Public Finance & Performance Committee

Wed 21 August 2024, 14:00 - 15:00

Virtual - MS Teams

Agenda

14:00 - 14:10
10 min

1. Standing Items (14:00 - 14:10)

1.1. Welcome & Introductions

John Union

1.2. Apologies for Absence

John Union

1.3. Declarations of Interest

John Union

1.4. Minutes from the Finance & Performance Committee meeting on 17.07.2024

John Union

1.4 Finance & Performance Minutes 17.07.24.pdf (8 pages)

1.5. Actions following the Finance & Performance Committee held on 17.07.2024

John Union

1.5 Action Log 21.08.2024 - Finance and Performance.pdf (1 pages)

1.6. Chairs Actions since previous meeting

John Union

1.7.

14:10 - 14:50
40 min

2. Items for Review and Assurance (14:10 - 14:50)

2.1. Financial Report - Month 4 Position & Savings Plan Progress (including savings tracker)

Catherine Phillips / Andrew Gough / Robert Mahoney

20 Mins

2.1 Public Finance Committee SUMMARY Finance Position Report for Month 4 final.pdf (14 pages)

2.2. Operational Performance Update

Paul Bostock

20 Mins

2.2 Operational Performance report cover paper.pdf (7 pages)
2.2a Integrated Performance Report.pdf (38 pages)

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14:50 - 14:55
5 min

3. Items for Approval / Ratification (14:50 - 14:55)

3.1. Business Cases: CAR-T (this went to SLB on 18.07.24 and will go to CAV UHB Board on 26.09.24)

Paul Bostock

- 3.1 CAR-T Cover Paper.pdf (3 pages)
- 3.1a CAR-T business case.pdf (41 pages)

14:55 - 15:00
5 min

4. Items for Information & Noting

4.1. Monthly Monitoring Return - Month 3

Catherine Phillips / Robert Mahoney

- 4.1a WG 2024 _25 month 3 MMR Covering Report.pdf (2 pages)
- 4.1b CV Financial Monitoring Returns 2024-25 - Month 3.pdf (9 pages)
- 4.1c 2024-25 MMR Template - Cardiff Vale UHB Month 3.pdf (5 pages)

15:00 - 15:00
0 min

5. Any Other Business

John Union

15:00 - 15:00
0 min

6. Review & Final Closure

John Union

6.1. Items to be deferred to Board / Committee

John Union

6.2. Date & Time of next Committee meeting - Wednesday 18 September 2024 via MS Teams

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Minutes of the Public Finance and Performance Committee Meeting
Held on 17 July 2024
Via MS Teams

Chair:		
John Union	JU	Independent Member – Finance
Present:		
Charles Janczewski	CJ	UHB Chair
Ceri Phillips	CP	UHB Vice Chair
In Attendance:		
Paul Bostock	PB	Chief Operating Officer
Adam Christian	AC	Clinical Board Director CD&T
Andrew Gough	AG	Deputy Director of Finance (Strategic)
Sarah Lloyd	SL	Director of Operations – CD&T
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Catherine Phillips	CP	Executive Director of Finance
Matt Phillips	MP	Director of Corporate Governance
Jason Roberts	JR	Executive Nursing Director
Melanie Wilkey	MW	Deputy Director of Commissioning
Secretariat:		
Nathan Saunders	NS	Senior Corporate Governance Officer
Rachel Chilcott	RC	Corporate Governance Officer
Apologies:		
Suzanne Rankin	SR	Chief Executive Officer
Marie Davies	MD	Interim Executive Director of Strategic Planning

Item No	Agenda Item	Action
FPC 17/07/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FPC 17/07/002	**Apologies for Absence** Apologies for Absence were noted. **The Finance and Performance Committee resolved that:** a) Apologies for Absence were noted.	
FPC 17/07/003	**Declarations of Interest** No Declarations of Interest were noted.	
FPC 17/07/004	**Minutes of the Finance and Performance Meeting held on 19 June 2024** *To view the minute:* https://youtu.be/7zb1LEQrP2k?list=PLLVdfcKNzmAA7B9lVZC6mzngn8msCNnOV&t=160 The minutes of the meeting held on 19 June 2024 were received. **The Finance Committee resolved that:** a) The minutes of the Finance and Performance Committee meeting held on 19 June 2024, were held as a true and accurate record of the meeting.	
FPC 17/07/005	**Actions following the Finance and Performance Committee meeting on 19 June 2024** *To view the minute:* https://youtu.be/7zb1LEQrP2k?list=PLLVdfcKNzmAA7B9lVZC6mzngn8msCNnOV&t=216	

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	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 17/07/006	**Chairs Action since previous meeting** There had been no Chair's Actions taken since the last meeting	
FPC 17/07/007	**1) Financial Report – Month 3 Position & Savings Plan Progress** *To view the minute:* *https://youtu.be/7zb1LEQrP2k?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=257* The Financial Report – Month 3 was received. The Deputy Director of Finance Operational (DDFO) advised the Committee that he would take the report as read and summarised the ley points which included: • At month 3, the Health Board had reported an overspend to Welsh Government (WG) of £11.564m against the forecast year-end position / the 1-year plan that had been submitted to WG which anticipated at £15.9m overspend. • Table 1 in the report provided information how the financial plan was arrived at and the Committee were advised the that position continued to be of concern as it had been at month 1 and 2 when reported. The UHB Chair noted that the report did not appear to be confident that the Health Board could correct the deficit as would normally be expected which would be a difficult position for the Board to consider so early on in the year. He asked how confident were the finance team that the position could be corrected and what sort of timeline would that entail as well as highlighting that a full discussion would be required at the August Board Development session to help the Board understand the financial position using month 4 data and to discuss difficult decisions if required. The DDFO responded that the actions identified in the paper would hopefully alleviate some concerns as to how the position could be presented to the Board which he would outline later in the meeting. • The Committee received a summary financial position which analysed the £11.564m overspend at Month 3, between Income, Pay and Non-Pay and were provided with a graph outlining the Total Variance compared to a straight-line Projection of the Planned Deficit which showed the reported position at month 3 compared to the planned deficit. It was noted that the actual position was £7.589m above the planned deficit because of the combined operational deficit and savings gap and that the forecast position assumed that this would be recovered over the course of the year through management action to ensure that services operated within delegated budgets. • Long Term Agreements (LTAs) – the Committee was reminded that there had been difficulties in finalising the LTAs with the commissioner bodies (other Health Boards in Wales and the Joint Commissioning Committee – formerly Welsh Health Specialised Services Committee) and it was noted that the Health Board had avoided going into arbitration and that some of the contracts had been reshaped although it did leave a performance risk for the Health Board that would need to be delivered to try and secure the requisite levels of income in the plan. The UHB Chair thanked the DDFO for managing to settle the LTAs without having to go into arbitration but noted his concern at the outcome in terms of what the Health Board would receive vs what it had expected to receive.	

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He added that it was not acceptable that the Health Board carry the risk year on year and that the dispute should have resolved sooner.

- Financial Performance of Clinical Boards was received and it was noted that Clinical Boards were anticipating managing the operational financial risks that they faced within their delegated budgets. The most significant of those risks were outlined within the report.

  It was noted that review meetings had been scheduled with the Clinical Boards to assess their Month 3 positions and the robustness of actions to improve the financial outlook.

The DDFO advised the Committee that there had also been high costs associated with additional mental health support needed in respect of complex behavioural patients on a number of medical wards across UHW and UHL.

The UHB Vice Chair asked to what extent were the mental health patients' residents of Cardiff and Vale.

The DDFO responded that the expectation would be that most of the medicine admissions would be Cardiff and Vale residents due to the way flows worked but some of the more elective specialities would be more of a mix.

The Chief Operating Officer (COO) reiterated that review meetings had been scheduled with the Clinical Boards to assess their Month 3 positions and the robustness of actions to improve the financial outlook which would include attendance from the Clinical Board Triumvirate.

The Executive Director of Finance (EDF) added that Clinical Boards would be undertaking Quality Impact Assessments (QIAs) on their red and ambers schemes identified within their savings trackers which would then be fed back to the Board as appropriate.

- The Committee were provided with a summary of Month 3 COVID 19 Net Expenditure where it was noted that funding for local response costs was allocated to Clinical Boards through the Health Boards Financial Plan.

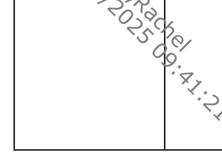
  It was noted that local response expenditure was no longer funded directly by WG and residual costs were reported within delegated clinical board positions and not included in summary provided.

- Savings Programme Update - at month 3, £28.750m of green and amber savings had been identified towards the £47.2m savings target. £15.199m of those schemes were recurrent and it represented an increase of £7.761m from Month1 and identified 61% of the annual target.

  The progress in the identification of schemes during the year was shown in a graph to the Committee

  It was noted that the draft financial plan required the Health Board to meet its £47.2m Recurrent Savings target and deliver a balanced recurrent operational position to reduce the brought forward underlying deficit (ULD) from £60.9m to £15.9m at the end of 2024/25.

  The DDFO advised the Committee that a £2.438m operational overspend was reported at month 3 which would need to be managed to a balanced position at year end to meet the target ULD.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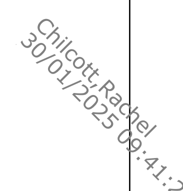
- Financial Risks – the Committee was advised that the risk register had been updated and revised and it was noted that the key risk which feed into the Health Board Corporate Risk Register was the failure of the Health Board to deliver a breakeven position by 2024-25-year end with a current planned deficit of £15.9m.

	• Cash Flow Forecast – the DDFO advised the Committee that cash flow would become a problem later in the year if the Health Board carried on the current trajectory which emphasised the need for escalation and new action. • Public Sector Payment Compliance - The Health Boards public sector payment compliance performance was above the target of 95% with the performance for the month to the end of June being 97.8%. The DDFO noted that if the Health Board did move into cash flow difficulties because of the financial position, one of the first thing that would be a casualty to that would be the compliance rate. • Capital – it was noted that the Health Boards approved capital resource limit was in line with the latest CRL received from WG. The DDFO summarised that the finance team did hold concern, savings were not moving fast enough and there was further concern around operational blowouts being observed. He added that the Health Board were in a period of escalation and enhanced monitoring. The COO added that it was a very challenging year for the Health Board because the savings target was much higher than the previous year. **The Finance and Performance Committee resolved:** a) The reported year to date overspend of £11.564m and the forecast deficit of £15.900m was noted. b) The month 3 operational overspend against plan of £2.438m with a further £5.151m savings gap was noted. c) The progress against the savings target, with £28.750m (61%) of green and amber schemes identified at Month 3 against the £47.2m target was noted. d) It was noted that delivery of the forecast was predicated on the confirmation of all expected income streams including Welsh Government anticipated allocations and LTA performance income.	
FPC 17/07/009  Chilcott, Rachel 30/01/2025 09:41:21	**Operational Performance** *To view the minute:* *https://youtu.be/7zb1LEQrP2k?list=PLLVdfcKNzmAA7B9lVZC6mzngn8msCNnOV&t=2611* The Operational Performance update was received. The COO advised the Committee that he would take the report as read and noted that it had not changed much from the report received in the previous month. He added that he would highlight key points which included: • Urgent and Emergency Care – The Health Board were struggling to hold onto the performance delivered so far with the last few weeks being harder for the teams that expected. It was noted that despite the challenges, the Health Board was still the best performing Health Board in Wales and it had outlined an improvement trajectory to meet its own, and the Cabinet Secretary's ambitions. • Hospital Flow and Discharge - it was noted that delayed pathways of care had reduced and the Health Board had seen some reduction in length of stay for 7 and 21 days • Cancer – the Committee was reminded that WG had reset the bar and stated that they had wanted all Health Boards to achieve a 62-day single Cancer Pathway standard of 60% and it was noted that the Health Board had delivered against that in December to 70.2% but that recent months had seen a reduction to around the 60% mark.	

