular for children with chronic and life-long infections conditions (e.g. blood borne viruses) form a smaller component. Close links with adult counter parts are vital for transition.
- A further large workstream involves provision of paediatric clinical expertise to ensure inclusion of CYP in all Public Health Wales policy, as well as clinical management of outbreaks, emerging diseases, surveillance, screening, mother to child transmission prevention and eradication programs.
- Furthermore, they provide joint clinic leadership with microbiology colleagues in antimicrobial steward ship and o-PAT programs.

The typical service model to provide regional equity of access and resilience is through managed clinical MDT network.

Current position: This is unfunded. It is partially delivered, largely in own time, and on some CAV secondary care funding. There is heavy reliance from clinicians across the region particularly for consults and advice. Nonetheless, there is highly likely a degree of under-diagnosis and under-treatment. Without operational support, we have limited data on activity, incidence and outcome. Welsh specific program targets are likely not met. See *Appendix 1* for available data on HIV, TB case and outbreak management, atypical mycobacteria, Hepatitis B & C, Syphilis, CMV, other congenital infections, PIMS-TS and recent Neonatal Enterovirus Myocarditis outbreaks.

4.2.3 Clinical and laboratory Microbiology/Virology/Mycology service from Public Health Wales

This service currently provides paediatric antimicrobial ward rounds at CHfW to PICU, NICU, Haematology/Oncology and General Paediatrics as well as a 24/7 telephone advice and liaison service. A full PIID services relies on and requires close collaboration with these important clinical and laboratory services.

Current position:

- Excellent working relationships exist between PIID and microbiology clinicians.
- Absence of a funded Paediatric Infectious Disease service means that their clinical support to antimicrobial ward rounds cannot be provided and joint PIID-microbiology consultations and mutual liaison are frequent but ad hoc.
- Of note, supporting a tertiary paediatric infectious diseases service, and particularly a regional PAS and p-OPAT service would require additional clinical Microbiology/Virology/Mycology resource.

4.2.4 Summary of current position and risks for PIID

Paediatric Infectious Diseases

Over the past 10 years the most pressing care has been delivered within CHfW and across the region by two senior highly motivated consultants with required tertiary expertise. This work has been outside their job plans and has not been re-numerated. Many other components have not been delivered or at best ad hoc.

The unsustainability of this situation was brought into sharp focus by the COVID pandemic, where there was a need to assemble and lead the paediatric COVID/PIMS-TS-MDT with all associated clinical and R&D support on a 1 in 2 on call for South Wales (in excess of 600 hrs consultant time across the 2 waves).

With ever increasing demand, this has now reached break point and cannot continue safely. Both consultants are senior, and unless support and resource are now put in place, they will seek retirement or alternative employment by September 2023.

Impact on Paediatric Immunology

Retirement or resignation of one or both PIID consultants also precipitates a crisis in Paediatric Immunology for Wales as they hold the largest cohort (6 sessions), with some incoming support of a General Paediatrician at CHfW (1 session). This is particularly sensitive as the overall service lead of the Immunodeficiency Service for Wales (1 paediatric session) is also approaching retirement. This WHSSC service is already invested in and aligned to strategies in other nations, and without funded Paediatric Infectious Disease component this will be a very difficult and costly recovery.

Risk to patients

There is profound clinical interdependency with delivery of tertiary services delivered at Noah's Ark Children's Hospital, notably Paediatric Intensive Care, Neonatal Intensive Care, and system based medical & surgical paediatric specialties, e.g. haematology-oncology, respiratory, cardiac, rheumatology, gastro-enterology, renal, neurology, neuro-surgery, ENT, trauma and orthopaedics, surgery, and ophthalmology. Close links between PIID and secondary care paediatric units and regional Neonatal units are essential to ensure equitable access to timely diagnosis, appropriate local management, referrals and transfers.

Whilst their expertise is highly valued by clinicians across the region, the current situation highly likely incurs missed prevention opportunities, delayed diagnosis and incorrect treatment, with associated further morbidity. The absence of a managed network means further variation in access to excellence.

Ad hoc working under high time pressure with no designated support or governance structures is inefficient use of consultant time and importantly adds risk to patients.

Imminent collapse of the services will much exacerbate this risk and necessitate immediate recommissioning outside Wales with increased transfers and travel to England, and for many children in reality no service at all.

Risk to regional capacity building – PIID training

An effective clinical PIID network requires expertise building across the region. There are no opportunities within Wales to train in PIID, either at SPIN or GRID level and there are no other paediatricians in Wales who have such qualifications. Ambitious Welsh trainees have to go to England for PIID training and often do not return. When the current PIID consultants leave, there is no back up within Wales, and with this legacy any future competitive recruitment into Wales would be compromised.

The current tertiary PIID consultants are accredited trainers, and have extensive expertise in workforce management also.

Hence the current tertiary PIID consultants have obtained provisional CSAC approval (Aug 22) to offer both SPIN and GRID training, but this is subject to a fully funded PIID service and training post. There is keen interest and some high calibre Welsh Paediatric trainees have registered their interest with CSAC.

Current plan:

- **SPIN (special interest module**) for ST6-8 trainees and PIID network consultants
  Subject to funding Senior Clinical Fellow post – 1.2 WTE trainees due to start date Sept 2023.
- **Tertiary GRID training (Paediatric Infectious Disease focus)**
  Subject to creation of HEIW funded ST6-8 post at UHW. Wales School of Paediatrics supportive, pursuing HEIW funding – earliest possible start September 2024 (subject to HEIW funding)

The prospect of a funded PIID service and training program has already enhanced our reputation and generated high calibre interest not only in training but also in our future consultant PIID posts and CNS and ANP posts. There is yet hope to turn the tide. However, the timelines are tight, and if funding is not confirmed within the coming months, this scheme will collapse and set us back years.

5. Case of change - *The evidence*

Through the implementation of the WHSSC Tertiary Paediatric Strategy this case is an opportunity to capitalise on the extensive clinical, research, teaching and leadership expertise of these senior consultants to build a comprehensive regional Paediatric ID service, and one to which Wales can competitively recruit excellence in due course.

Expertise and skillset of the current senior tertiary PIID consultants at CHfW:

- Strong clinical, teaching and academic track record, and a wide (inter) national peer network
- Accredited PIID trainers, and medical mentors to Clinical Nurse Specialists undertaking MSCs
- Expertise in workforce management and in leading culture change management, cross-silo working and transformation of services, notably the successful creation of Paediatric Integrated Primary Care Cluster clinics in Cardiff and Vale and Community Health Pathways.
- Extensive network of excellent working relationships right across South Wales, and with colleagues in Public Health, providing an invaluable basis for the development of a managed clinical network.

All elements of the proposed package for Paediatric Infectious Diseases are deeply interdependent and required to provide:

1. Equitable access to expert clinical care and research, irrespective of postcode. Key elements

2. Ensured inclusion of CYP in all Public Health Wales policy, as well as clinical management of outbreaks, emerging diseases, surveillance, screening and eradication programs.
3. Regional paediatric antimicrobial stewardship (PAS) and a paediatric Outpatient Parenteral Antimicrobial Therapy (p-OPAT) program as part of hospital at home.
4. Regional PIID capacity, expertise and future sustainability building program
5. Robust clinical and educational governance structures underpinning the PIID service.

Managed clinical network

A network has many benefits beyond equity of access and much strengthens resilience of small services within South Wales. There is keen interest from paediatric units across South Wales in the formation of a managed PIID network and initial discussions are underway. Broadly the architecture will involve funded leadership from the PIID team, with named local lead consultants in each unit. Important ingredients include development of secondary-tertiary care pathways defining referral thresholds and reciprocal clinical remits, and strong business, governance and QI frameworks.

Commitment to mutual learning and teaching is expected and educational opportunities and training will be provided, e.g. PIID SPIN module for consultants. The 'Bringing Networks to Life' resource from RCPCH offers useful guidance, and a scoping exercise of successful networks will be undertaken as part of the formation.

Of note, the PIID service will not be able to offer out of hours cover as this would require 4WTE. This will be mitigated by clear expectation setting across the region, e.g. advance weekend planning. Out of hours care to PIID inpatients at CHfW will be provided through integration with General Paediatrics at CHfW.

The backbone of the service is PIID consultant leadership, but supported by a senior clinical fellow, Clinical Nurse Specialists and administrative staff.

The proposed development of an AMS and OPAT service will require further staff including an advanced nurse practitioner, Clinical Microbiology support, and a Pharmacist.

The table below sets out the predicted job planned Direct Clinical Care (DCC) activity required to support a Paediatric Infectious Diseases service in Cardiff and Vale (21 DCCs).

Table 4 Total PIID consultant Direct Clinical Care sessions (annualised) provided through full investment in this case

Activities	Description	DCC Sessions per annum
Acute services		
Consultant CHfW ward rounds	3 hrs twice weekly. One service consultant, once all	150.40
Acute consult service Mon-Fri 9-18 for CHfW and local units & ad hoc case MDTs and joint clinic reviews & micro-viro-myco lab liaison	2.5 hrs weekdays	173.33
Joint Micro rounds CHfW PICU, NICU, haem onc, Paeds and antimicrobial stewardship	8 hrs per week	111.09
Weekly UHW regional rapid access slots combined with & Paeds ID & Viral Hep clinic	52 clinics per year	78.00
Regional OPAT service joint with Microbiology	Leadership and patient management	168
Scheduled services		

Monthly regional network clinical MDT (with 5 UHBs)	2 hrs MDT (plus admin)	22.40
HIV family clinics (includes transition) at UHW	12 per year	18.00
TB clinics CAV at CRI	12 per year	18.00
TB CNS MDTs and queries	0.5 hrs per week	6.93
TB regional cohort MDT	4 per year (2 sessions per MDT)	8.00
TB outbreak ad hoc outbreak clinics	6 per annum	9.00
TB outbreak leadership & MDTs (including refugees)	12 MDTs (2 hrs per Consultant)	6.40
Paeds ID outreach clinics (SBUHB, HDHD, ABUHB, CTM)	4 per year per site	32.00
Paeds ID UHW team clinical MDT (CNS support) all consultants @ 42 wks py	1 hr per week 52 weeks	33.60
Clinical leadership - outbreaks, emerging diseases	1 session per week 52 weeks	33.60
Fetal Medicine MDT	24 per year (30 min for 1 Consultant)	3.20
Ante natal ID MDT	12 per year (1 hour for 2 Consultants)	12.80
Total DCC sessions		**21.06 Per Week**

As explained previously, Paediatric Infectious Disease services are heavily biased towards acute consultation services and outpatient clinics present a smaller time commitment. However, for further reference Table 5 below summarises the total clinic capacity offered.