	The COO advised the Committee that there were couple of hotspots within cancer which included: - Pathology - Microtomy backlog - Reporting backlog The COO added that although improvements had been observed, a deep dive would be undertaken with the Clinical Board and presented to the Executives to talk about what support may be required. • Rapid Diagnostics Centre (RDC) – the COO advised the Committee that the RDC data had be included which had not been done before and was a “good news” story. • Planned Care – it was noted that a more detailed update would be received by the Board at the private Board meeting being held in July which would outline what was driving some of the issues in planned care and how those could be addressed. The COO added that it was known that planned care was moving in the wrong direction with a number of 104 week waits increasing, as well as 52 week waits and there were 100 patients waiting over 3 years for treatment and 4 patients waiting over 4 years. It was noted that there was a commitment to getting those patients treated over the coming months and confidence that it would be achieved by September 2024. Progress was made in overdue follow-ups with 175 patients who were 18 months past heir scheduled follow up appointment which was down from 500 at the beginning of April 2024. The COO advised the Committee that overdue follow ups were monitored weekly through the operational delivery group (ODG). • Diagnostics – it was noted that the waiting list position for Diagnostics had deteriorated in recent months, with particular challenges in Radiology and Endoscopy and that it was anticipated that the upcoming development of a Community Diagnostic Hub, and interim use of mobile facilities would address radiological backlogs. • Mental Health – the COO advised the Committee that a Mental Health summit was held in June 2024 with attendance from Primary Care, Mental Health and Community colleagues. He added that discussion were held around a new community model of care and a new model of care for ADHD with some working groups established to define those areas with a follow up summit being held later in the year. It was noted that in relation to Mental Health Clinical Board, demand for adult and children’s Mental Health services remained significantly above pre-Covid levels, including an increased presentation of patients with complex mental health and behavioural needs. The COO advised the Committee that performance was expected to remain low through the year and recover to compliance in Q4 2024/25 **The Finance and Performance Committee resolved:** a) The year to date position against key organisational performance indicators for 2023-24 and the update against the Operational Plan programmes were noted.	
FPC 17/07/010	Business Cases: • **<u>Transforming Access to Medicine Business (TRAMS) Justification Case (Radiopharmacy)</u>**	

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The Transforming Access to Medicine Business (TRAMS) Justification Case (Radiopharmacy) was received.

The Director of Operations – CD&T provided the Committee with detail around the business case and noted that from a financial perspective, the new arrangements were within the Health Boards current financial outlay and so there was no additional ask from a revenue perspective from the Health Board.

The Finance and Performance Committee resolved:

a) The business model presented in the Business Justification Case prepared by Shared Services Partnership for the future provision of Radiopharmaceutical products to NHS Wales organisations including C&V UHB was noted.

b) The fair shares financial risk share principle that underpins the funding model was noted.

c) Recommendation to the Board that it approves and provides support for the BJC

- **Pentyrch Business Justification Case**

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https://youtu.be/7zb1LEQrP2k?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=3835

The Pentyrch Business Justification Case was received.
The Deputy Director of Commissioning provided the Committee with detail around the business case and noted that there was a revenue consequence which was non-recurrent to the Health Board of £53,000, which was the start-up costs to provide technology and infrastructure and to set up the new service.

She added that there would be ongoing recurrent revenue cost of £25K, but noted that those were in line with the existing revenue costs of running the service.

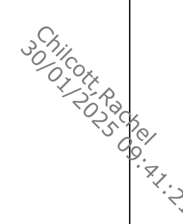
The Finance and Performance Committee resolved:

a) The Pentyrch Branch Surgery Development - Business Justification Case was supported
b) It was recommended to the Board that it:

- approved the submission of the Pentyrch Branch Surgery Development – Business Justification Case to Welsh Government for capital funding support

- Approved awarding of the construction contract, subject to Welsh Government approval of the BJC, at the cost of £3.908m (inclusive of VAT) under the terms and conditions of the NEC 4, Option B contract

- Note the appointment of the Health Board's Project Manager and Cost Advisor will be undertaken at a later date and that there is a fee allowance in the overall Business Case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- **Digital Cellular Pathology Business Case**

	To view the minute: https://youtu.be/7zb1LEQrP2k?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=4254 The Digital Cellular Pathology Business Case was received. The Clinical Board Director CD&T (CBDCDT) provided the Committee with detail around the business case and noted that for 2025/26 the cost would be £75K for the procurement phase outlined within the paper and then the costs increased to £1m every year for the Health Board was were proportionate based on the volume of work that would be undertaken. It was noted that Digital Cellular Pathology had been running for around 8 or 9 years and the UHB Chair asked why the Health Board were so far behind in undertaking it. The CBDCDT responded that there had been issues with firewalls and getting the scanner connected to servers around Wales as well as staffing issues. The UHB Chair asked how confident the CBDCDT was that the Health Board could get up to speed in relation to resource to make the most of the investment. The CBDCDT responded that the money that WG had released included staff for scanning specifically. **The Finance and Performance Committee resolved:** a) The Business Justification Case for Digital Cellular Pathology Programme Phase 3 - National Scale Up was approved.	
FPC 17/07/011	**Draft Capital Plan** *To view the minute:* https://youtu.be/7zb1LEQrP2k?list=PLLVdfcKNzmAA7B9lVZC6mznqn8msCNnOV&t=5047 The Draft Capital Plan was received. The EDF advised the Committee that she would take the report as read and apologised to the Committee because it should have formed part of the Annual Plan but noted that there had been some back and forth from WG around the allocation. Key points were highlighted which included: • The desire to move Cardiothoracic and Cardiology around in the UHW and UHL sites meant that the Health Board were in a position at the current point of the year where there was limited (if not no) contingency which was not a comfortable position for the Health Board to be in. The EDF added that work was ongoing to try and manage with less resources • The appendices received by the Committee were papers that the Health Board had sent to WG to ask them for a share of a £30m fund that they were holding and it was noted that some success had be found with those schemes for urgent IM&T and medical equipment. The UHB Chair advised the Committee a slot would be held at the Board Development session in August 2024 to explore UHW in particular in terms of its estate condition and the risks posed by those conditions to patients and staff who work within the premises and the impact it had on performance. **The Finance and Performance Committee resolved:**	

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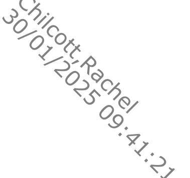
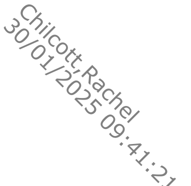
	a) The content of the paper and in particular the prioritisation process undertaken was noted. b) The draft capital plan 2024/25 was supported and it was recommended that the Board approve the plan, recognising the reported overcommitment and risk associated with the unavailability of contingency. c) The potential additional Welsh Government funding allocation to support items 4,5,6&8 in table 3 of the report was noted.	
FPC 17/07/012	**Any Other Business** No other business was raised.	
	Date & time of next Meeting Wednesday 21 August 2024 via Teams	



Public Action Log

Following Finance and Performance Committee Meeting
17.07.2024
(For the Meeting 21 August 2024)

Completed actions					
REF	**SUBJECT**	**AGREED ACTION**	**ACTIONED TO**	**DATE**	**STATUS/COMMENTS**
FPC **17/07/007**	Finance Position Update – Month 3 Position & Savings Plan Progress	For an update to be provided around the outstanding allocations from Welsh Government.	Rob Mahoney	21.08.2024	**Completed – on the agenda for 21.08.24**
FPC **17/07/010**	Digital Cellular Pathology Business Case	The wording of the recommendation needs to be altered: '*To recommend to the Board the approval of the Business Justification Case for Digital Cellular Pathology Programme Phase 3 - National Scale Up*'	Corporate Governance Officer	21.08.2024	**Completed**
Actions referred to Board/Committees					



Report Title:	Finance Report for the Period Ended 31st July 2024			Agenda Item no.	2.1
Meeting:	Finance Committee	Public	x	Meeting Date:	21st August 2024
		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 4 the UHB is reporting an overspend of £14.163m.

This is comprised of £5.493m unidentified savings, £3.370m of operational overspend and the planned deficit of £5.300m (four twelfths of the annual planned deficit of £15.9m set out in 2024-25 financial plan approved by the UHB Board and submitted to Welsh Government).

The UHB is working to recover the month 4 operational and savings overspend to remain within the £15.900m planned deficit.

Table 1: Month 4 Financial Position 2024/25

	Month 4 Position £m	Forecast Year-End Position £m
Planned deficit	5.300	15.900
Savings Programme	5.493	0.000
Operational position (Surplus) / Deficit	3.370	0.000
Financial Position £m (Surplus) / Deficit £m	**14.163**	**15.900**

Financial Plan Approved by Board and submitted to Welsh Government

The UHB's Financial Plan in 2024-25 reflected the following key components:

- Brought forward underlying deficit of £60.9m
- 2024-25 Demand and cost growth and unavoidable investments of £45.4m

This brought the UHB's draft 2024-25 position to £106.3m deficit before the following new funding and savings programmes:

- Additional Allocations of £37.3m
- Anticipated pass-through funding on Long Term Agreements of £5.9m (3.67%)
- Savings plans to reduce expenditure by £47.2m

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This resulted in a 2024-25 planning deficit of £15.9m that was approved by the UHB Board for submission to Welsh Government.

Discussions continue between the UHB and Welsh Government over the acceptability of this Financial Plan.

The submitted 2024-25 plan represents a failure of the UHB's statutory requirement to deliver a balanced financial plan over a three-year rolling period. The submitted Financial Plan has not been approved by Ministers and this also represent the failure of a statutory financial duty in respect of an approved plan.

Summary Financial Table

The following table analyses the £14.163m overspend at Month 4, between Income, Pay and Non-Pay.

Table 2: Summary Financial Position for the period ended 31st July 2024

Income/Pay/Non Pay	Memorandum Annual Budget £m	Current Period Actual £m	Total Variance (Fav)/Adv £m
In Month			
Income	(639.287)	(159.289)	0.553
Pay	301.312	75.318	(0.630)
Non Pay	337.975	85.245	1.351
Sub Total £m	0.000	1.274	1.274
2024/25 Planned Deficit	15.900	1.325	1.325
Variance to Plan £m	15.900	2.599	2.599
Cumulative			
Income	(639.287)	(639.667)	(0.379)
Pay	301.312	301.755	0.443
Non Pay	337.975	346.774	8.799
Sub Total £m	0.000	8.863	8.863
2024/25 Planned Deficit	15.900	5.300	5.300
Variance to Plan £m	15.900	14.163	14.163

The adverse variance reported against Income in month relates to the under-performance of Long Term Agreement (LTA) arrangements funded by other Welsh Health Boards. Activity delivery has not returned to pre Covid levels and interim financial protection arrangements agreed by Directors of Finance have ceased in the 2024-25 financial year.

The in-month improvement against pay reflects a cost neutral realignment of budgets within the CD&T Clinical Board and does not reflect an underlying reduction in pay costs.