Table 5 Paediatric Infectious Disease clinic capacity provided by full investment in this case

Clinic	**Frequency**	**Clinics per annum**	**Appointments**
Weekly UHW regional rapid access slots combined with & Paeds ID & Viral Hep clinic	52 clinics per year	52	312
HIV family clinics (includes transition) at UHW	12 per year	12	72
TB clinics CAV at CRI	12 per year	12	72
TB outbreak ad hoc outbreak clinics	6 per annum	6	36
Paeds ID **outreach clinics** (SBUHB, HDHD, ABUHB, CTM)	4 per year per HB	16	96
Total clinics / clinic appointments		**98**	**588**

6. Option Appraisal

The options available are:

Option 1 Status quo

This will not address the current inequity across Wales. Inaction will mean change. As described above the inability develop a sustainable a Paediatric Infectious Disease service, poses a real risk of losing Welsh Paediatric Infectious Disease expertise altogether and precipitate collapse of Paediatric Immunology services also. Paediatric ID is reliant on two individuals who do not have dedicated time in their job plan and will be retiring within 0-5 years, or, as the current situation is morally and practically untenable, indeed seek alternative employment. This will pose a clinical risk to patients and poor patient experience and

significant reputational damage to Wales. Furthermore, Paediatric Infectious Diseases is by nature an acute specialty with highly unpredictable surges (outbreaks, pandemics) and close ties to Public Health Wales, and does not lend itself to commissioning outside Wales. This is not considered to be an option.

Option 2 Partial or delayed funding
All proposed elements are deeply interdependent as well as time sensitive. Partial or delayed funding is undeliverable and will continue the crisis. In the event of an invited review of a partially funded service, this is likely to fail (RCPCH Invited Reviews Service www.rcpch.ac.uk and Academy of Medical Royal Colleges, aomrc-invited-reviews framework). Collapse of both Paediatric Immunology and Paediatric Infectious disease provision will not be averted.

Option 3 Expansion of service
The proposal is that 21 dedicated paediatric consultant ID sessions are commissioned to enable the delivery of a paediatric infectious diseases service alongside the current paediatric immunology service. This in total would amount to 2.8 WTE paediatric consultants to deliver both paediatric immunology and paediatric ID services, with 2 further Paediatric Immunology sessions remaining with the adult immunology lead and the immunology laboratory. The Consultant team would be supported by nursing, junior doctors, and administration and other supporting therapy input.

As a consequence of having a defined fully commissioned service as above a number of subsidiary benefits across the system are enabled and described in section 7.

7. The Preferred option

Paeds ID is a small service, and any investment in the team below the levels described in this paper will not meet the service specification or sustainability required for the service. Full investment in this case as described in option three is therefore recommended as the only viable option.

7.1 Benefits of investment in a full Paediatric Infectious Diseases Service

Quantifiable benefits	*Non-quantifiable benefits*
Provision of clinical Paediatric Infectious disease services for South Wales in network model 1.Timely and equitable access to the highest quality of care and clinical research close to home irrespective of postcode. *Result:* Increased early diagnosis and correct treatment, and discharge with reduced morbidity from delays and complications 2.Standardised and integrated service through development of care pathways *Result*: Increased quality of referrals, referral avoidance, increased, increased efficiency and reduced wait times 3. Maximal responsiveness to new insights *Result:* rapid implementation of care improvements	1.**Life-long effects of:** • of earlier correct diagnosis and reduced iatrogenic complications on later morbidity. • of reduced hospital stays and visits on social/financial/wellbeing of CYP, siblings, parents/carers and social deprivation scores 2.Down stream effects of **rebuilding TRUST** in seamless care on jobsatisfaction, patient and staff wellbeing. **3. Wider effects of building confidence in self care for childhood infections on** future health care seeking behaviours of CYP in adult life.

4. Expertise framework supporting local development of integrated pathways with primary care, and self-care for families.	4. **Ripple effec**ts on of the above on siblings, family, friends and wider community
Designated regional paediatric programs and care bundles for: • paediatric antibiotic stewardship **(PAS)** • paediatric Parenteral (IV) antibiotic therapy **(p-OPAT)** • **Blood culture taking** • **IV-line care** To support excellent care at home or as close to home as possible (local paediatric units).	**Wider and longer term impact** • on antimicrobial resistance • on microbiome health • on public perception/knowledge of antibiotic use
Provision of CYP/family centred programs for • Outbreaks • Emerging Diseases • Prevention (incl vaccination) • Surveillance • Screening • Eradication	**Wider impact on:** • Community transmission • Longterm physical and mental health (incl stigma) and well being of CYP/families • Educational/professional/social attainment • Longterm social deprivation scores
Regional PIID Capacity Building and succession planning **Existing extensive teaching portfolio** of PIID delivered clinical to PICU, NICUs, tertiary specialisms, micro/viro trainees, maternity services, Public Health, regional Paediatric grand rounds e.a. **Network model** accelerates this across the region as membership will have defined learning & local teaching commitments **Increased local R&D expertise** through participation in clinical trials and studies. **SPIN and GRID PIID training will become available in Wales** (currently trainees go to England and often do not return) **PIID training support of allied professionals**, e.g. PIID CNS, ANP, AM Pharmacist (e.g. MSc mentoring). **Overall much increased resilience** of PIID service (major surges, outbreaks, pandemics, staff absence) and of small local paediatric	**Reputational benefits** • For Children's Hospital and Welsh paediatric units • For HEIW and Welsh School of Paediatrics among UK trainees, senior nursing colleagues and other allied professionals. • To standing of Wales among PIID consultant peers across the UK and internationally **Enhancement of competitive recruitment to Wales** of high calibre ambitious: • tertiary PIID consultants for Children's Hospital for Wales • secondary care consultants with a special interest in PIID to NICUs and paediatric units across South Wales • Paediatric trainees (PIID and all) ***Note:*** Expressions of interest are indeed coming in since inclusion of WHSSC Paediatric Strategy

services in managing common and rare childhood infections.	Longterm impacts of above on regional **clinical and academic excellence, sustainability and succession planning.**
Clinical Goverance PIID Full electronic auditable clinical activity and outcome records of consults, MDTs, referrals, admissions and clinics. Improved quality of enhanced surveillance programs (e.g. respiratory viruses in 0-5 yrs) Robust QI mechanisms ensuring measurable clinical and systems learning (VBHC) Public transparency and involvement of children, young people and families in improvement and shaping of services	**Culture shift** in other paediatric and wider services from using Value Based Health Care methodology within the PIID service Wider impact from **listening to the voices of children and young people**.

7.1.1 Benefits Tracker

The grace and favour nature of the existing service, coded largely through General paediatrics, and absence of a regional model makes coding of existing and an assessment of unmet demand challenging. The benefits of investment of the case will regularly be visited and refined by the Directorate and Clinical Board Team as the service is initiated and matures.

Benefit title	Benefit descriptor including	Expected realisation date	Measure(s) to be used	Baseline position at 22-23	Projected position at Oct 23	Actual position at Oct 23	Projected position at Apr 24	Actual position at Apr 24	Projected position at end 2024/25	Actual position at end 2024/25
Lead and support: **Provision of clinical Paediatric Infectious disease services for South Wales**	Formation and leadership of managed clinical Paediatric Infectious disease MDT network for South Wales Acute Paediatric Infectious Diseases consult service Mon-Fri 9-18 hrs for South Wales Rapid Paediatric Infectious Diseases review service for South Wales at CHfW Support joint ward rounds & MDTs with Microbiology/PICU/NICUs/HaemOnc/Immunology/medical and surgical specialties/secondary (CHfW and South Wales) Paediatric Infectious Diseases clinics at CHfW and outreach clinics 4 UHBs Support and delivery of Paediatric TB services for South Wales Lead clinical paediatric blood borne virus service and deliver clinics for South Wales (HIV, Hep B and C) As integral part of clinical care provision of equitable access to all relevant studies and NIHR portfolio clinical trials for CYP across South Wales		Compliance with NHSE PIID service specification Compliance with disease specific standards of care Equity of access to care within South Wales, and compared with North Wales and UK Alignment with Welsh Digital Strategy and National Clinical Framework for a learning health and care system. Compliance with UN Convention on Rights of the Child (2013) Sustainable development goals Unicef (SDG 3, 2015) Rights of Children and Young persons Wales art 24 (2011) Turning the Tide RCPCH 2018 (excellent care includes equitable access to research and trials) Reduction in LOS for those conditions requiring PIID input Improved equity of access (atlas of variation Increase in activity through improved diagnosis	Unfunded with exceptions of HIV service 6 sessions Microbiology support (SLA with PHW)	Recruitment into Consultant posts and infrastructure complete Workplan to achieve compliance with standards of care drafted		Progress made towards meeting compliance with standards of care, strategic direction. Evidence of reduction in Length of Stay for PIID patient cohort Update Welsh access data to evidence improved equity of service access outside Cardiff and Vale Evidence of increase in activity due to improved diagnosis/access		Service fully embedded Compliance with standards listed Revisit data points from Apr 24 in terms of activity, LOS Efficiency identified	
Provide clinical Paediatric Infectious Diseases expertise to policy and clinical management of: **Outbreaks Emerging Diseases, Surveillance, Screening**	Ensure inclusion of appropriate plans for children and young people and their families/carers in all relevant workstreams Support local implementation and clinical case management via the clinical MDT network Strengthen collaborations with • PHW working parties • Infection Control • Immunisation		Meet WHO, UK and Welsh program specific targets Provide Joint briefings with Public Health Wales, e.g to Welsh Government **Examples** MERS, **SARS-Cov1 &2, PIMS-TS** Monkeypox, **Ebola 1&2 HCID guidance for children and families,** severe hepatitis syndrome, neonatal enterovirus myocarditis, iGAS, refugee	Unfunded					WHO, UK and Welsh targets met. Where not met clear project plan and timescales identified	