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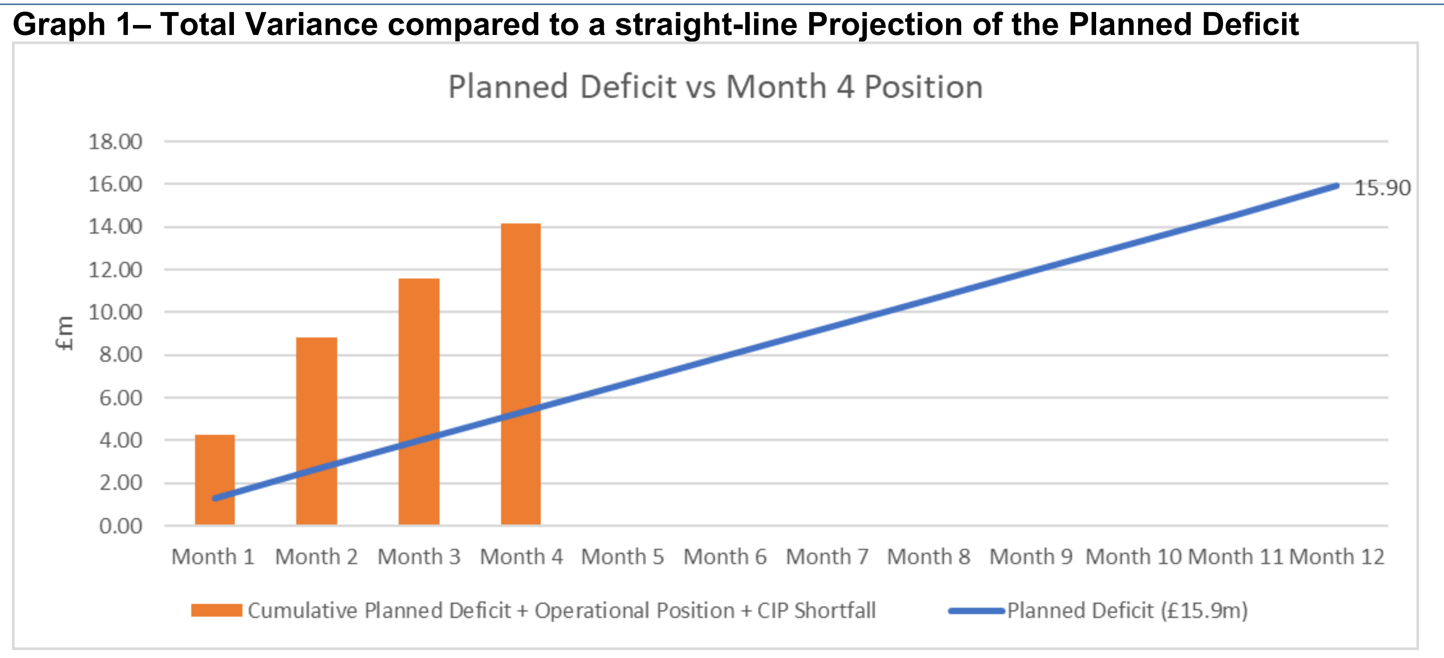
Graph 1– Total Variance compared to a straight-line Projection of the Planned Deficit

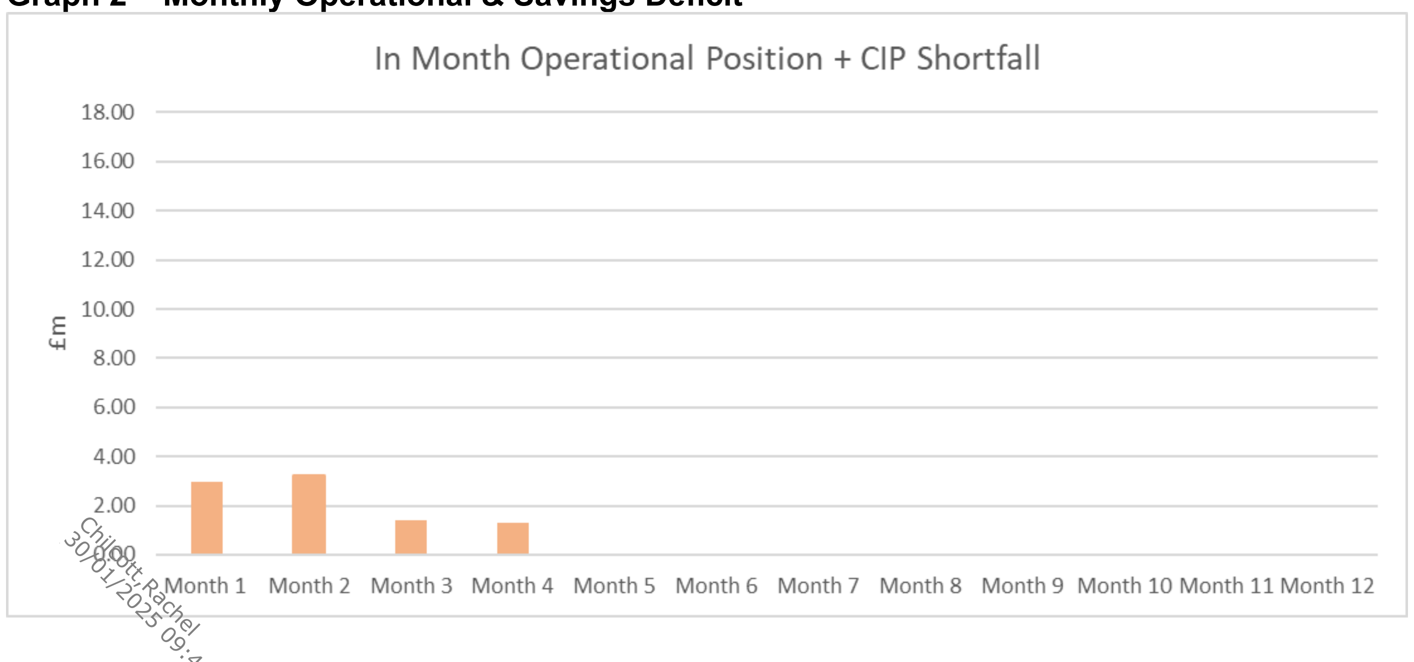


Graph 1 shows the reported position at month 4 compared to the planned deficit. The actual position is £8.863m above the planned deficit reflecting an in year operational overspend in delegated positions combined with a failure to fully identify and deliver the planned savings programme.

The level of overspend continues to cause concern, albeit the in-month level of overspend against the planned deficit has improved since month 3.

Given the deficit position at Month 3 against plan, an enhanced focus through the existing savings governance arrangements has led to the identification of further schemes to de-risk the savings programme. There is also a clear focus on addressing operational overspends as the UHB moves through quarter 2.

Graph 2 – Monthly Operational & Savings Deficit



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The further schemes identified through enhanced focus were risk rated as Green, Amber and Red. Green schemes have been initiated and are reflected in the Month 4 position. Amber and Red schemes are being evaluated within the context of quality and safety.

The delivery of the UHB financial plan assumes that further recurrent actions are required to reduce rates of expenditure and the savings governance processes are focussed on this.

Long Term Agreements

The UHB has completed discussions to agree and sign contracts (Long Term Agreements (LTA) and Service Level Agreements with other Welsh NHS organisations, without the need to resort to arbitration. Most LTAs were uplifted in line with the Welsh Government guidelines with a general funding uplift of 3.67%. Some settlements are expected to recover the necessary income to support the anticipated plan position with improved output and productivity.

The financial impact of year to date underperformance against LTA activity targets is incorporated within the year to date reported position.

Financial Performance of Clinical Boards

2024-25 operational budgets delegated to Clinical Boards included £12m of operational pressures funding. Financial performance for Month 4 by Clinical Board is shown in Table 3.

Table 3: Financial Performance for the period ended 31st July 2024

Clinical Board Cumulative	Operational Position (Surplus) / Deficit Variance £m	Savings Position (Surplus) / Deficit Variance £m	Total (Surplus) / Deficit Variance £m	Prior Month (Surplus) / Deficit Variance £m
Clinical Diagnostics & Therapeutics	12	654	666	580
Children & Women	1,091	532	1,623	1,619
Capital Estates and Facilities	(93)	566	473	330
Executives	(821)	66	(755)	(484)
Genomics	(15)	0	(15)	(13)
Medicine	2,141	1,176	3,316	2,490
Mental Health	14	665	679	654
PCIC	1,605	160	1,765	2,158
Specialist	357	601	958	572
Surgery	726	1,412	2,138	1,627
Clinical Board budgets to be delegated	(1,766)		(1,766)	(1,325)
Sub-Total Delegated Position	**3,250**	**5,832**	**9,083**	**8,209**
Central Budgets	113	(840)	(727)	(992)
Commissioning	6	500	506	372
Cost Improvement Themes	0	0	0	0
Total (Surplus)/Deficit	**3,370**	**5,493**	**8,863**	**7,589**
Planned Deficit	5,300	0	5,300	3,975
Total Operational (Surplus)/Deficit	**8,670**	**5,493**	**14,163**	**11,564**

The UHB reported an overspend of £8.863m against the draft financial plan for the year to date before the £5.300m year to date impact of the planned annual deficit.

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The deficit against the £47.2m savings plan deteriorated by £0.342m from £5.151m to £5.493m in month and is due to the straight-line phasing of the gap against the target over months 1 to 12. The in month deficit was £1.375m less than the average deficit of £1.717m reported in months 1-3, which reflects the implementation of new schemes in month. The position is expected to improve further as further schemes develop and mature during the financial year including enhanced recovery actions.

The pressures on operational positions, reported across delegated clinical boards, have been partially offset in Month 4 by a release of remaining plan provision to support known brought forward operational pressures. £5.3 million remains un-allocated at present, pending the agreement of recovery actions, most notably in the Medicine Clinical Board. The year to date impact (£1.766m) of this reserve has been brought into the Month 4 position (This is included in Table 3 in the row 'Clinical Board budgets to be delegated').

Clinical Boards are required to manage the operational financial risks within their delegated budgets. The most significant of these risks are outlined below:

C&W: Driven by increased variable medical pay spend (£0.523m) combined with additional costs of planned care between April and June, where the service has been re-aligned with funding in July.

Medicine: Driven by medical staff and registered nursing, where there is continuing scrutiny of temporary expenditure and a drive to recruit to substantive posts. Leave due to sickness was a continuing pressure through July. It is anticipated that the focus on job planning, rota and sickness management will reduce reliance on agency clinicians and that the benefits of bio-similar drugs switches will be realised in the latter half of the financial year.

Surgery: Significant costs have been incurred in the first quarter in respect of planned care initiatives where costs have exceeded available funding. The UHB's forecast position assumes that the cost profile will reduce as the year progresses and work is underway with the Chief Operating Officer to deliver on this basis. In addition, pressures are reported due to continuing costs arising from GP Interface sessions where non recurrent Welsh Government support has now ended. Additional wastage costs have been incurred in month due to the failure of refrigeration and air conditioning systems.

PCIC: The rate of overspend has slowed in month following discussions with Welsh Government and the acknowledgement of the additional financial costs of the new Optometry contract agreed with community opticians in Wales. The UHB is now expecting Welsh Government to provide additional funding up to £1.2m to cover the increased costs arising from implementation. The UHB's financial plan reshaped the funding framework for some PCIC urgent care initiatives which included the filling of community nursing posts. The savings to right-size the remaining urgent care programmes will be delivered in the second half of the financial year.

Review meetings are scheduled with the Clinical Boards to assess their Month 4 positions and the robustness of actions to improve the financial outlook.

Welsh Government COVID 19 Allocations & Expenditure

Profiled Welsh Government funding at Month 4 is summarised in Table 4 below.

Table 4: Summary of Month 4 COVID 19 Net Expenditure

	Funded by WG £m	Funding to Month 4 £m
Health Protection/Vaccination & PPE	9.040	3.013
Long Covid	1.144	0.381
Sub Total WG Funded Covid Expenditure £m	**10.184**	**3.395**

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Funding for local response costs is allocated to Clinical Boards through the UHB's Financial Plan. However, local response expenditure is no longer funded directly by Welsh Government and residual costs are reported within delegated clinical board positions and not included in table 4 above.

The UHB plan assumes that any underspends against Covid funding will be retained by the UHB.

Financial 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 2024-25 year end with a current planned deficit of £15.9m.

Table 5: Risk Register at July 2024

Finance Risk	Rating	Comment
The submitted Financial Plan has a planned deficit of £15.9m for 2024/25. This does not allow the Minister to approve the an IMTP due to the lack of financial balance over a three year rolling period. How ever the 2024-25 Financial plan does require support from Welsh Government even in the absence of Ministerial approval.	15	The UHB has developed a plan w hich has a deficit of £15.9m in 2024-25 and break even positions in FY 2026 and FY 2027 w hich the Minister is not able to approve. Support for the one year 2024-25 financial plan w ill be required. Welsh Government has not confirmed its support at the present time. Enhanced Monitoring meetings w ith Welsh Government at Executive level continue to discuss this issue.
Due to a planned deficit of £15.9m for 2024/25 the UHB is unable to achieve financial balance over a three year rolling period. This does not allow the Minister to approve the UHB IMTP (Three year plan) and has contributed to the UHB follow ing Enhanced Monitoring arrangements by Welsh Government.	15	The failure to submit a balance plan for 2024-25 means that the UHB cannot achieve its statutory duty to balance over a three year rolling period. The UHB has plans to return the UHB to financial balance in FY 2025 and 2026. Progress is monitored internally through established governance reporting and monitoring arrangements through operational teams, Finance Committee and Board Internal Audit provides assurance that controls are in place. Enhanced Monitoring meetings and Joint Executive meetings w ith Welsh Government maintain discussions over progress tow ards a financially balanced three year IMTP .
Achievement of Capital statutory breakeven duty The Health Board has a capital allocation, w hich it should not exceed on a three year rolling basis.	8	The current 2024-25 UHB Capital Plan is structured to remain w ithin the Capital Resource Limit. Capital Management Group manages the capital programme and reports into the Management Executive. Governance reporting and monitoring arrangements through the Finance Committee, Board and WG. Internal Audit provides assurance that controls are in place.
Failure to adequately manage budget pressures in line w ith the submitted £15.9m deficit plan for 2024-25	20	The period to Month 4 has reported financial pressures against the £47.2m savings target and operational pressures w ithin delegated positions. The requirement to manage budget pressures is clearly communicated to primary budget holders. Enhanced monitoring of delegated financial positions is exercised through monthly meetings including Executive Performance Review s w ith each Clinical Board; Monthly Finance meetings w ith all Clinical Boards and COOs Office; w eekly Savings meetings of delegated budget holders; and bi w eekly multi leadership Sustainability Board meetings chaired by the CEO.
A recurrent Cost Improvement Programme target of £47.2m has been set for 2024/25. Failure to deliver this level of saving in 2024-25 impacts the ability of the UHB to meet its planned 2024/25 deficit of £15.9m. This combined w ith any savings w hich are achieved but non recurrently impacts the ability of the UHB to deliver financial balance in future financial years	20	The CIP savings target has been clearly communicated and delegated to budget holders. At Month 4, only £18m of Green and Amber schemes against the £47.2m target have been identified as recurrent in nature. A CIP pipeline tracker is in place w ith a w eekly monitoring progress across the organisation. Monthly Financial Clearance Meeting include specific focus on CIPs. Further focus is provided in Executive / Clinical Board Performance Review s, bi w eekly Sustainability Boards and w eekly Savings meetings. Governance reporting and monitoring arrangements through the Finance Committee and Board.
2024-25 LTA framew ork in NHS Wales.	15	LTAS have now been agreed w ith Commissioners, generally in line w ith the guideline 3.67% uplift recommended by Welsh Government. Elements of income w ill be contingent on improved LTA outturn performamnce and this remains a risk for the UHB.
Remain w ithin Cash limit	15	The UHB w ill require cash support from WG for the 24/25 planned deficit of £15.9m alongside w orking capital for any movements from the 2023/24 balance sheet. In addition outstanding allocations from previous financial years to be confirmed by WG in 2024-25 may bring forw ard the point of the year w hen cash controls w ill require consideration. Cash controls w ill include the careful management of creditor payment feeds and potential compromise the achievement of the UHB's payment performance targets.

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Savings Programme Update

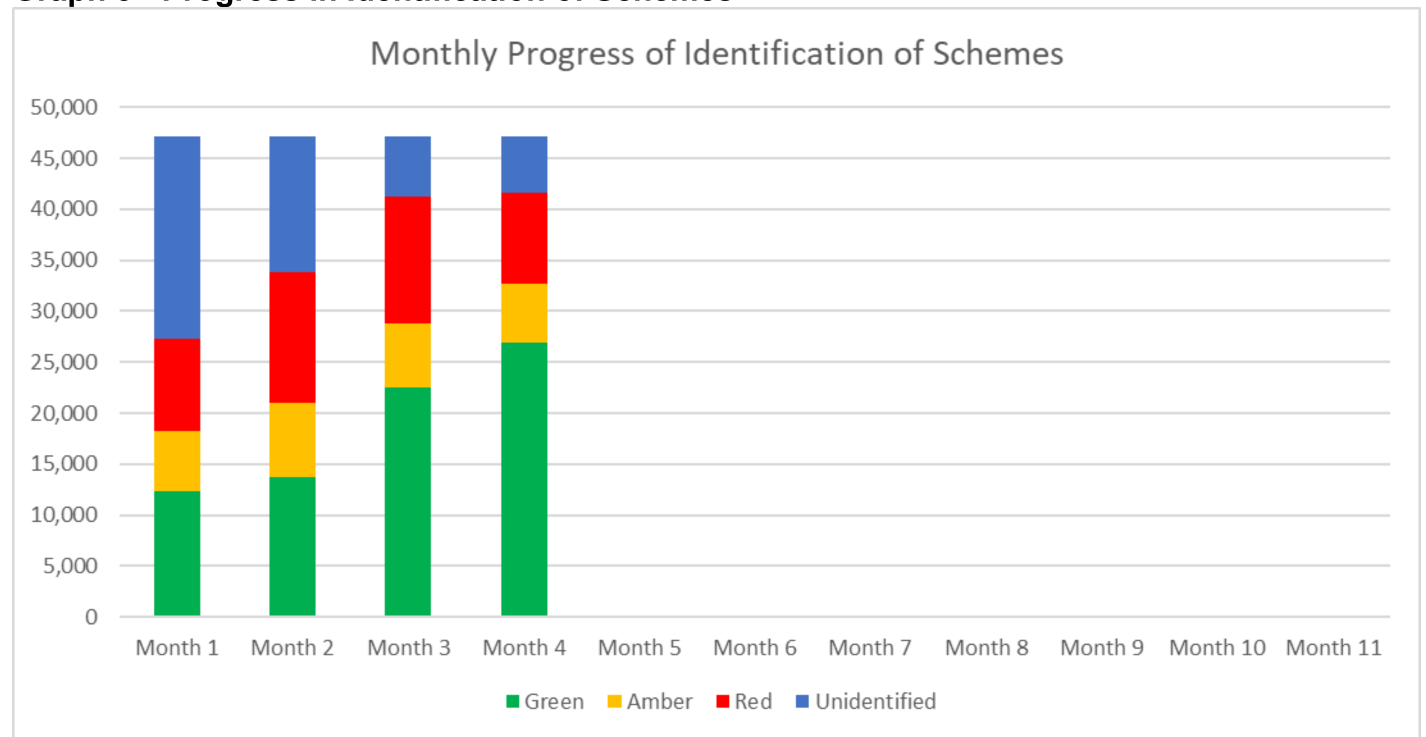
At month 4, £32.708m (69%) of green and amber savings had been identified towards the £47.2m savings target. £18.002m of these schemes are recurrent.

The reported gap in identified savings incorporates red schemes and the unidentified balance. Red schemes are not included in accordance with the instruction from Welsh Government that red schemes are excluded from the Monthly Monitoring Returns savings tables. However, a proportion of red schemes are expected to deliver in 2024/25. At a 50% delivery level an additional £4.474m of savings schemes for 2024-25 would be reported as identified at Month 4.

The total of green, amber and red schemes (£41.656m) represents 88% of the annual target.

The progress in the identification of schemes during the year is shown in the graph below:

Graph 3 - Progress in Identification of Schemes



Further detail of the progress by Clinical Boards and Improvement Themes is provided in Table 6.

Table 6: Savings Schemes

Clinical/Service Board	24-25 Target £'000	Green £'000	Amber £'000	Sub Total Green & Amber £'000	Red £'000	Total Savings Identified £'000
Capital Estates and Facilities	947	698	262	960	100	1,060
Children and Women	1,304	957	210	1,166	146	1,313
Clinical Diagnostics and Therapeutics	1,199	732	92	824	14	838
Corporate Executives	501	1,267	0	1,267	98	1,365
Medicine	1,379	134	300	434	0	434
Mental Health	1,079	401	0	401	56	457
Primary, Community and Intermediate Care	2,423	2,249	260	2,509	9	2,518
Specialist Services	1,482	1,466	176	1,641	50	1,691
Surgical Services	1,689	464	536	1,000	242	1,242
Subtotal - Grip and Control	**12,000**	**8,368**	**1,835**	**10,203**	**715**	**10,918**
Medicines Management	4,530	2,733	1,444	4,177	248	4,425
Reducing Length of Stay	3,500	3,064	0	3,064	1,250	4,314
Optimising Planned Care	1,000	0	0	0	897	897
Income Generation	1,000	645	20	665	253	918
Continuing Healthcare	2,500	1,073	856	1,929	471	2,400
Facilities and Estates / Service Reconfiguration	500	0	0	0	606	606
Value/Clinical Variation	0	0	0	0	0	0
Procurement	5,000	3,298	488	3,786	565	4,352
Recording Patient Care	1,500	0	0	0	150	150
Other Digital Benefits	0	0	0	0	50	50
Workforce - Temporary Pay	7,403	3,370	777	4,147	3,258	7,405
Workforce Reshaping	8,268	1,320	416	1,736	486	2,222
Corporate Opportunities	0	3,000	0	3,000	0	3,000
Subtotal Cost Improvement Themes	**35,200**	**18,503**	**4,001**	**22,505**	**8,234**	**30,738**
Total Savings Position	**47,200**	**26,871**	**5,837**	**32,708**	**8,948**	**41,656**

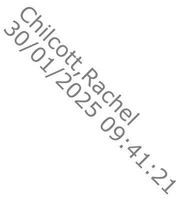
Key:

Green Schemes: Complete, appropriate to complexity, project plan in place, brief available reflecting timescales, milestones, enablers and risk considered. Complete project brief provides clear base for financial assessment.

Amber Schemes: Clear components of project plan in place with elements not fully confirmed and addressed.

Red schemes: Pipeline schemes yet to be finalised.

At month 4, £18.002m of the identified green and amber schemes and £4.336m of red schemes were recurrent.



Achievement of financial sustainability and recurrent financial balance by the end of 2025/26

The draft financial plan requires the UHB to meet its £47.2m Recurrent Savings target and deliver a balanced recurrent operational position to reduce the brought forward underlying deficit (ULD) from £60.9m to £15.9m at the end of 2024/25.