and eradication Programs	• UK networks and registers • Maternity services • Health Inclusion Services (refugees and asylum seeker screening) • Sexual Health • Homeless services • Young offenders • Substance misuse/ CAMHS		screening & emergencies (Afghanistan TB, Ukraine Hep C and MDRTB risk). Ongoing screening, prevention and treatment programs (e.g. HIV and Hep B). Paediatric TB outbreaks South Wales (~ 1 yearly); Hep C eradication.							
Lead and support development of **Paediatric Antibiotic Stewardship (PAS) program** **&** **Paediatric Outpatient Parenteral Antimicrobial Therapy (p-OPAT) service** **as part of hospital at home initiative across the 5 UHBs in Wales**	Development of regional designated paediatric programs and care bundles for: • paediatric antibiotic stewardship **(PAS)** • paediatric Parenteral (IV) antibiotic therapy **(p-OPAT)** As essential pre-requisite also bolstering of existing programs for: • **Blood culture taking** • **IV-line care** In collaboration with Paediatric Microbiology, Infection Control, Paediatric Antimicrobial Pharmacists, and with designated CNS/ANP support. Support local implementation, monitoring and access to Clinical Trials participation through managed regional clinical PIID network.		Compliance with UK best practice guidance (BSAC, UK-PAS, Chapman et al) Reduction in antibiotic (IV and oral) prescribing/patient Reduction in antimicrobial prescribing/patient	Unfunded Requires 6 additional Microbiology sessions also (SLA via PHW)			Any outstanding requirement to meet UK best practice identified and workplan in place Review pharmacy data to evidence reduction in antibiotic IV and oral prescribing / patient Review pharmacy data to evidence reduction in antimicrobial prescribing / patient		UK best practice guidance met Further reduction in antibiotic IV, Oral and Antimicrobial prescribing	
Building Paediatric Infectious Diseases expertise, capacity and sustainability for South Wales	To Capitalise on the expertise in leadership, change management, teaching, training and academia, and the extensive (inter)national peer networks of the two current senior consultants in Paediatric Immunology and Infectious Diseases at CHfW to establish a comprehensive sustainable and future proof service for South Wales, prior to their retirement.		1. **Formation of managed clinical MDT network for South Wales** (strong regional momentum, initial discussions underway) • Teaching and peer learning (monthly network MDTs) • Network membership includes defined learning and local teaching commitments (e.g. SPIN module for local lead consultant) 2.**Creation of HEIW funded post for CSAC accredited GRID and SPIN module Training for Wales** • Provisional CSAC approval obtained (Aug 22) subject to funding of full Paeds ID business case.	Unfunded Requires support from Clinical Research Facility at CHfW also.	Recruitment of key posts to support MDT network complete		Clinical MDT network for South Wales implemented Any outstanding support from Clinical Research Facility identified and actioned Discussions with HEIW to secure funding complete PIID training requirements for allied professionals and access published Teaching portfolio plans finalised		MDT embedded HEIW funded post recruited Training programme for allied health professionals delivered R&D trials identified and progress made towards recognised funded recruitment onto trials Continued retention of trained staff	

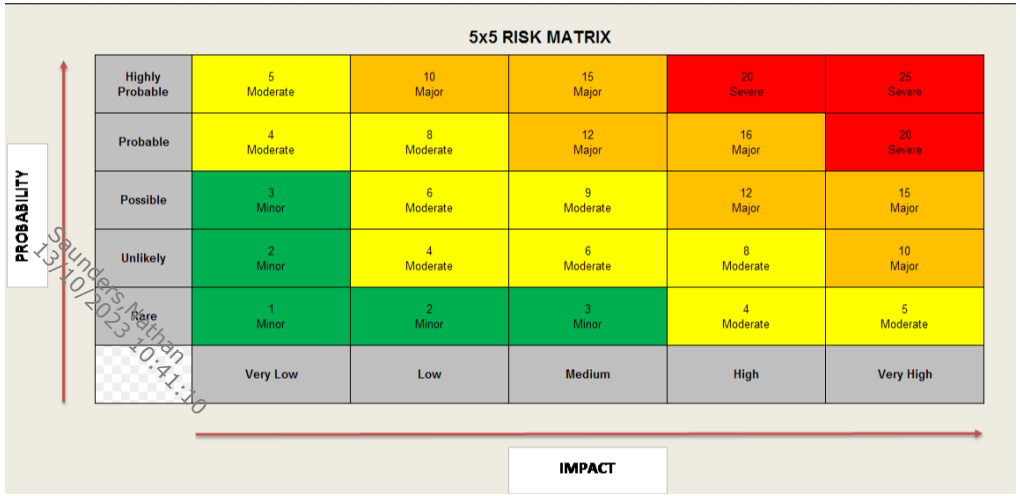
			• School of Paediatrics for Wales supportive; in discussion with HEIW. **PIID training support of allied professionals,** e.g. PIID CNS, ANP, AM Pharmacist (e.g. MSc mentoring). **Extensive PIID delivered South Wales teaching portfolio** e.g. regional Paediatric grand rounds, PICU, NICUs, tertiary specialisms, micro/viro trainees, maternity services, Public Health, e.a. **Building local R&D expertise** through supported participation in Clinical Trials and studies across South Wales **Reputational benefits enhancing recruitment of high calibre trainees, consultants and specialist nurses for Wales.** Management of vacancies and retention				Posts recruited retained and trained			
Clinical Governance Saunders,Nathan 13/10/2023 10:41:10	Underpinning all Paediatric Infectious Disease service elements with robust clinical governance (current governance of unfunded activity is restricted by absence of resource)		Full electronic auditable clinical activity and outcome records of consults, MDTs, referrals, admissions and clinics. Establishment and regular audit of condition specific integrated care pathways Adoption of VBHC methodology for ongoing evaluation of patient/family, patient organisations and staff feedback and systems learning Regular evaluation of regional Paediatric Infectious expertise development and learning Designated clinical and educational governance review meetings, e.g. Incident reviews, morbidity &mortality meetings, quarterly	unfunded	MDT/data coordinator post recruited and trained		Data collected routinely and available for audit /MDT Audit plan in place Clinical Governance review meetings, incident reviews, morbidity and mortality meetings, quarterly clinical network business meetings set up and well attended		Work with Finance colleagues to ensure VBHC methodology embedded and opportunities for efficiencies through value identified Sharing of good practice	

			clinical network business meetings							

Risk

This section must outline the key risks associated with successful implementation (should the case be approved) and plans for mitigating their removel. Where cases are approved this will form a key part of future review meetings with BCAG and provide assurance as to risks are being managed to maximise chnaces of success.

Risk Title	Descriptor	Probability (1-5)	Impact (1-5)	Total risk score (PxI)	Mitigating Action	Owner
Base line fragility of overburdened service	Service set up heavily relies on leadership expertise from current 2 senior consultants within 1-5 years of retirement. Sickness/burn-out/unforeseen absence would cause significant set back (years)	*5*	*5*	*25*	Immediate funding of Paediatric ID sessions for existing consultants, to allow backfill of their current job plans Immediate appointment of locum Paediatric ID consultant pending substantive post	
Clinical outputs	Service set up activity will displace current (unfunded) clinical output, notably consult service until additional staff in post.	*3*	*3*	*9*	Immediate appointment of locum Paediatric ID consultant pending substantive post	
24/7 on call for telephone advice	Part of NHSE PIID service specification Cannot be provided with this business case (needs 4WTE PIID)	*5*	*1*	*5*	Regional expectation setting (pre-weekend planning) Integration with General Paediatrics at CHfW for out of hours inpatient care	
Interdependencies/ Infrastructure	p-OPAT requires PIC line service (theatre time is scarce). p-OPAT provision on weekends (local CNS and community nursing availability)	*5*	*1*	*5*	Internal escalation Pre-agree local escalation plans	
Major activity surges and pandemics	Small service with highly variable unpredictable demand (i.e. vulnerable)	*4*	*5*	*20*	Formulate escalation plan for immediate support (e.g. from within network)	



7.3 Total Cost - Resource Implications and Affordability

This service is currently being provided without funded or remunerated resource.

The phasing of planned implementation recognises a lead into recruitment and the requirement to embed a new service which will develop during the early years. The impact and resulting efficiencies in the existing service will take time to realise and work undertaken to identify the value of these.

The table below describes the financial impact of meeting implementation of a Paediatric Infectious Diseases Services into Cardiff and Vale UHB.

The investment reflects a **£0.678m** recurrent requirement, with **£0.369m** in 2023/24 and a further **£0.309m** in 2024/25.

	Year 1 £'000s	Year 2 £'000s	Year 3 £'000s
TOTAL RECURRENT (not formula driven – complete)	363	678	678
TOTAL NON RECURRENT (not formula driven – complete)	6	0	0
	369	678	678

Assumed start date	2023-24 with slippage on recruitment in year 1
Funding Source Revenue	WHSSC with Cardiff & Vale UHB investment via risk share
Funding Source Capital	N/A

	Resource Requirement/Role	Band	WTE	Per post FYE £'000	PYE 23/24 £'000	FYE 24/25 £'000	Comments
Medical	Consultant PIID	Cons	2.10	143	150	299	Job plans detailed in Table 1
	Senior Clinical Fellow	CF	1.20	70	74	128	out of hours rota 2B
Nursing	Clinical Nurse Specialist	7	0.80	64	30	51	
AHP and Other Clinical	Psychology	8b	0.20	88	4	18	
Admin and Management	Clinic Coordinator	3	0.60	31	11	19	
	Medical Secretary	4	1.00	35	20	35	
Non Pay	Staff Set up				6	0	
	Non Pay				31	55	
	Micro/Vir/Mycology				7	14	Laboratory Non-Pay
	Overheads				35	60	
TOTAL			**5.90**		**369**	**678**	

Appendix 1

1. **HIV case management and transmission prevention in pregnancy**

   As per UK guidelines, this is managed by a multidisciplinary team comprising of an adult HIV specialist, obstetrician, specialist midwife and paediatrician with expertise in the management of HIV (part of PIID).

   Currently 14 children are known to be infected with HIV in South Wales, coming from 4 health boards. Three of them are aged under 10 and the youngest is 3 years old. Care is provided from Cardiff and treatment requires infectious disease expertise.

   Approximately ten women per year are managed by the team in Cardiff. Patients are referred from within Cardiff and Vale but also regularly from Cwm Taf Morgannwg and Aneurin Bevan UHBs.

2. **Tuberculosis**

   This is rare, but potentially fatal in children, and, as many infectious diseases, it is strongly associated with social deprivation. UK guidelines for the management of TB states that every UHB should have a named local paediatrician for TB, who should have access to tertiary paediatric infectious disease advice. This requires PIID expert guidance. In 2019, 100 cases of TB disease were reported in adults with 11 in children under 15 years.

   Paediatric team routinely works closely with adult TB teams offering prompt screening to child contacts of all diagnosed infectious adults. Where clusters of adults are involved in extended families this can mean a coordinated approach to screening up to 20 children sometimes on a repeated basis while the adult outbreak is brought under control.

   In addition, only in the past 5-10 years in South Wales there have been 3 TB incidents involving infected staff members in nursery schools, and 2 incidents in neonatal units (one was in Bristol, involving South-Wales patients). In all of these incidents PIID expertise was required by Public Health Wales to assist in the management of the incidents. This are major undertakings, e.g. the last outbreak alone required counselling and screening tests on 87 children.

   Cardiff is an initial reception centre for asylum seekers, who are offered screening for TB soon after arrival. In this population, language and other cultural issues may pose challenges for TB control. Approximately 20 children per year are diagnosed with latent TB and treated with three months of antimicrobial therapy.

3. **Atypical mycobacterial infections**

   In the past three years 20 children with complicated atypical mycobacterial lymphadenitis, not amenable to surgical treatment have been referred to Cardiff from all the South Wales Health Boards. They require prolonged periods of combination antibiotics and monitoring for up to 18 months.

4. **Viral hepatitis B and C (HBV and HCV)**

   Paediatric HBV and HCV infection is generally asymptomatic but carries a significant life time risk of liver-failure or liver cancer. HBV requires monitoring +/- suppressive treatment, and curative treatment HCV for children >3 years of age has been available since May 2021.

   Around 15 children across South Wales, are currently receiving care for HBV or HCV (8 HBV, 7 HCV) delivered by the PIID consultant with support from quartenary hepatology centres as needed. Both HBV and HCV are highly likely underdiagnosed in children in Wales. The Welsh liver disease implementation group (LDIG) have provided 0.2WTE CNS for 1 year to support cure of the current HCV cohort, and develop a range of case finding

pathways with Maternity services, Health Inclusion Services (asylum seeker screening), Sexual Health, Homeless, Young offenders A/E, Secondary Paediatrics, Substance misuse/ CAMHS
This work is restricted by absence of funded consultant time for leadership and targets will not be met.

5. Paediatric COVID and PIMS-TS

Although COVID 19 is generally a mild illness in children, occasional life-threatening chest disease occurs and needs prompt expert management. More importantly, the emergence of the rare but potentially life-threatening paediatric condition PIMS-TS (paediatric multisystem inflammatory syndrome temporarily associated with COVID 19) has required urgent pathway development and coordination for very unwell children presenting in Wales during the pandemic with this condition (~50 cases 2020-2022).

6. Congenital infections – antenatal screening, counselling and MDT work with Maternity services

Beyond HIV and Hepatitis B, antenatal blood screening and ultrasounds also detect a range of other maternal infections, which have important implications for their babies. Importantly examples include CMV and syphilis, but this list is not exhaustive. Clinical management requires an MDT approach, typically including and adult ID physician, obstetrician, midwife, neonatologist and paediatric ID specialist.

CMV - Cytomegalovirus is the commonest congenital infection and is the most frequent cause of sensorineural hearing loss. It is estimated to occur in 1 in 200 pregnancies and 1 in 1000 births will result in a child with significant sequelae. This means that 300 affected children per year are born across South Wales. Although awareness is increasing and the consultants in Cardiff are working closely with the neonatal network to increase CMV testing many infants go undiagnosed and present later in childhood with deafness and neurodevelopmental problems.

Syphilis - syphilis in pregnancy can have life changing consequences for babies, if not diagnosed and treated promptly and correctly. Syphilis infections amongst adults have tripled in the past ten years with the result of increasing numbers of women and their infants requiring management.
Between 5 and 10 pregnant women with evidence of syphilis infection are referred to the MDT each year, including two recent cases of active early infection putting the baby at very high risk of significant morbidity.

Report Title:	**2023-24 Month 6 Monthly Financial Monitoring Return**				Agenda Item no.	4.1	
Meeting:	**Finance Committee**		Public	X	Meeting Date:	**18th October 2023**	
			Private				
Status *(please tick one only):*	Assurance	x	Approval		Information		x
Lead Executive:	**Executive Director of Finance**						
Report Author (Title):	**Deputy Director of Finance**						

Main Report
Background and current situation:

SITUATION

WHC (2023) 012 - Welsh Government 2023/24 LHB, SHA & Trust Monthly Financial Monitoring Return Guidance requires the UHB to provide a main Committee of the Board with copy of the monthly Financial Monitoring Return (consisting of the Narrative, Table A and Tables C to C4) in order to provide the Committee with transparency on the submission made to the Welsh Government.

A copy of the September 2023/24 MMR is attached.

Executive Director Opinion and Key Issues to bring to the attention of the Board/Committee:

The extract from the UHBs Monthly Financial Monitoring Return is provided for information and assurance.

Recommendation:

The Board / Committee are requested to:

NOTE the extract from the UHBs Monthly Financial Monitoring Return.

Link to Strategic Objectives of Shaping our Future Wellbeing:
Please tick as relevant

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered
Please tick as relevant

Prevention		Long term	x	Integration		Collaboration		Involvement	

Impact Assessment:
Please state yes or no for each category. If yes please provide further details.

Risk: No
Safety: No
Financial: Yes
As detailed above.
Workforce: No
Legal: No
Reputational: Yes
Yes, if forecast financial position is not delivered.
Socio Economic: No
Equality and Health: No
Decarbonisation: No

Approval/Scrutiny Route:	
Finance Committee	Date: 18th October 2023

THE WELSH GOVERNMENT FINANCIAL COMMENTARY

FINANCIAL POSITION FOR THE SIX MONTH PERIOD ENDED 31st SEPTEMBER 2023

INTRODUCTION

The Health Board submitted an initial draft financial plan to Welsh Government at the end of March 2023.The draft plan incorporated: -

- Brought forward underlying deficit of £40.3m
- Local Covid Consequential costs of £34.2m
- Additional energy costs of £11.5m
- 23/24 Demand and cost growth and unavoidable investments of £48.8m
- Allocations and inflationary uplifts of £14.4m
- A £32m (4%) Savings programme

This results in a 2023/24 planning deficit of £88.4m.

In line with guidance from Welsh Government, the UHB's plan anticipated Welsh Government funding for three National Inflationary Pressure costs as outlined below:

1) Health Protection including TTP and Immunisation costs of £8.8m

2) PPE cost of £2.9m.

3) The 2022/23 recurrent impact of paying Real Living Wage (RLW) for staff working within social care and Third Sector cost at £2.9m.

The plan assumes that the 2023/24 cost of the RLW, being paid to staff directly employed by the UHB will be funded through the 2023-24 pay award funding in addition to the £4.4m cost currently forecast in the social/third sector.

At month 6, the UHB is reporting an overspend of £51.3m. This is comprised of £5.747m unidentified savings, £1.353m of operational overspend and the planned deficit of £44.2m (six twelfths of the annual planned deficit of £88.4m set out in 2023/24 financial plan)

BACKGROUND

The Board agreed and submitted a draft financial plan to Welsh Government at the end of March 2023. A summary of the core draft plan submitted is provided in Table 1.

Table 1: 2023/24 Core Draft Plan

	2023/24 Plan £m
2022/23 Forecast Outturn	**26.9**
Adjustment for recurrent /non-recurrent items	13.4
2023/24 b/f underlying deficit	**40.3**
COVID local response / consequentials	34.2
Energy cost pressure	11.5
2023/24 Cost Pressures Inflation & Growth	43.8
Service Investments	5.0
Total Planned Deficit before Allocation Uplift and savings	**134.8**
2023/24 Allocation Uplift / Assumed Income	(14.4)
2023/24 Cost Improvement Ambition	(32.0)
Total Allocation Uplift and Planned Savings	**(46.4)**
2023/24 Planned Deficit	**88.4**

This represents the core financial plan of the Health Board.

These financial monitoring returns have been prepared within the framework of the UHB's submitted Core Financial Plan, which includes a planning deficit of £88.4m for 2023-24. This report details the financial position of the UHB for the period ended 30th September 2023.

The UHB has separately identified non COVID 19 and COVID 19 expenditure against its submitted plan in order to assess the financial impact of COVID 19.

A full commentary has been provided to cover the tables requested for the month 6 financial position.

MOVEMENT OF OPENING FINANCIAL PLAN TO FORECAST OUTTURN and UNDERLYING POSITION (TABLE A & A1)

Table A sets out the financial plan and latest position at month 6 for which the following should be noted:

- The UHB's £32m 2023/24 savings target is reported on lines 8 & 9
- The forecast position reflects the assessed COVID 19 national programme costs in Table B3 and assumes that additional Welsh Government Funding will be provided to match the costs;
- It is assumed that LTA inflation of £2.118m that will be passed to the UHB from other Health Boards;
- The brought forward underlying deficit is £40.3m as outlined in the draft financial plan.

The identification and delivery of the initial planned £32m recurrent savings target supported by additional recovery actions is key to delivery of the planned in year and underlying position.

OVERVIEW OF KEY RISKS & OPPORTUNITIES (TABLE A2)

Table A2 reflects the risks identified in the draft plan and these will be reviewed on a monthly basis.

ACTUAL YEAR TO DATE (TABLE B AND B2)

Table B confirms the year to date deficit and reflects the analysis contained in the annual operating plan in Table A. The UHB is reporting a deficit of £51.300m for the year to date and a forecast deficit of £88.400m as shown in Table 2.