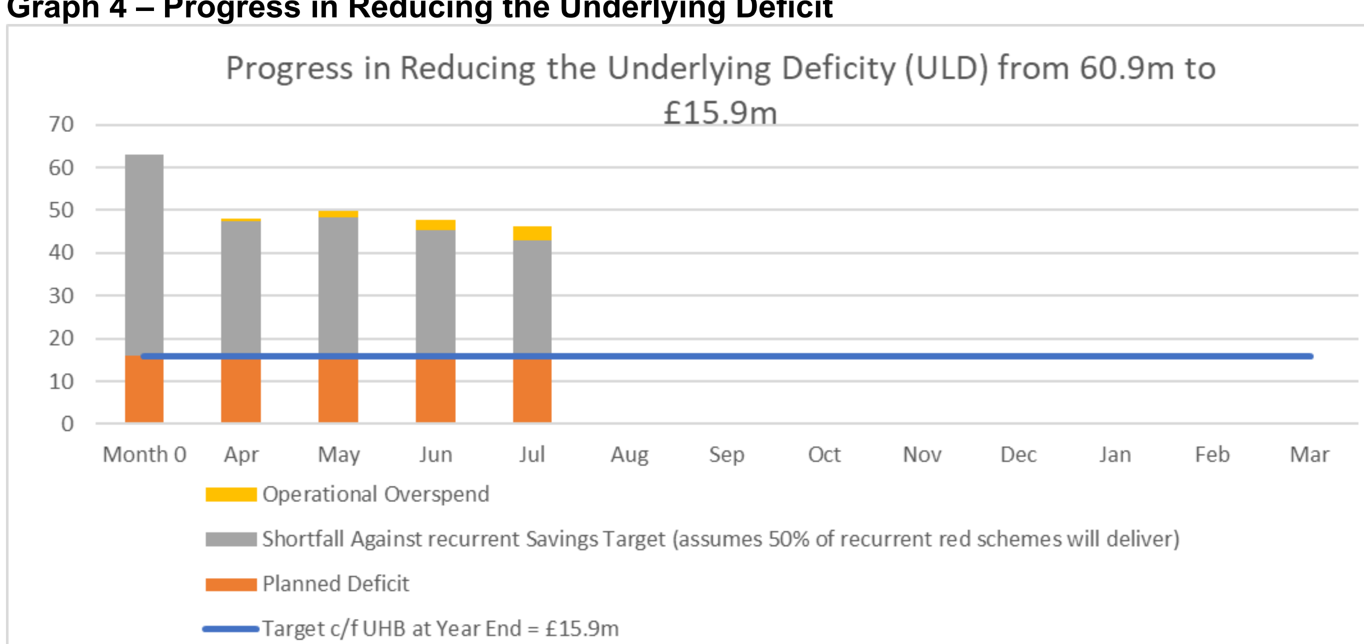
At month 4, the UHB had identified £18.002m of recurrent green and amber savings. In addition, it is assumed that 50% of the £4.336m of red schemes would be achieved recurrently.

A £3.370m operational overspend was reported at month 4 and this will also need to be managed to a balanced position at year end to meet the target ULD.

In summary, a further £27.030m of recurrent savings and a balanced operational position are required to enable the UHB to reduce its ULD to £15.9m at the end of March.

Graph 4 presents the current high level picture of the UHB's underlying position that will be reviewed and updated as the financial plan is progressed throughout 2024-25.

Graph 4 – Progress in Reducing the Underlying Deficit



Cash Flow Forecast

The closing cash balance at the end of July, was £3.522m.

In due course, the UHB expects to seek Finance Committee and Board approval to request £15.900m strategic cash support from Welsh Government to cover the cash shortfall arising from the forecast deficit.

Graph 4 below outlines Cumulative Cash Drawn against the Revenue and Capital Drawing Limit

In addition to cash drawn from Welsh Government, the UHB cashflow will depend on the recovery of a circa £610m annual income through LTA and other income agreements separate to Welsh Government funding flows.

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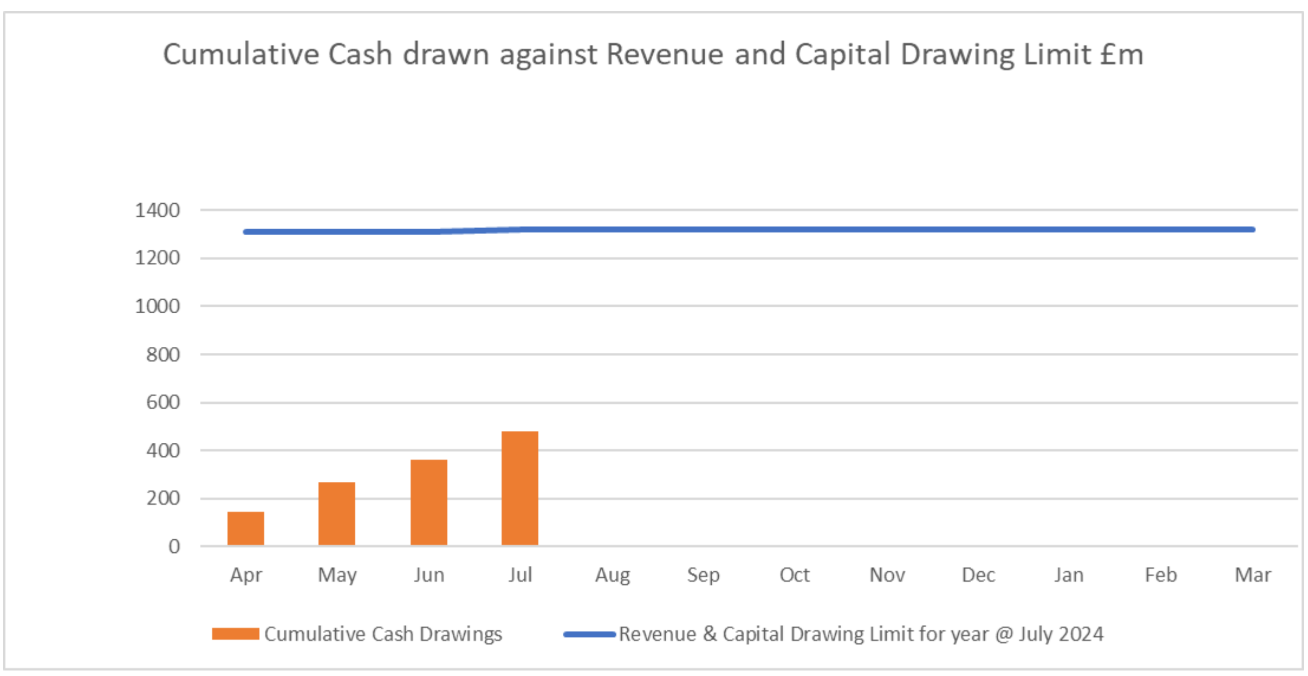
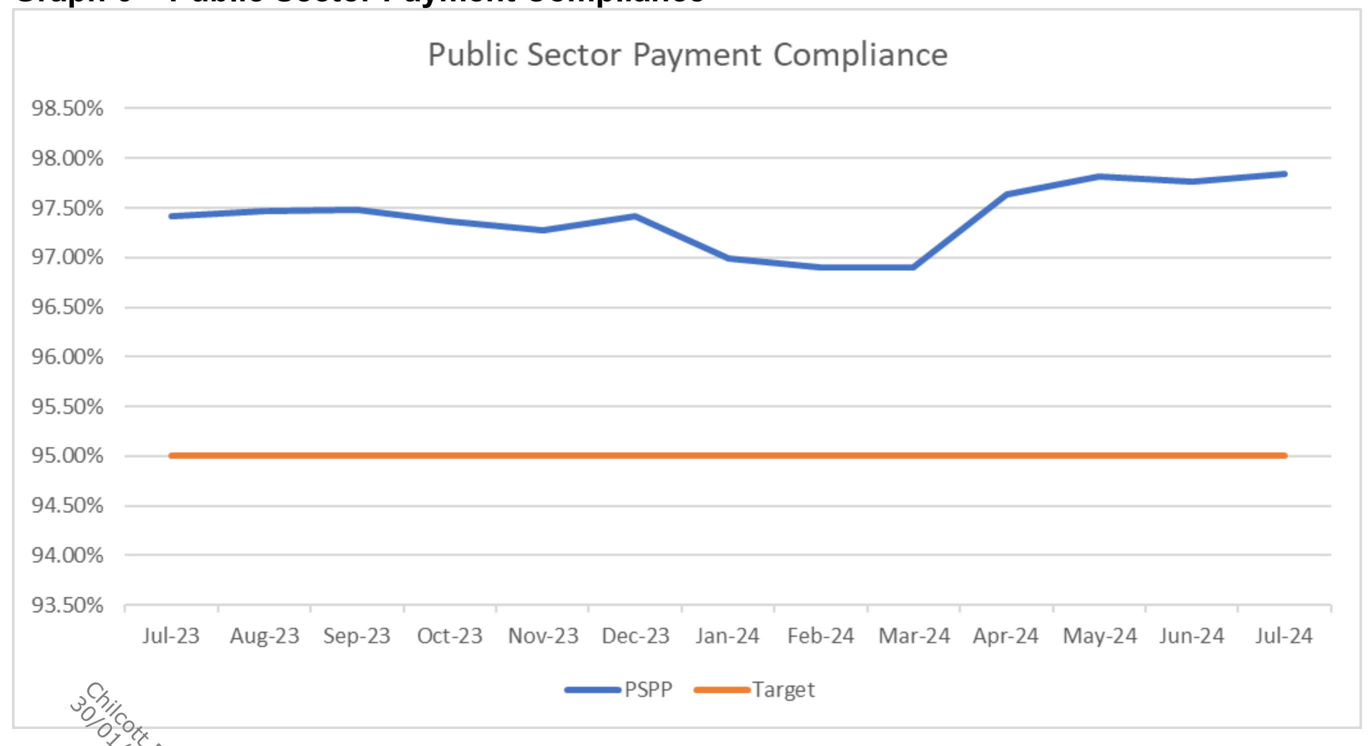
Graph 5 Cumulative Cash Drawn against the Revenue and Capital Drawing Limit



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 July was 97.8% for the year to date as illustrated in Graph 6 below.

Graph 6 – Public Sector Payment Compliance



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Capital

The UHBs approved capital resource limit is £41.440m in line with the latest CRL received from Welsh Government on the 19th of July 2024. This comprises of £13.564m discretionary funding and £27.786m towards specific projects (including Efab, Interventional Neuroradiology Equipment,

Mortuary, UHW Lift Refurb, Backlog Maintenance, Diagnostic Equipment and Park View Well Being Hub).

The capital programme is planned and monitored through the UHBs Capital Management Group (CMG) and the UHB forecasts that it will remain within its CRL in 2024-25.

INCOME ASSUMPTIONS 2024/25 – REVENUE RESOUCE LIMIT

The UHBs Confirmed Revenue Resource Limit as at August 6th 2024 was £1,297m with a further £29m of assumed allocations as detailed below:

Table 7 : Unconfirmed Anticipated Allocations

	Unconfirmed Allocations £m
Depreciation, Impairments & IFRS 16	7.105
Real Living Wage Health & Social Care Providers	4.612
Real Living Wage UHB Pay Award	4.000
Substance Misuse	2.916
Clinical Excellence & Impact Awards	2.121
Optometry Contract Reform	2.000
Welsh Government Funded New Medical Posts	1.736
Memory Assessment Service	1.500
Welsh Risk Pool 2024_25	(4.886)
Other	7.492
Total Unconfirmed Allocations £m	**28.596**

The UHB's financial forecast is based on confirmation of all unconfirmed allocations. The UHB's anticipated allocations are reported within the Monthly Monitoring Returns submitted to Welsh Government to allow Welsh Government to be sighted on the UHB financial assumptions.

Table 8: Finance - Key Performance Indicator Dashboard at July 2024

	STATUS REPORT				
Measure	**July 2024**	**RAG Rating**	**Latest Trend**	**Target**	**Time Period**
Deliver 2024/25 Draft Financial Plan	£14.163m deficit at month 4, being £5.300m forecast deficit, £5.493m savings gap and a £3.370m operational overspend.	R	↓	Deliver 2023/24 £15.900m Revised Planned Deficit	M4 2024-25
Return to Financial Balance and approved IMTP status	Achieve financial sustainability and recurrent financial balance by the end of 2025/26. At month 4, the UHB is reporting a £3.370m operational ovesrpend and a £29.198m shortfall against the £47.2m recurrent savings target.	R	↓	Reduce c/f underlying defict to £15.900m at year end	M4 2024-25
Management of operational budget pressures	The UHB reported a £3.370m operational overspend at month 3.	R	↓	Operational Spend to be maintained within Budgets	M4 2024-25
Delivery of recurrent £47.2m savings target	£32.708m Green and Amber schemes identified at month 4, of which £18.002m were recurrent.	R	9	£47.2m	M4 2024-25
Remain within Cash Limit	The UHB forecasts to remain within its 2024/25 cash limit, on the assumption that strategic cash support is provided for the forecast deficit.	A	9	To remain within Cash Limit	M4 2024-25

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

The UHB 2024-25 Financial Plan is based on a forecast deficit of £15.900m. The month 4 position is a reported overspend of £14.163m, which is £8.863m above the £5.300m straight line profile of the planned deficit.