Table 2: Summary Financial Position for the period ended 30th September 2023

	Forecast Month 6 Position £m	Forecast Year-End Position £m
Planned deficit	44.200	88.400
Savings Programme	5.747	0.000
Operational position (Surplus) / Deficit	1.352	0.000
Financial Position £m (Surplus) / Deficit £m	**51.300**	**88.400**

The month 6 deficit of £51.300m comprised of the following:

- £44.200m planned deficit
- £5.747m savings gap
- £1.352m adverse variance against plan.

Pressure on Achievement of Savings

The unachieved CRP gap at month 6 is expected to be recovered, supported by a number of additional actions as the year progresses, enabling the UHB to deliver its planned deficit position of £88.4m.

Executive Performance Reviews with the UHBs Clinical Boards are focussing on the management of operational pressures and progress in identifying and delivering recurrent savings schemes that in turn will de-risk the financial plan.

The following additional actions are progressing to recover the month 6 operational & CRP overspend to enable the UHB to deliver the planned £88.4m deficit:

Scheme	Theme	£000 Opportunity
Limit catalogue for non clinial non pay expenditure	Procurement	1,000
Eliminate non clinical agency with exception process	Workforce	1,000
Eliminate non clinical overtime	Workforce	1,000
Enhanced vacancy review through Vacancy Scrutiny Panel/Workforce reshaping	Workforce	2,240
Eliminate clinical agency with exception process	Workforce	5,390
Eliminate clinical overtime with exception process	Workforce	3,570
Waiting list initiative management following Health Board rate card	Workforce	1,120
Rationalise study leave to the minimum required to meet regulatory requirements	Workforce	700
Actions to Deliver Planned Deficit £88.4m		**16,020**

Pressure on Operational Position

The UHB continues to face a significant challenge as it delivers services from an operational footprint that is still predominantly designed to address Covid demands and infection control.

In particular the UHB experienced unprecedented demand for its Mental Health Services in the first half of the year when it was difficult to source appropriately trained and experienced staff. This has manifested itself by way of increased numbers of patients requiring inpatient care combined with longer lengths of stay. The Mental Health CB has worked to improve discharge and repatriate a number of the patients placed out of area and the actions taken have started to mitigate the pressures which have emerged.

Pressures against medical staff budgets continue across a number of Clinical areas and the UHB has reported a spike in the cost of medical staff in month.

The WHSCC provider position deteriorated in month, however this was in part offset by an improvement in the forecast commissioning position. This primarily impacts on paediatric and specialist services as a result of the stepped relationship between activity levels and the cost base. The UHB provider plan was based on the national Directors of Finance Agreement that

allowed a level of contract under-performance to a 5% reflecting the ongoing restricted ability of post Covid service footprints to restore activity to full per Covid levels. During June and July WHSSC informed the UHB that it would no longer comply with the DoF agreed arrangements and expected full restoration of pre Covid levels of activity. This has the effect of redistributing resource from Cardiff and Vale UHB to other commissioning health boards in Wales and has had a £3m net impact on the UHB's contract income position after considering the Cardiff and Vale Commissioner benefits of the stance**.**

PAY & AGENCY (TABLE B2)

The UHB recorded Agency costs of £1.134m in month primarily due to nursing pressures. £0.738m and £0.294m of the costs recorded in September related to registered nursing and midwifery and medical and dental respectively. **Reported costs in September are £0.568m less than the average reported in the first 5 months and this is also corroborated by workforce data used to monitor savings actions.**

COVID 19 ANALYSIS (TABLE B3)

At month 6, Table B3 reported forecast outturn expenditure due to COVID-19 to be £13.064m. This includes expenditure related to the Covid funding for Health Protection (£8.800m), PPE (£2.500m) Long Covid (£1.144m), Anti-viral (£0.100m), and Nosocomial (£0.520m) allocations.

Year to date and forecast Covid Expenditure is summarised in Table 3 below.

Table 3: Summary of Forecast COVID 19 Net Expenditure

	Month 6 £m	Forecast £m	Funded by WG or Financial Plan £m	Variance to Plan/Funding £m
Health Protection	4.107	8.800	8.800	0.000
PPE	1.007	2.500	2.500	0.000
Long Covid	0.572	1.144	1.144	0.000
Nosocomial	0.260	0.520	0.520	0.000
Anti-Viral	0.050	0.100	0.100	0.000
Sub Total WG Funded Covid Expenditure £m	**5.996**	**13.064**	**13.064**	**0.000**
Included in Financial Plan - COVID Local Response	14.020	31.200	34.200	(3.000)
Total COVID Expenditure £m	20.016	44.264	47.264	(3.000)

The UHB forecast is in line with the anticipated Welsh Government COVID Funding totaling £13.064m.

Savings Programme 2023-24 (TABLE C, C1, C2, C3 & C4)

At month 6, the UHB had identified £36.046m of green, amber and red schemes to deliver against the initial planned savings target of £32m. Focus is now on turning all red schemes to green/amber which would result in £4.046m being realised to offset the operational deficit.

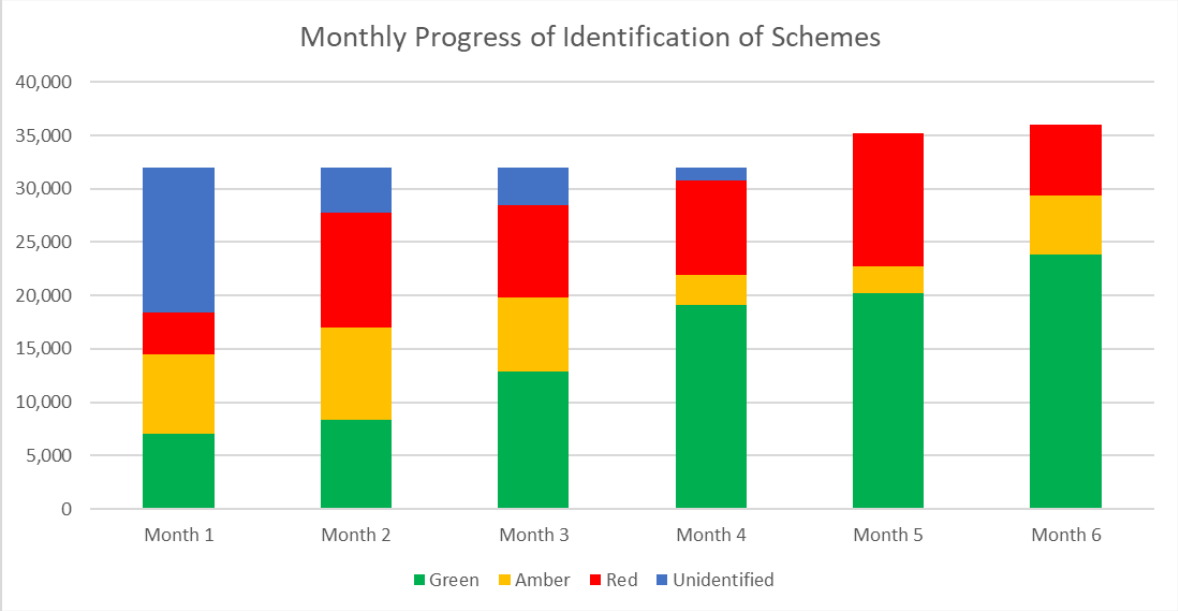
Overall performance in the identification of initial planned savings schemes is outlined in table 4 below:

Table 4: Savings Schemes

	Total Savings Target £m	Total Savings Identified £m	Total Savings (Unidentified) £m
Total £m	32.000	36.046	4.046

The table above includes green, amber and red schemes. Progress on the identification of schemes can be found in Graph 1 below.

Graph 1 – Progress of Identification of Schemes



The UHB will continue to identify and deliver savings schemes at pace.

In addition, as indicated earlier in the narrative, additional plans have been identified to recover the year to date position.

INCOME/EXPENDITURE ASSUMPTIONS (TABLE D)

The UHB progressed LTA discussions in line with the Welsh Government timetable.

The Welsh LTAs listed below have now been agreed through the UHBs governance framework and signed off:

- Aneurin Bevan
- Swansea Bay
- Hywel Dda
- Powys
- Cwm Taf Morgannwg
- Velindre.
- WHSCC

In addition to this, a covering letter was sent to WHSCC indicating that the UHB's plans to review the cost of delivery in respect of WHSCC services alongside the appropriateness of current currencies. This is aimed at ensuring the costs of delivery are appropriately recovered.

INCOME ASSUMPTIONS 2023/24 (TABLE E)

Table E outlines the UHB's 2023/24 resource limit.

Similar to practice in previous years, the UHB reported position continues to exclude recurrent expenditure which has arisen following a change in the accounting treatment of UHB PFI schemes under International Financial Reporting Standards (IFRS). The UHB is assuming that Welsh Government will continue to provide resource cover for this cost, which was assessed at £0.222m in the previous financial year.

The UHB assumes that the following pay awards actioned in 2023/24 will be fully covered by additional Welsh Government Funding:

- 1.5% 2022/23 consolidated increase
- 5.0% 2023/24 Pay Uplift

The cost of the Medical and Dental Pay award will be added to anticipated allocations following the first payment in October.

The draft financial plan assumes that the Directors of Finance agreement on LTAs is upheld by all parties in NHS Wales.

BALANCE SHEET - STATEMENT OF FINANCIAL POSITION (TABLE F)

The opening balances at the beginning of April 2023 reflect the closing balances in the 2022/23 Draft Accounts.

Property, plant & equipment is in line with the start of the year. This is due to the combined impact of annual indexation and a decrease in the carrying value of the assets reflecting monthly depreciation charges.

Overall trade and other debtors increased by £19m in month largely due to movement in Welsh risk pool claims (three new confirmed cases and a significant movement in quantum on an existing case in month).

The carrying value of trade creditors decreased by £10.2m in month largely due to a decrease in the level of Cashbook payments not cleared.

The forecast balance sheet reflects the UHB's latest non cash estimates and its anticipated capital funding.

MONTHLY CASHFLOW FORECAST (TABLE G)

The cash balance at the end of September was £4.998m with a forecast deficit of £100.888m at year end pending confirmation of cash support.

Due to the significant requirement for strategic cash support in 2023/24, combined with the timing of pay award cash flows and the level of outstanding allocation, the UHB anticipates restricting payments to suppliers from November 2023 onwards. This will impact the PSPP performance. From December onwards the UHBs cashflow will be severely impaired.

The UHB is preparing an accountable officer's letter to formally request the strategic cash assistance in line with the forecast outturn that has been maintained by the UHB since the beginning of the financial year. In addition, the UHB urgently requires confirmation and action of outstanding cash allocations that have been included in table E since the beginning of the year.

The combination of strategic cash support and outstanding allocations not confirmed is circa £175m.

The UHB's working cash assumption for 2023-24 assumes coverage from Welsh Government for the following :-

- Strategic Cash support for the £88.4m deficit of the UHB 2023-24 Financial Plan. Health Boards are required to submit an Accountable Officer letter (once requirements are established) in support of a request for Strategic Cash Support. In this context, the UHB is seeking approval for its application to Welsh Government for Strategic Cash Support in support of its 2023/24 forecast deficit at its Finance Committee of the 18th October and its Board meeting of 26th October. Given the significant level of strategic cash support the UHB requires confirmation of the associated cash cover in advance of March 2024.

- £12.488m of resource cover provided in 2022-23 where additional cash cover was not provided because of the proximity to year end . This includes the additional 1.5% consolidated pay award (£11.8m) for which Resource cover was received from Welsh Government in 2022-23 but has been paid out in 2023-24 and requires cash support.

- Movements in Revenue and Capital working capital from the 2022-23 Balance Sheet including circa £7m of capital payments relating to 2022/23 where the cash was paid to suppliers in 2023/24. This will continue to be assessed as the year progresses.

- In addition to the UHBs strategic and working cash requirements, there are a significant amount of anticipated allocations as per the table below, (circa 74m including £44m of pay increase funding) which are yet to be confirmed. The UHB is not able to draw down the associated cash, until these allocations are confirmed and this in turn is expected to impact on the UHBs scheduling of payments from month 8 onwards if confirmation of the allocations remain outstanding and additional strategic cash support alos remains outstanding.

Table - Outstanding Cash Limit Allocations @ Month 6

Description	Amount £
Consolidated Pay Uplift 2023_24 5% AFC	**32,000**
2022_23 Consolidated Award 1.5%	**11,505**
COVID-19 TTP,PPE & Vaccinations	**10,337**
Planned Care Funding South West Region	**6,400**
Inflation - RLW 22/23 & 23/24	**7,311**
Six Goals for Urgent and Emergency Care Programme	**2,960**
Digital Priorities Investment Fund for AWIP	**1,600**
Clinical Excellence/Distinction Awards	**1,497**
Welsh Government Funded New Medical Posts _ 6691	**1,313**
GP IM&T Refresh Programme and Maintenance	**1,225**
Other Allocations (includes (£3.036) deduction for IFRS12 leases and (£3.823) deduction for Welsh Risk Pool)	**(2,158)**
Total Unconfirmed Cash Limit Allocations as at Month 6 £'000s	**73,990**

In addition, cash expenditure associated with the cost of the 2023/24 Medical and Dental Pay award will be incurred from October onwards . This will be added to anticipated allocations following the first payment in October.

Strategic cash support is likely to be required from Month 8 if anticipated allocations are unable to be confirmed in time.

CAPITAL SCHEMES (TABLES I, J & K)

Of the UHB's approved Capital Resource Limit, 20% has been expended to date.

One capital scheme is currently classified as medium risk:

- Genomics - forecasting a potential £1.041m overspend. This is to be managed through the discretionary programme and is reflected in the 'Estates' line of the capital tables. The overspend is due to a number of factors including inflation, IT spec and the rerouting of drainage.

Eye Care – discussions are ongoing with DCHW in relation to the transfer of assets and historic project costs from C&V. The ongoing project/service transferred to DCHW as of the 1/6/2023.

Neuroradiology Equipment at University Hospital of Wales – The project is currently being reviewed to confirm what is deliverable in 2023/24.

All other schemes are currently in line with the annual forecast. UHL infrastructure, Endoscopy, Genomics, and Park View are all slightly behind plan year to date, however these are currently still expected to deliver in 23/24.

Planned expenditure for the year reflects the CRL received from Welsh Government dated 1st September 2023 - £29.644m.

AGED WELSH NHS DEBTORS (TABLE M)

At the 30th September 2023 there was one invoice raised by the UHB against other Welsh NHS bodies which had been outstanding for more than 17 weeks. This invoice for £96 has subsequently been cancelled.

PUBLIC SECTOR PAYMENT PERFORMANCE (TABLE H)

The UHB achieved its Public Sector Payment Performance target with 97.5% being achieved cumulatively to-date.

The UHB has included the improvement of high volume and low value NHS invoices into its modernisation programme to find system improvements to ensure all four PSPP targets are met.

OTHER ISSUES

The financial information reported in these monitoring returns aligns to the financial details included within Finance Committee and Board papers. These monitoring returns will be taken to the 18th October 2023 meeting of the Finance Committee for information.

GMS & DENTAL (TABLES N & O)

Year to date and forecast GMS and Dental expenditure is reported on tables N & O.

CONCLUSION

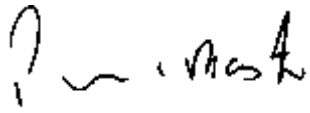
The UHB submitted a draft financial plan at the end of March 2023 and submitted a final plan at the end of May in line with the Welsh Government timetable.

The UHB is committed to achieving in year and recurrent financial balance as soon as possible.

At month 6, the UHB is reporting an overspend of £51.300m. This is comprised of £5.747m unidentified savings, £1.352m of operational overspend and the planned deficit of £44.200m (six twelfths of the annual planned deficit of £88.4m set out in 2023/24 financial plan)

Actions are in place to recover the month 6 position and deliver the planned £88.4m deficit.

In addition, the UHB increasingly requires confirmation of strategic cash support and outstanding allocations to maintain its cash position and PSPP performance.



……..
PAUL BOSTOCK
DEPUTY CHIEF EXECUTIVE

12th October 2023

……..
ANDREW GOUGH
DEPUTY DIRECTOR OF FINANCE

12th October 2023

Cardiff & Vale ULHB **Period : Sep 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)	-40,300	0	-40,300	-40,300
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-94,523	0	-94,523	-94,523
3	Planned Expenditure For Covid-19 (Negative Value)	-13,465	-13,465		
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	12,305	0	12,305	12,305
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	13,465	13,465		
6	Planned Provider Income (Positive Value)	2,118	0	2,118	2,118
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0
8	Planned (Finalised) Savings Plan	14,042	4,098	9,944	10,813
9	Planned (Finalised) Net Income Generation	454	124	330	357
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
12		0	0		
13	Planning Assumptions still to be finalised at Month 1	17,505	0	17,505	20,830
14	**Opening IMTP / Annual Operating Plan**	**-88,400**	**4,222**	**-92,622**	**-88,400**
15	Reversal of Planning Assumptions still to be finalised at Month 1	-17,505	0	-17,505	-20,830
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)	0	0		
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
18	Other Movement in Month 1 Planned & In Year Net Income Generation	173	0	173	290
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-484	-124	-360	-314
20	Additional In Year Identified Savings - Forecast	14,393	10,565	3,829	4,981
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)	-400	-400		
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)	400	400		
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)	29	29		
27	Additional savings to be identified	-12,626	-12,626		-148
28	Roundings	0	0		
29	Limit catalogue for non clinial non pay expenditure	1,000	0	1,000	1,000
30	Eliminate non clinical agency with exception process	1,000	0	1,000	1,000
31	Eliminate non clinical overtime	1,000	0	1,000	1,000
32	Enhanced vacancy review through Vacancy Scrutiny Panel	2,240	0	2,240	2,240
33	Eliminate clinical agency with exception process	5,390	0	5,390	5,390
34	Eliminate clinical overtime with exception process	3,570	0	3,570	3,570
35	Waiting list initiative management following Health Board rate card	1,120	0	1,120	1,120
36	Rationalise study leave to the minimum required to meet regulatory requirements	700	0	700	700
37		0	0		
38		0	0		
39		0	0		
40	**Forecast Outturn (- Deficit / + Surplus)**	**-88,400**	**2,065**	**-90,465**	**-88,400**
41	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**			
42	**Operational - Forecast Outturn (- Deficit / + Surplus)**	**-88,400**			