As at month 3 £32.708m of green and amber savings schemes were identified against the £47.2m savings target. Further work, focus and resolve is required to identify sufficient schemes to deliver this target and is being progressed through enhanced savings meetings and initiatives led at Executive Board level.

Public Sector Payments are above the 95% target and the UHB forecasts that it will remain within its Capital Resource Limit.

Recommendation:

At Month 4 the Committee are requested to:

- **NOTE** the reported year to date overspend of £14.163m and the forecast deficit of £15.900m.
- **NOTE** the month 4 operational overspend against plan of £3.370m with a further £5.493m savings gap.
- **NOTE** the progress against the savings target, with £32.708m (69%) of green and amber schemes identified at Month 4 against the £47.2m target.
- **NOTE** that delivery of the forecast is predicated on the confirmation of all expected income streams including Welsh Government anticipated allocations and LTA performance income.

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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: 21st August 2024

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Report Title:	Operational Performance Report			Agenda Item no.	2.2
Meeting:	Finance and Performance Committee	Public	a	Meeting Date:	21/08/24
		Private			
Status *(please tick one only)*:	Assurance	a	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 Cabinet Secretary's priorities and our performance ambitions/IMTP priorities. It also includes performance against the updated NHS Performance Framework for 24/25.

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

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

Urgent and Emergency Care

Delays to ambulance handovers and patient waiting times in Emergency Units markedly improved through 23/24 – the UHB eliminated 4-hour delays and significantly reduced 3, 2 and 1 hours delays at UHW. Recent performance has been affected by unseasonal operational pressures through May and June which has impacted both ambulance handover times and the length of time patients some patients are waiting in the Emergency Unit before admission, transfer or discharge. The challenges posed by these pressures were reflected at the end of June and start of July with three 4-hour ambulance delays, the only such delays in over 15 months. Since December 2023, where the number of 1-hour ambulance delays reduced to 167, the number has risen and in May and June and is above our trajectory. We have seen a similar picture for 12-hour EU waits where reductions through Q3 have not been sustained during 2024.

Initial analysis suggests that there is a **12%** increase in patients presenting to EU as 'majors' compared with the same period last year. This equates to an increase of more than **550** extra patients attending EU a month in the category most likely to to need extended stay or admission.

Despite these challenges, the UHB is still the best performing Health Board in Wales and we have outlined an improvement trajectory to meet our own, and the Cabinet Secretary's, ambitions.

Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown improvement against our historic trends. 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 – this reduction has been maintained though some very challenging weeks through the whole winter period and beyond. Compliance with the KPI for Admission to a Specialist Ward and Prompt Surgery remains well above the NHFD average. We have seen lower compliance though Q1 against the door-to-ward KPI and our

own internal operational standards. Time to specialist beds for hip fracture and stroke patients remain operational an operational priority and we are conducting regular analysis of breaches to improve implementation of the pathways.

Using the annualised NHFD data, the UHB are at or above the UK national average for 6 of the 8 KPIs. While we are below the average using annualized data for KPI5 (Not Delirious Post-op), compliance has improved from March last year. For May KPI3 (NICE compliant surgery) has also reduced to just below the national average. Our recent breach analysis has shown a high number of 'clinical exceptions' as part of our recorded door to ward and time to theatre breaches which can impact our performance as these times are still recorded in our compliance data. The team are also reviewing theatre documentation to ensure that our true level of compliance is recorded and thus reflected in the national data.

May saw an increase in our compliance against some key SSNAP measures for our Stroke Pathway. The percentage of patients directly admitted to the stroke unit within 4-hours increased to 47.5% and remains significantly above the All Wales average. Our percentage compliance and median time to ward and CT scan remains improved from our historic performance, we continue to work across Clinical Boards to progress the Stroke Service Improvement Plan.

April saw a high number of stroke patients admitted to UHW with a higher number of haemorrhagic stroke patients who are non-suitable for thrombolysis/thrombectomy. As a result, April saw our thrombolysis rate drop to 14.5% following consecutive months at over 20%. In May this improved to 26%, above our ambition and above the Wales average. Operational pressures through June, as referenced in the UEC section have led to delays to in EU and a reduction in compliance across the measures at the front end of the pathway. July performance is still being validated but we saw a very high number of admissions on the stroke pathway (125) with 89 confirmed strokes, approximately **30** more than an average month.

Our SSNAP grade improved to A for the period July-September 2023, this was a significant improvement from the previous quarters and a reflection of the work undertaken by the teams. Our most recent review saw a drop to Grade B but performance remains improved from last year. The challenges in delivering consistent performance in Stroke pathways have been well documented, particularly out of hours. A plan for investing in the front end of our stroke pathway has received endorsement at this Committee before progressing for consideration at Board.

Hospital Flow and Discharge

The proportion of beds occupied by long length-of-stay patients has fluctuated in recent months as additional beds have been opened and closed in line with the winter plan. The number of delayed pathways of care reduced between March and May and in July following a small increase in June.

We have seen length of stay improvements which have allowed us to close **c55** beds compared to Q4. However, the unexpected increased demand from EU means we are not feeling the benefit of the reduced length of stay and we are now refreshing our capacity plans for Q3 and the winter period.

We continue to work with colleagues across the health and social care system to reduce delays in patient's care pathways. Reducing the time patients spend in hospital is a current operational focus. The ongoing work focusses on patients and family, our clinicians, integrated discharge service, hub and flow teams. It is anticipated that this work will result in an improved experience and shorter length of stay for patients, and deliver operation benefits such as improved flow, taking some pressure out of the Emergency Unit.

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Delayed pathways of Care remain an area of national focus and our monthly delays are highlighted in Section 1 of the accompanying IPR – we are currently delivering our commitment to reduce against the same period in 23/24.

In addition to the monthly POCD census, patients with a length of stay >7 and >21 days in acute beds forms part of our weekly 'hot' reporting and end of month snapshots are provided in the IPR. We have seen a fluctuating picture as we moved through Q1, however, the most recently reported weekly snapshot has shown a reduction from the end of Q4. Our nationally submitted data on emergency admissions with a 21-day length of stay shows also a reduction from March to April and May.

Cancer

Our compliance with the 62-day Single Cancer Pathway standard improved in December to 70.2%, our highest performance since the development of the Single Cancer Pathway. As forecasted we saw a drop in compliance to 64.4% in January and 60.8% in February, with continued Junior Doctor industrial action a factor through Q4. In March our SCP performance improved to 62.3%, with a further increase to 63.7% in April. The pathology delays experienced in March mean than our May performance reduced as forecast, as patients treated in May were potentially impacted by delays in this part of their pathway although our performance remained above 60%. In June we reported 64.6% compliance with the SCP with improvements noted in Gynecology and Haematology, with a total of 5 tumour groups achieving the 75% SCP standard.

Every quarter the UHB submits a refreshed position on our historic data to capture any treatments from previous months which have been confirmed as cancer since the original submission. The table below shows the rolling 12-month position including the latest data refresh for Q3 where we have seen improvements in the monthly compliance for October and November.

SCP compliance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Original submission	64.2%	61.7%	62.0%	65.6%	66.4%	56.6%	64.7%	58.0%	70.2%	64.4%	60.8%	62.3%	63.7%	62.1%	64.6%
Compliance following quaterly refresh	66.0%	64.5%	63.6%	67.5%	65.9%	57.8%	66.3%	62.4%	70.2%	63.5%	60.2%	62.3%			

Planned Care

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.

At the end of June there were **3,301** patients waiting 2 years for treatment, which represents 2.17% of patients on a waiting list. This is an increase from May but remains a considerable improvement from last year, however, there are still too many patients waiting too long for treatment across a number of key services. We continue to focus on the small number of spinal patients who are waiting over 4-years for treatment (two patients at the end of June), in addition to continuing to reduce the number of patients waiting over 3-years, c100 which are mainly concentrated in spines and urology. It is our intention to have no patients waiting over 3 years by the end of November 2024.

Last year we did not deliver our commitment to reduce 52-week outpatient waits to fewer than 9000. 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. June saw an increase in the number of patients waiting over 52 weeks for their first outpatient appointment, with the number of breaches forecast to increase as we move through Q2. This is not a UHB wide issue and we have seen a reduction in the number of specialties reporting 52-week waits. We continue to work with specialties, particularly in Paediatrics and Medicine, to reduce to or maintain their outpatient waits below 52 weeks.

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As discussed at the Board Development session in July, the UHB has submitted revised trajectories for 52-week outpatient and 104-week treatment waits, in addition to 8-week Diagnostics waits. These

reflect updated demand and capacity work and reflect the impact of ongoing operational pressure and our operational and financial decisions. The refreshed planned care approach and next steps were discussed as part of the session.

We have seen a reduction in the number of 100% delayed follow-up outpatient appointments over the last year. We have widened our focus to all patients who are delayed, not just those who are 100% beyond their follow-up target. From April 2024 we are only reporting the total number of patients who are a delayed follow-up as we work to reduce this cohort of patients. At the time of writing there are 50,781 patients who are past their target date for a follow-up appointment, of these 5 were over 2 years past their target date as shown below:

Overdue Follow-up Outpatients								
Clinical Board	Months past target date	07/02/2024	30/06/2024	07/07/2024	14/07/2024	21/07/2024	28/07/2024	04/08/2024
Total	Total overdue	61658	53065	52811	52229	51249	50812	50781
	Over 18 months	2948	152	87	86	77	67	61
	Over 24 months	1271	11	9	7	12	5	5
Surgery	Over 18 months	1523	82	55	53	59	49	44
	Over 24 months	643	6	4	3	6	1	1
Children & Women	Over 18 months	500	4	4	6	3	1	1
	Over 24 months	173	1	0	0	1	0	0
Specialist	Over 18 months	464	16	12	12	8	9	6
	Over 24 months	196	1	2	1	2	1	1
Medicine	Over 18 months	455	38	4	3	2	2	4
	Over 24 months	257	0	0	0	1	1	1

Clinical Boards are working through their action plans to reduce these numbers with specific focus on the longest delays. The table above shows the reduction in the total number of delayed appointments and the impact of the focused work on the longest delays. there are a small group of patients who have been given appointments in the coming weeks and others who have had their follow-up target extended following clinical validation and notes reviews. 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 with additional clinical support from specialties who have successfully implemented these pathways. The number of patients overdue for follow-up appointments will be an area of significant focus through this year.

Diagnostics

The waiting list position for Diagnostics has deteriorated in recent months, with particular challenges in Radiology and Endoscopy. As part of the **£2.8m** community diagnostic hub investment to improve imaging waiting times we will continue to use mobile solutions. Since December, we have seen sustained improvements for MRI and CT and remain on track ot deliver against the agreed trajectories. The number of patients waiting 8 weeks for a non-obstetric Ultrasound continues to grow, however a proposal to increased capacity through additional internal capacity was approved at the Senior Leadership Board in July and improvements are expected from mid-August.

Endoscopy capacity has been focused on Cancer, Urgent and long waiting surveillance patients. The service has 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. The number of 8-week waits has continued to increase through Q4 and Q1, albeit at a slower rate than through the rest of the year. To clear the backlog of patients and create enough core capacity is going to require significant investment and support from Welsh Government. A proposal has been drafted that will be discussed with the Executive team to agree how to proceed.

At the end of July, 16,324 patients had waited 8 weeks or longer for their treatment, equating to 61.3% of patients on a diagnostic waiting list.