	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	-3,358	-3,358	-3,358	-3,358	-3,358	-3,358	-3,358	-3,358	-3,358	-3,358	-3,358	-3,358	-20,150	-40,300
2	-7,877	-7,877	-7,877	-7,877	-7,877	-7,877	-7,877	-7,877	-7,877	-7,877	-7,877	-7,877	-47,262	-94,523
3	-521	-943	-1,235	-1,220	-1,194	-1,171	-1,146	-1,203	-1,208	-1,208	-1,167	-1,245	-6,285	-13,465
4	1,025	1,025	1,025	1,025	1,025	1,025	1,025	1,025	1,025	1,025	1,025	1,025	6,153	12,305
5	521	943	1,235	1,220	1,194	1,171	1,146	1,203	1,208	1,208	1,167	1,245	6,285	13,465
6	177	177	177	177	177	177	177	177	177	177	177	177	1,059	2,118
7	1,925	254	-61	97	-74	-6	-383	-358	-341	-341	-356	-355	2,135	0
8	665	808	1,093	935	1,106	1,038	1,415	1,390	1,390	1,390	1,405	1,404	5,646	14,042
9	77	13	43	43	43	43	43	43	26	26	26	26	262	454
10													0	0
11													0	0
12													0	0
13		1,591	1,591	1,591	1,591	1,591	1,591	1,591	1,591	1,591	1,591	1,591	7,957	17,505
14	**-7,367**	**-7,367**	**-7,367**	**-7,367**	**-7,367**	**-7,367**	**-7,367**	**-7,367**	**-7,367**	**-7,367**	**-7,367**	**-7,366**	**-44,200**	**-88,400**
15	0	-1,591	-1,591	-1,591	-1,591	-1,591	-1,591	-1,591	-1,591	-1,591	-1,591	-1,591	-7,957	-17,505
16													0	0
17													0	0
18	0	-3	7	13	13	63	13	13	13	13	13	13	93	173
19	0	0	-383	-232	314	-48	-23	-23	-23	-23	-23	-23	-348	-484
20	0	219	188	355	574	1,016	2,303	1,884	1,932	1,892	1,897	2,134	2,352	14,393
21													0	0
22	0	-231	23	23	-83	-59	-16	-49	-16	6	17	-15	-327	-400
23													0	0
24	0	231	-23	-23	83	59	16	49	16	-6	-17	15	327	400
25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	-83	158	-5	-5	-5	-5	-5	-5	-5	-5	-5	-5	57	29
27	-1,446	298	576	229	-413	-541	-2,184	-1,765	-1,813	-1,773	-1,778	-2,016	-1,297	-12,626
28													0	0
29							167	167	167	167	167	167	0	1,000
30							167	167	167	167	167	167	0	1,000
31							167	167	167	167	167	167	0	1,000
32							373	373	373	373	373	373	0	2,240
33							898	898	898	898	898	898	0	5,390
34							595	595	595	595	595	595	0	3,570
35							187	187	187	187	187	187	0	1,120
36							117	117	117	117	117	117	0	700
37													0	0
38													0	0
39													0	0
40	**-8,896**	**-8,287**	**-8,574**	**-8,597**	**-8,474**	**-8,473**	**-6,183**	**-6,183**	**-6,183**	**-6,183**	**-6,183**	**-6,183**	**-51,300**	**-88,400**
41	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
42	**-8,896**	**-8,287**	**-8,574**	**-8,597**	**-8,474**	**-8,473**	**-6,183**	**-6,183**	**-6,183**	**-6,183**	**-6,183**	**-6,183**	**-51,300**	**-88,400**

Cardiff & Vale ULHB

Period : Sep 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 %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	8	8	8	8	8	8	8	8	8	8	8	8	50	100		100	0			
2		Actual/F'cast	8	27	30	53	68	86	103	124	124	124	129	134	273	1,013	26.97%	700	313	105	908	1,288
3		Variance	0	19	22	45	60	78	95	116	116	116	121	126	223	913	*446.36%*	600	313			
4	Commissioned Services	Budget/Plan	7	7	19	19	19	19	19	19	19	19	19	19	90	204		204	0			
5		Actual/F'cast	7	7	19	19	19	19	19	19	19	19	19	19	90	204	43.87%	204	0	125	79	79
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	185	93	226	167	168	245	206	207	207	207	222	222	1,085	2,355		2,355	0			
8		Actual/F'cast	185	104	217	215	346	393	362	362	400	371	386	514	1,460	3,854	37.88%	3,854	0	889	2,965	3,854
9		Variance	0	11	(9)	48	178	148	155	155	193	164	164	292	375	1,499	*34.58%*	1,499	0			
10	Non Pay	Budget/Plan	214	226	383	283	428	283	268	268	268	268	268	268	1,819	3,425		3,425	0			
11		Actual/F'cast	214	257	344	344	589	354	1,393	953	963	952	952	960	2,102	8,276	25.40%	8,132	144	7,109	1,168	1,614
12		Variance	0	30	(39)	61	160	71	1,125	686	695	685	685	692	283	4,851	*15.57%*	4,707	144			
13	Pay	Budget/Plan	251	474	457	457	482	482	913	888	888	888	888	887	2,603	7,957		7,957	0			
14		Actual/F'cast	251	633	287	425	970	1,150	1,815	1,790	1,790	1,790	1,790	1,886	3,715	14,578	25.48%	14,578	0	6,310	8,268	8,621
15		Variance	0	159	(170)	(32)	487	668	902	902	902	902	902	999	1,112	6,621	*42.72%*	6,621	0			
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	3	3	3	3	3	3	3	3	3	3	10	25	40.00%	25	0	0	25	25
18		Variance	0	0	3	3	3	3	3	3	3	3	3	3	10	25		25	0			
19	Total	Budget/Plan	665	808	1,093	935	1,106	1,038	1,415	1,390	1,390	1,390	1,405	1,404	5,646	14,042		14,042	0			
20		Actual/F'cast	665	1,027	899	1,059	1,994	2,006	3,695	3,252	3,300	3,259	3,279	3,516	7,650	27,951	27.37%	27,494	457	14,538	13,412	15,481
21		Variance	0	219	(195)	124	888	967	2,280	1,862	1,909	1,869	1,874	2,112	2,003	13,909	*35.48%*	13,452	457			
22	Variance in month		0.00%	27.05%	(17.79%)	13.22%	80.34%	93.16%	161.13%	133.89%	137.32%	134.42%	133.34%	150.42%	35.48%							
23	In month achievement against FY forecast		2.38%	3.67%	3.22%	3.79%	7.13%	7.18%	13.22%	11.63%	11.81%	11.66%	11.73%	12.58%								

Saunders.Nathan
13/10/2023 10:41:10

Cardiff & Vale ULHB Period : Sep 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	245	92	195	195	195	195	626	626	626	626	626	625	1,117	4,873		4,873	0			
2		Actual/F'cast	245	237	181	196	280	284	727	727	727	727	727	724	1,424	5,782	24.62%	5,782	0	936	4,847	4,884
3		Variance	0	145	(14)	1	85	89	101	101	101	101	101	99	307	909	*27.45%*	909	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	9	6	130	130	130	130	130	130	130	145	928	15.65%	928	0	928	0	0
6		Variance	0	0	0	9	6	130	130	130	130	130	130	130	145	928		928	0			
7	Locum	Budget/Plan	0	0	0	0	25	25	25	0	0	0	0	0	50	75		75	0			
8		Actual/F'cast	0	0	8	21	41	46	46	21	21	21	21	21	115	263	43.75%	263	0	180	83	100
9		Variance	0	0	8	21	16	21	21	21	21	21	21	21	65	188	*130.34%*	188	0			
10	Agency / Locum paid at a premium	Budget/Plan	0	376	237	237	237	237	237	237	237	237	237	237	1,324	2,746		2,746	0			
11		Actual/F'cast	0	376	66	165	595	492	792	792	792	792	792	792	1,693	6,446	26.27%	6,446	0	3,400	3,046	3,261
12		Variance	0	0	(171)	(72)	358	255	555	555	555	555	555	555	370	3,700	*27.92%*	3,700	0			
13	Changes in Bank Staff	Budget/Plan	0	0	19	19	19	19	19	19	19	19	19	19	76	190		190	0			
14		Actual/F'cast	0	0	19	19	19	19	19	19	19	19	19	19	76	190	40.00%	190	0	0	190	190
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
16	Other (Please Specify)	Budget/Plan	6	6	6	6	6	6	6	6	6	6	6	6	36	73		73	0			
17		Actual/F'cast	6	20	12	16	29	179	101	101	101	101	101	200	261	968	26.99%	968	0	866	102	186
18		Variance	0	14	6	10	22	173	95	95	95	95	95	194	225	896	*625.80%*	896	0			
19	Total	Budget/Plan	251	474	457	457	482	482	913	888	888	888	888	887	2,603	7,957		7,957	0			
20		Actual/F'cast	251	633	287	425	970	1,150	1,815	1,790	1,790	1,790	1,790	1,886	3,715	14,578	25.48%	14,578	0	6,310	8,268	8,621
21		Variance	0	159	(170)	(32)	487	668	902	902	902	902	902	999	1,112	6,621	*42.72%*	6,621	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	376	237	237	237	237	237	237	237	237	237	237	1,324	2,746		2,746	0			
2		Actual/F'cast	0	376	66	165	595	492	792	792	792	792	792	792	1,693	6,446	26.27%	6,446	0	3,400	3,046	3,261
3		Variance	0	0	(171)	(72)	358	255	555	555	555	555	555	555	370	3,700	*27.92%*	3,700	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	376	237	237	237	237	237	237	237	237	237	237	1,324	2,746		2,746	0			
14		Actual/F'cast	0	376	66	165	595	492	792	792	792	792	792	792	1,693	6,446	26.27%	6,446	0	3,400	3,046	3,261
15		Variance	0	0	(171)	(72)	358	255	555	555	555	555	555	555	370	3,700	*27.92%*	3,700	0			

Table C3- Savings Schemes SoCNE/SCNI Analysis

			Month	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD	Full-year forecast
1		Budget/Plan		251	474	457	457	482	482	913	888	888	888	888	887	2,603	7,957
2	Pay	Actual/F'cast		251	633	287	425	970	1,150	1,815	1,790	1,790	1,790	1,790	1,886	3,715	14,578
3		Variance		0	159	(170)	(32)	487	668	902	902	902	902	902	999	1,112	6,621
4		Budget/Plan		214	226	396	296	441	296	280	280	280	280	280	280	1,869	3,551
5	Non Pay	Actual/F'cast		214	257	356	357	601	367	1,405	966	976	965	965	973	2,152	8,402
6		Variance		0	30	(39)	61	160	71	1,125	686	695	685	685	692	283	4,851
7		Budget/Plan		39	40	40	62	63	63	93	93	93	93	108	108	307	894
8	Primary Care Drugs	Actual/F'cast		39	40	78	92	240	219	211	211	249	211	226	264	708	2,080
9		Variance		0	0	38	30	177	156	118	118	156	118	118	156	402	1,186
7		Budget/Plan		146	53	185	105	105	182	114	114	114	114	114	114	778	1,461
8	Secondary Care Drugs	Actual/F'cast		146	64	138	123	106	174	151	151	151	160	160	250	752	1,774
9		Variance		0	11	(47)	17	1	(8)	37	37	37	46	46	136	(26)	313
10		Budget/Plan		8	8	8	8	8	8	8	8	8	8	8	8	50	100
11	CHC/FNC	Actual/F'cast		8	27	30	53	68	86	103	124	124	124	129	134	273	1,013
12		Variance		0	19	22	45	60	78	95	116	116	116	121	126	223	913
13		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	Primary Care Contractor	Actual/F'cast		0	0	3	3	3	3	3	3	3	3	3	3	10	25
15		Variance		0	0	3	3	3	3	3	3	3	3	3	3	10	25
16	Healthcare Services	Budget/Plan		7	7	7	7	7	7	7	7	7	7	7	7	40	79
17	Provided by Other NHS	Actual/F'cast		7	7	7	7	7	7	7	7	7	7	7	7	40	79
18	Bodies	Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Non Healthcare Services	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
20	Provided by Other NHS	Actual/F'cast		0	0	0	0	0	0	0	0	0	0	0	0	0	0
21	Bodies	Variance		0	0	0	0	0	0	0	0	0	0	0	0	0	0
22	Other Private & Voluntary	Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
23	Sector	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		Budget/Plan		0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	Joint Financing & Other	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		Budget/Plan		665	808	1,093	935	1,106	1,038	1,415	1,390	1,390	1,390	1,405	1,404	5,646	14,042
29	Total	Actual/F'cast		665	1,027	899	1,059	1,994	2,006	3,695	3,252	3,300	3,259	3,279	3,516	7,650	27,951
30		Variance		0	219	(195)	124	888	967	2,280	1,862	1,909	1,869	1,874	2,112	2,003	13,909

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Sep 23

This Table is currently showing 0 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	665	808	1,093	935	1,106	1,038	1,415	1,390	1,390	1,390	1,405	1,404	5,646	14,042	4,098	9,944	870	10,813
	Month 1 - Actual/Forecast	665	808	711	704	1,420	990	1,392	1,368	1,368	1,368	1,383	1,381	5,298	13,557	3,973	9,584	916	10,499
	Variance	0	0	(383)	(232)	314	(48)	(23)	(23)	(23)	(23)	(23)	(23)	(348)	(484)	(124)	(360)	46	(314)
	In Year - Plan	0	219	268	494	592	1,058	2,331	1,930	1,988	1,947	1,952	2,194	2,631	14,973	11,099	3,874	1,107	4,981
	In Year - Actual/Forecast	0	219	188	355	574	1,016	2,303	1,884	1,932	1,892	1,897	2,134	2,352	14,393	10,565	3,829	1,153	4,981
	Variance	0	0	(79)	(139)	(18)	(43)	(28)	(45)	(56)	(56)	(56)	(59)	(279)	(580)	(534)	(45)	45	0
	Total Plan	665	1,027	1,361	1,429	1,698	2,097	3,746	3,320	3,378	3,338	3,358	3,598	8,277	29,015	15,197	13,818	1,977	15,795
	Total Actual/Forecast	665	1,027	899	1,059	1,994	2,006	3,695	3,252	3,300	3,259	3,279	3,516	7,650	27,951	14,538	13,412	2,068	15,481
	Total Variance	0	0	(462)	(370)	296	(91)	(51)	(68)	(79)	(79)	(79)	(82)	(628)	(1,064)	(659)	(405)	91	(314)
Net Income Generation	Month 1 - Plan	77	13	43	43	43	43	43	43	26	26	26	26	262	454	124	330	27	357
	Month 1 - Actual/Forecast	77	(6)	34	40	38	38	38	38	21	21	21	21	220	382	124	258	99	357
	Variance	0	(19)	(9)	(4)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(42)	(72)	0	(72)	72	0
	In Year - Plan	0	16	16	16	18	68	18	18	18	18	18	18	135	245	0	245	45	290
	In Year - Actual/Forecast	0	16	16	16	18	68	18	18	18	18	18	18	135	245	0	245	45	290
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	77	28	60	60	61	111	61	61	45	45	45	45	397	699	124	575	72	647
	Total Actual/Forecast	77	10	50	56	56	106	56	56	40	40	40	40	355	627	124	503	144	647
	Total Variance	0	(19)	(9)	(4)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(42)	(72)	0	(72)	72	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	742	821	1,137	978	1,149	1,081	1,458	1,433	1,417	1,417	1,432	1,430	5,908	14,495	4,222	10,273	897	11,170
	Month 1 - Actual/Forecast	742	803	744	743	1,458	1,028	1,430	1,406	1,389	1,389	1,404	1,403	5,518	13,939	4,097	9,842	1,015	10,856
	Variance	0	(19)	(392)	(235)	309	(53)	(28)	(28)	(28)	(28)	(28)	(28)	(390)	(556)	(124)	(432)	118	(314)
	In Year - Plan	0	234	284	510	611	1,127	2,349	1,948	2,006	1,966	1,971	2,212	2,766	15,218	11,099	4,119	1,152	5,271
	In Year - Actual/Forecast	0	234	205	372	592	1,084	2,321	1,902	1,950	1,910	1,915	2,153	2,487	14,638	10,565	4,074	1,198	5,271
	Variance	0	0	(79)	(139)	(18)	(43)	(28)	(45)	(56)	(56)	(56)	(59)	(279)	(580)	(534)	(45)	45	0
	Total Plan	742	1,055	1,421	1,489	1,759	2,208	3,807	3,381	3,423	3,383	3,403	3,642	8,674	29,713	15,321	14,393	2,049	16,442
	Total Actual/Forecast	742	1,037	949	1,115	2,051	2,112	3,751	3,308	3,339	3,299	3,319	3,555	8,005	28,577	14,662	13,915	2,213	16,128
	Total Variance	0	(19)	(472)	(374)	291	(96)	(56)	(73)	(84)	(84)	(84)	(87)	(669)	(1,136)	(659)	(477)	163	(314)

Summary of Forecast Month 1 & In Year (£000's) - Green & Amber	Cash-Releasing Saving (Pay)	Cash-Releasing Saving (Non Pay)	Cost Avoidance	Savings Total	Income Generation	Accountancy Gains
Planned Care	757	986	5	**1,748**	115	0
Unscheduled Care	1,202	0	0	**1,202**	0	0
Primary and Community Care (Excl Prescribing)	293	627	0	**920**	0	0
Mental Health	65	227	0	**292**	0	0
Clinical Support	282	515	0	**796**	114	0
Non Clinical Support (Facilities/Estates/Corporate)	353	906	0	**1,259**	194	0
Commissioning	0	349	0	**349**	30	0
Across Service Areas	11,626	5,094	276	**16,996**	164	0
CHC	0	988	0	**988**	0	0
Prescribing	0	2,070	0	**2,070**	0	0
Medicines Management (Secondary Care)	0	1,329	0	**1,329**	10	0
Total	**14,578**	**13,091**	**281**	**27,951**	**627**	**0**

Cardiff & Vale ULHB

Period : Sep 23

This Table is currently showing 0 errors

This table needs completing monthly from Month: 2

Table G - Monthly Cashflow Forecast

		April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £,000	Total £,000
	RECEIPTS													
1	WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA only	130,987	98,095	141,605	109,120	100,470	110,970	93,330	102,085	117,197	77,403	77,403	28,600	1,187,266
2	WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only	1,190	1,190	650	525	1,425	2,150	1,575	1,230	1,230	1,230	1,230	1,230	14,855
3	WG Revenue Funding - Other (e.g. invoices)	1,788	1,320	1,310	1,354	2,951	2,006	1,284	1,284	2,784	1,284	2,784	2,784	22,933
4	WG Capital Funding - Cash Limit - LHB & SHA only	10,000	2,500	0	943	(518)	1,985	1,995	965	2,090	4,510	3,980	4,230	32,680
5	Income from other Welsh NHS Organisations	40,222	35,616	39,767	40,658	45,593	37,762	34,311	43,184	34,769	34,450	43,650	42,587	472,569
6	Short Term Loans - Trust only													0
7	PDC - Trust only													0
8	Interest Receivable - Trust only													0
9	Sale of Assets	0	0	0	0	0	0	0	0	0	0	0	0	0
10	Other - (Specify in narrative)	4,032	13,939	6,310	11,994	8,870	5,253	16,316	8,276	7,129	13,894	7,259	11,564	114,837
11	TOTAL RECEIPTS	**188,219**	**152,659**	**189,642**	**164,594**	**158,792**	**160,126**	**148,811**	**157,024**	**165,199**	**132,772**	**136,306**	**90,995**	**1,845,139**
	PAYMENTS													
12	Primary Care Services : General Medical Services	6,777	6,107	7,281	5,773	5,947	6,024	6,289	6,305	7,010	6,305	6,305	7,010	77,130
13	Primary Care Services : Pharmacy Services	280	177	134	115	106	134	122	155	310	620	310	310	2,773
14	Primary Care Services : Prescribed Drugs & Appliances	18,097	0	18,283	0	9,279	17,876	0	9,200	18,400	0	9,200	9,200	109,535
15	Primary Care Services : General Dental Services	2,061	2,268	2,301	2,397	2,459	2,228	2,234	2,310	2,310	2,310	2,310	2,310	27,497
16	Non Cash Limited Payments	1,870	1,850	1,928	1,998	1,976	1,962	1,953	1,935	1,935	1,935	1,935	1,935	23,213
17	Salaries and Wages	65,920	69,595	79,720	74,501	70,537	66,932	70,083	69,941	68,156	68,746	69,705	69,171	843,006
18	Non Pay Expenditure	86,046	71,140	75,762	78,261	62,587	67,236	67,047	64,889	64,986	48,347	42,563	101,719	830,583
19	Short Term Loan Repayment - Trust only													0
20	PDC Repayment - Trust only													0
21	Capital Payment	7,201	852	2,602	1,990	486	863	2,000	2,290	2,090	4,510	3,980	4,231	33,094
22	Other items (Specify in narrative)	339	123	659	53	144	641	81	0	0	0	0	0	2,041
23	TOTAL PAYMENTS	**188,592**	**152,112**	**188,671**	**165,086**	**153,522**	**163,896**	**149,808**	**157,024**	**165,197**	**132,772**	**136,307**	**195,885**	**1,948,873**
24	Net cash inflow/outflow	(373)	547	971	(492)	5,270	(3,770)	(996)	(0)	2	(0)	(1)	(104,890)	
25	Balance b/f	2,846	2,473	3,019	3,990	3,498	8,768	4,998	4,002	4,001	4,003	4,003	4,002	
26	Balance c/f	2,473	3,019	3,990	3,498	8,768	4,998	4,002	4,001	4,003	4,003	4,002	(100,888)	