Diagnostic		Apr-24	May-24	Jun-24	Jul-24	Longest wait (weeks)	Median wait (weeks)	Total waiting list	% under 8w	% over 8w
Cardiology	Myocardial Perfusion Scanning	15	20	23	15	24	15	23	34.8%	65.2%
	Echo Cardiogram	4	0	0	0	6	1	676	100.0%	0.0%
	Dobutamine Stress Echocardiogram	22	10	25	21	16	6	59	64.4%	35.6%
	Stress Test	1	3	1	0	6	1	46	100.0%	0.0%
	Blood Pressure Monitoring	0	0	0	0	4	0	39	100.0%	0.0%
	Heart Rhythm Recording	0	3	0	0	6	0	129	100.0%	0.0%
	Diagnostic Angiography	78	71	33	30	29	6	76	60.5%	39.5%
	Trans Oesophageal Echocardiogram	5	2	0	0	5	2	13	100.0%	0.0%
	Cardiac CT	151	134	107	36	24	4	140	74.3%	25.7%
	Cardiac MRI	203	198	214	209	67	13	317	34.1%	65.9%
	Diagnostic Electrophysiology (EP Study)	2	2	2	0	3	3	1	100.0%	0.0%
Diagnostic Endoscopy	Cystoscopy	160	119	122	147	150	8	282	47.9%	52.1%
	Colonoscopy	1536	1565	1626	1712	103	27	2254	24.0%	76.0%
	Flexible Sigmoidoscopy	1120	1131	1176	1195	102	42	1373	13.0%	87.0%
	Gastroscopy	2499	2603	2692	2761	107	40	3238	14.7%	85.3%
	Bronchoscopy	19	25	14	14	111	11	27	48.1%	51.9%
Imaging	Fluoroscopy	37	30	45	30	71	3	127	76.4%	23.6%
Neurophysiology	Nerve Conduction Studies	0	0	0	0	6	3	57	100.0%	0.0%
	Electromyography	0	1	0	0	6	2	55	100.0%	0.0%
Physiological Measurement	Urodynamic Tests	35	74	76	58	86	5	164	64.6%	35.4%
	Vascular Technology	0	0	0	0	6	1	103	100.0%	0.0%
Radiology	MRI	1116	1045	892	974	78	5	3077	68.3%	31.7%
	Non-Obstetric Ultrasound	7773	8130	8808	9036	56	18	13386	32.5%	67.5%
	CT	21	26	20	14	64	1	226	93.8%	6.2%
	Nuclear Medicine	38	53	62	72	35	5	720	90.0%	10.0%
Total		14835	15245	15938	16324			26608	38.7%	61.3%

The above table shows the scale of the impact that long waits for endoscopy and non-obstetric US are having on performance, while a number of modalities report zero or small numbers of patients waiting over the 8-week standard. Actions for improvements in the challenged modalities were discussed in the recent Board Development session.

Mental Health

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 in January 2024 and we reported 37.5% compliance with the 28-day standard, while this improved to 90% in February, the team expected this performance to fluctuate in Q1 as the service work though the referrals to recover the position. In March 2024 we reported 54% compliance, with a further reduction in April reported. The May position improved to 19.1% but remains low in line with our forecast. Performance is expected to remain low through this year and recover to compliance in Q4. Part 1b compliance remains strong with >99% of patients receiving interventions within 28 months on the vast majority of months. Part 2 compliance remains challenged, an improvement trajectory has been shared with NHS Executive colleagues, with Part 1 service developments supporting improvements.

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For children and young people, Part 1a compliance dropped below the 80% standard at 78% in January as a result of a number of factors including workforce challenges and the number of complex cases. Part 1a compliance improved to 91% in February, remaining high into May (92%). Part 1b remains challenged as the team work through the backlog, further impacted by an increased in referrals through the summer months. A full demand and capacity review has taken place which

acknowledges the services reduced capacity to deliver interventions within 28 days due to vacancies and sickness. The team are developing a psychoeducation resource and looking to recruit additional support workers to deliver this. A recovery plan was presented as part of the Executive led Clinical Board Review sessions which sees recovery of compliance by the end of Q2

Primary and Community Care

We continue to see a high number of GP practices in high escalation (level 3 and 4), reflecting the pressures on all parts of our health system. Our primary care teams continue to support practices as required and work has been ongoing at a national level to negotiate changes to the GMS contract for 2023-24. Despite a lack of consensus, there has been a mutual decision to conclude negotiations for this year's settlement which will see a £20m financial investment into GMS across Wales.

Through this year greater visibility will be brought the activity carried out in Primary and Community Care. Work is ongoing to provide high level data across a number of services; this data will be updated as available and is intended to demonstrate the volume of activity undertaken through primacy and community care services. GMS saw an increase in calls, appointments and items issued via prescription from the previous month.

GMS activity		May 2024	Year to date 24/25
	Calls to GP surgeries	385,813	1,188,062
	GP appointments offered	264,337	748,416
	Items issued via presciption	768,920	2,297,780

Source: Primary Care Information Portal. Note: *The analyses and associated visualizations presented within this tile of the Primary Care Information Portal (PCIP) are a product of source data that has been provided at the initial stages of a quality improvement process and as such the completeness, accuracy, and validity of this source data (and hence any analyses/visualizations derived from such data) cannot be guaranteed.*

We continue to see high utilisation of our Urgent Primary Care Centers across Cardiff and the Vale. Overall utilisation remained above 90% in June 2024, with total utilisation across all 6 sites at 93%, with c4600 appointments booked in month.

Recommendation:

The Finance and Performance Committee is asked to **NOTE** the year to date position against key organisational performance indicators for 2024-25 and the update against the Operational Plan programmes.

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

Objective	Tick	Objective	Tick
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	a
2. Deliver outcomes that matter to people	a	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	a
4. Offer services that deliver the population health our citizens are entitled to expect	a	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	

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5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	a	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	a	Integration	a	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:

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Cardiff and Vale
Integrated Performance Report

2024/25

July 2024

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Report Contents

1. Cabinet Secretary Priorities

2. Cardiff and Vale Performance Report

Click on a hyperlink to navigate directly to the section required

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The Cabinet Secretary for Health and Social Services has set out National Programmes of work covering the priority areas of delivery. These priority areas are:

- Enhanced Care in the Community, with a focus on reducing delayed pathways of care
- Primary and Community Care, with a focus on improving access and shifting resources into primary and community care
- Urgent and Emergency Care, with a focus on delivery of the 6 goals programme
- Planned Care and Cancer, with a focus on reducing the longest waits
- Mental Health, including CAMHS, with a focus on delivery of the national programme

Further to these priority areas the Welsh Government and NHS Wales have identified 8 Key Performance Indicators across Urgent and Emergency Care, Cancer, Diagnostics, Elective Care and Mental Health Services.

Section 1 provides an overview of the Health Board performance of the Key Performance Indicators outlined by Welsh Government and Health Board commitments related to the delivery of the priority areas.

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

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Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Enhanced Care in the Community	**Measure:** Number of delayed transfers of care. **National standard/ambition:** 12 month reduction trend **Reporting period:** Monthly	Reduction against 23/24	Yes	Mar-25	194 June-24	Hyperlink to section
Primary and Community Care	**Measure:** General Medical Services – Number of GP practices achieving core access standards **National standard/ambition:** 100% **Reporting period:** Annual – in month position for information	100%	Yes	Mar-25	100% May-24	Hyperlink to section
	Measure: General Dental Services - % of contract value fulfilled **National standard:** 30% of contract value by end Q2, 100% Q4 **Reporting period:** Monthly	25% Q1 50%Q2 75% Q3 100% Q4	Yes	Mar-25	13.7% May-24 (incomplete for Q1)	Hyperlink to section
Urgent and Emergency Care	**Measure:** Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge **National standard/ambition:** 20% reduction by September 2024, further 20% reduction by March 2025 **Reporting period:** Monthly	670 Sept-24 532 Mar-25	Yes	Mar-25	915 June-24	Hyperlink to section
	Measure: Number of ambulance patient handovers over 1 hour **National standard/ambition:** 30% reduction by December 2024 **Reporting period:** Monthly	232	Yes	Dec-25	458 June-24	Hyperlink to section

Performance Key: Meeting standard / trajectory off target/trajectory

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Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Mental Health	**Measure:** Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years **National standard/ambition:** 80% by end of December 2024 **Reporting period:** Monthly	80%	Yes	Dec-24	14% May-24	Hyperlink to section
	Measure: Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over **National standard/ambition:** 80% by end of December 2024 **Reporting period:** Monthly	99%	Yes	Dec-24	100% May-24	Hyperlink to section

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Performance Key: Meeting standard / trajectory off target/trajectory

Priority	Aim	C&V Commitment	Commitment to meet national standard?	By When	In Month Performance against C&V commitment	Link in Performance Report
Planned Care and Cancer	**Measure:** Number of patients waiting more than 52 weeks for a new outpatient appointment **National standard/ambition:** 40% reduction by end of September 2024, 0 by end of March 2025 **Reporting period:** Monthly	10,825 Sep-24 9,823 Mar-25	No		13,285 May-24	Hyperlink to section
	Measure: Number of patients waiting more than 104 weeks for referral to treatment **National standard/ambition:** 0 by end of December 2024 **Reporting period:** Monthly	1,989 Dec-25	No		3,018 May-24	Hyperlink to section
	Measure: Percentage of patients starting their first definitive treatment within 62 days from point of suspicion (regardless of the referral route) **National standard/ambition:** 60% by end of December 2024, 70% by end of March 2025 **Reporting period:** Monthly	70% Dec-25	Yes	Dec-25	62.1% May-24	Hyperlink to section
	Measure: Number of patients waiting more than 8 weeks for a specified diagnostic **National standard/ambition**: 95% of patients waiting less than 8 weeks by end of December 2024 **Reporting period:** Monthly	11,908 Dec-25	No		15,425 May-25	Hyperlink to section

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Performance Key: Meeting standard / trajectory off target/trajectory

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.

National Performance Framework monitoring data is available from DHCW showing performance across all Welsh Health Boards and Trusts (where relevant). This information can be accessed by clicking here.

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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

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Priority	Performance Summary	Reported Period	On target?	Data
Health Protection	**Seasonal respiratory infections** **Immunisation** – COVID-19 and influenza • **The Covid-19 vaccine spring booster campaign** is now underway and it has delivered 33,312 vaccines since the 2nd of April when the campaign started. Eligibility groups are individuals aged 6 months and over who are immunosuppressed, residents in a care home for older adults, adults aged 75 years and over. This amounts to an eligible population of 55,751 in Cardiff and the Vale and the current vaccine coverage is therefore 61.13% which is the second highest uptake of all Health Boards and above the Welsh average of 58.48%. **Surveillance** • Influenza activity remains low, between seasonal activity • Hospital admissions for Covid-19 increased have been elevated during June compared with May though the recent trend is unclear. PCR incidence and positivity increased throughout June • Omicron sub-variant JN.1 remains the most prevalent variant in Wales • There are currently **5** Covid-19 outbreaks and **zero** incidents in hospital; and **zero** influenza incidents or outbreaks. • Since the start of April 2024, **211** bed days have been lost due to Covid-19 incidents or outbreaks, and **7** bed days have been lost due to influenza incidents or outbreaks • 16% of C&V UHB staff sickness during May 2024 was due to influenza/COVID-19/respiratory conditions • RSV activity in under 5s remains at low intensity • Whooping cough notification levels across Wales remain high overall, though confirmed cases peaked mid/end April and are now declining	Week 25	Below standard	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 Weekly COVID-19 vaccination report by health board https://www2.nphs.wales.nhs.uk/CommunitySurveillanceDocs.nsf/3dc04669c9e1eaa880257062003b246b/cf7a9a9adcddbb0a8025866b003a51a1/$FILE/Wales%20COVID-19%20vaccination%20surveillance%20weekly%20report.pdf Source: PHW weekly flu/ARI report

For areas of underperformance please see cover paper for details on actions being taken

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Priority	Performance Summary	Reported Period	On target?	Data
Health Protection	**Routine childhood immunisation** • 81.2% of children are up to date with vaccination at age 4, which is below the target of 95% and a Welsh average of 84.7%, uptake of all childhood vaccinations at age 5 is 84.1% which is still below the Welsh average of 87.9%.	Q4 2023/24 Jan 2024-Mar 2024	Below standard	Source quarterly COVER data
Health Protection	**Health Protection System** • The Cardiff and Vale Health Protection Plan has been fully signed off via partnership governance processes (completed April 2024) • An action plan for 2024/25 is being developed, following a partnership workshop in May 2024, to further strengthen the agreed approach. • A measles action plan has been developed for implementation within the UHB and with partner organisations	Q1 2024/25	On target	*n/a*

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Priority	Performance Summary	Reported Period	On target?	Data
Health Improvement	**Healthy weight:** • 77.5% of reception aged children in Cardiff and Vale of Glamorgan are categorised as healthy weight (Child Measurement Programme, 2022/23). Cardiff and Vale have the highest proportion of healthy weight children compared to other Health Board areas based on the latest available data; however, the English average for 2022/23 was 77.5%). The healthy weight local target for 2022/23 was 75%, which we met. Data produced annually. • 40% of adults in Cardiff and Vale of Glamorgan are a healthy weight, as compared to 36% of the Welsh average (NSfW, 2021/22+2022/23); 39% are eating five portions of fruit/vegetables a day, compared to 30% in Wales (NSfW, 2021/22+2022/23) and 68% are meeting physical activity guidelines of being active for at least 150 minutes per week, as compared to 57% in Wales (NSfW, 2021/22+2022/23)*. There are no comparable data in other UK countries due to different methodologies being used. • Differences remain between our most and least deprived communities with levels of healthy weight lower, and consumption of fruit and vegetables/physical activity levels also lower in the most deprived areas of Cardiff and Vale. **Weight management services** • % people with body mass index (BMI)>30 who can be treated through: ○ Level 2 services: 1.6% (target: 1.5%) ○ Level 3 services: 0.2% (target: 0.5%)	Q4 2023/24	**Healthy weight:** On standard **Weight management services:** Level 2 above standard Level 3 below standard	Cardiff and Vale of Glamorgan Child Measurement Programme - Healthy Weight trend - Reception Year children 90.0, 80.0, 70.0, 60.0, 50.0, 40.0, 30.0, 20.0, 10.0, 0.0 2011/12, 2012/13, 2013/14, 2014/15, 2015/16, 2016/17, 2017/18, 2018/19, 2019/20, 2020/21, 2021/22, 2022/23 Cardiff and Vale UHB, Cardiff, Vale of Glamorgan, Wales

For areas of underperformance please see cover paper for details on actions being taken

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Priority	Performance Summary	Reported Period	On target?	Data

Health Improvement	**Tobacco**
	• 13% of Cardiff and Vale of Glamorgan smoke.
	• NHS Wales Performance Measure - Percentage of adult smokers who make a quit attempt via smoking cessation services - Target = 5% annually.
	• In Quarter 4 23/24 (the most up to date data received) 0.6 % of smokers set a firm quit date. This is below target. 70 % of these quit smoking at 4 weeks, which is above target (in total from Help Me Quit [HMQ], Pharmacy Level 3 and Hospital Smoking Cessation Service combined) . This breaks down by service as follows:
	  • HMQ community – 78% of Treated Smokers had quit smoking at 4 weeks.
	  • Level 3 Pharmacy –53% of Treated Smokers had quit smoking at 4 weeks.
	  • Hospital Service - 45% of Treated Smokers had quit smoking at 4 weeks.
		Quarter 4 2023/24	Smokers setting quit date:
			
			Below target for percentage of adult smokers who make a quit attempt
			
			Meeting or exceeding target for 4 week quits
				Graph showing 4 week quit rates by service, in percentages
				100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%
				Quarter 1 Quarter 2 Quarter 3 Quarter 4 (2022-2023) Quarter 1 Quarter 2 Quarter 3 (2023/24)
				HMQ, L3, Hospital, QTR TOTALS, Tier 1 Target

For areas of underperformance please see cover paper for details on actions being taken

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Smoking and substance misuse

NHS Wales Performance Framework measures

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 April 23 2023 to 31 March 2024	0.8% (per quarter) National target is 1.25% per quarter, 5% per year	0.6% Below standard	Q1	Q2	Q3	Q4
					0.6%	0.6%	0.6%	0.6%
2.	Percentage of adult smokers who make a quit attempt via smoking cessation services who are CO-validated as quit at 4 weeks. ***CO validated quits are being recorded from 1.4.24 as per guidance from Welsh Gov.***	1 April 23 2023 to 31 March 2024	40%	70% Exceeding standard	Q1	Q2	Q3	Q4
					59%	68%	68%	70%
3.	Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs and alcohol)	No data yet available. Data to be supplied by substance misuse team and updated by UHB analysis team						

Chair's objectives

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
n/a	% of pregnant people undergoing CO testing at their initial booking appointment	2023/24	100%	96.51% Below standard	Q1	Q2	Q3	Q4
					86%	85.7%	93%	96.51 %
n/a	% of pregnant smokers who are referred to smoking cessation support following initial booking assessment	2023/24	100%	36% Below standard	Q1	Q2	Q3	Q4
					49%	49%	50%	36%

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Immunisation and vaccination

NHS Wales Performance Framework measures and Chair's objectives

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend			
4.	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 January 2024 to 31 March 2024	95%	84.1% Below standard	**Q1**	**Q2**	**Q3**	**Q4**
					84.1	83.5	85.7	84.8
5.	Percentage of children 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 (still awaiting data for the 2024 HPV campaign)*	1 January 2023 to 30 June 2023	90%	74.4% Below standard	**Q1**	**Q2**	**Q3**	**Q4**
					74.4	72.6	70.3	71.3
6.	Percentage uptake of the influenza vaccination amongst adults aged 65 years and over *Applicable during: 01.09.2023 - 31.03.2024 (autumn booster campaign concluded)*	1 September 2023 to 31 March 2024	75%	72.8% Below standard	**01/03/24**	**26/03/24**	**27/12/23**	**16/02/24**
					72.8%	72.8%	70.9%	72.6%
7.	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 (autumn booster campaign concluded)*	1 April 2024 to 30 June 2024	75%	61.13% Below standard	**25/04/24**	**04/06/24**	**27/06/24**	
					20.8%	51.7%	61.1%	

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Weight Management Services

Chair's objectives

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
n/a	% of people with BMI > 30 that can be treated through Level 2 Weight Management Services	Jun 2024	1.5%	1.6% Above standard	
n/a	% of people with BMI > 30 that can be treated through Level 3 Weight Management Services	Jun 2024	0.5%	0.2% Below standard	

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Screening

NHS Wales Performance Framework measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
8.	Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	Apr-24	90%	**14.7%** Below standard	Jan-24: 22.50%; Feb-24: 25.20%; Mar-24: 31.10%; Apr-24: 14.70%
9.	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	Mar-24	90%	**96.4%** Above standard	Dec-23: 91.20%; Jan-24: 94.50%; Feb-24: 97.70%; Mar-24: 96.40%
10.	Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	May-24	95%	**96.1%** Above standard	Feb-24: 95.90%; Mar-24: 96.10%; Apr-24: 96.20%; May-24: 96.10%

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary, Community and Out of Hospital Care	**Urgent Primary Care Centre Utilisation – Maintain 90% utilisation** In June utilisation was 93% and remains above our commitment **Safe@home referrals – Increase to 6 accepted referrals per day in Q1 to 30 per day in Q4** Q1 to date 160 referrals were accepted by S@H – Capacity to accept 6 referrals per day from July 2024 **Community visits – 95% of face-to-face visits within 8 hours** Q1 to date 96% compliance with 8-hour standard	Jun-24 May-24	94% utilisation Above standard To date 160 accepted referrals Below standard 96% Above standard	UPCC Utilisation
Emergency Department and Same Day Emergency Care	**Ambulance handover delays – eliminate 2-hour delays. Reduce lost minutes per arrival to <20. National Commitment to reduce 1-hour delays by 30% by December** In June we reported 30 2-hour ambulance delays, above our ambition of 0 In June we reported 458 1-hour ambulance delays, above our trajectory to reduce by 30% by Q3. In June we reported lost minutes per arrival had increased to 24 **ED waits - No patients waiting >24 hours in ED, 93% of patients waiting <12 hours in ED in Q1 (94% Q2, 95% Q3, 95% Q4)** In June we reported an increase in patients waiting 12-hours in EU compared to May. This equates to 92.3% of attendances waiting less than 12-hours and below our ambition for Q1 **SDEC units – Increase attendances compared to the same period 23/24** In May we reported an increase in activity compared to April, however this is slightly below our May 2023 activity. A drop in medical SDEC has been noted and the team have identified a potential underreporting of attendances which is being investigated – attendances are forecast to increase in June	Jun-24 May-24	30 2-hour delays Above standard 458 1-hour delays Above standard 24 minutes lost/arrival Above standard 92.3% patients <12h Below standard 1700 SDEC attends Below standard	Ambulance handover >1 hour EU more than 12 hours Number of patients seen in SDECs
Reducing time in hospital and Continuity of Care	**Length of stay - <20% patients in acute beds to have a LOS >21 days, <40% patients in acute beds to have a LOS >7 days** This data is a monthly snapshot taken at on the final Friday of each month. At the end off June 29.4% of patients in acute beds had a LOS of >7 days, 55.2% >21 days – reduced from April's snapshot but above out ambition **Pathway of Care Delays – Reduction in number of POCD compared to same period in 23/24** In April 2024 the number of POCDs was 179 – this is below the number of delays reported in April 2023 in line with our ambition	May-24 Jun-24	29.4% >7d Above standard 55.2% >21d Above standard 194 Below standard	Delayed Pathways of Care)

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
High Impact Pathways - Stroke	**CT scan – 70% of patients scanned within 1 hour of arrival at EU** In May 52.0% of patients were received their CT scan within 1 hour of arrival at EU, below our ambition. **Thrombolysis – 20% thrombolysis rate** In May 26.0% of stroke patients were thrombolysed, an improvement from April and in excess of our ambition **Admission – 80 % of patients admitted directly to the stroke unit within 4 hours** In May 47.5% of patients were admitted directly to the Stroke Unit within 4 hours. Door-to-ward pathways continue to be impacted by operational pressures within the Emergency Unit Our door-to-ward and CT Stoke performance measures are below our ambitions for performance on the stroke pathway. We have seen considerable improvements compared to last year – a business case for development of the service is being presented this month which will allow more sustainable improvements to be embedded Overall Stroke performance is assessed through the Sentinel Stroke National Audit Programme (SSNAP) – which uses metrics across the whole patient pathway. In the most recent assessment period UHW received a grade B.	May-24	52.0% CT Below standard 26.0% Thrombolysis Above standard 47.5% Door-to-ward Below standard	CT Scan within 1 hour Stroke patient thrombolysis rate Direct admission to stroke unit within 4 hours
High Impact pathways – Hip fracture	**Hip Fracture Door to Ward time – 60% of patients admitted to the ward within 4 hours Q1, 65% Q2, 70% Q3, 75% Q4** Door to Ward time is the first KPI used by the National Hip Fracture Database to monitor national performance across the patient pathway. In May 30.2% of patients were admitted to the ward within 4 hours. This is below our ambition but well above the national annualised average of 8.3%.	May-24	43.5% (Annualised) Below standard	Admitted within 4 hours

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Primary and Community Care	**GMS access – 100% of practices achieving core access standards** In April 100% of practices met the standard – the official data is provided annual but our monthly tracking data will be updated here for information **GDS access – 25% of contract value by end Q1, 50% Q2, 75% Q3, 100% Q4** At the end of May 13.7% of the contract value had been delivered. Q1 data will be available next month **Pharmacy access – 95% of practices providing Clinical Community Pharmacy Service (CCPS) in Q1, 10% increase PIP sites each Quarter** In May 99% of practices were providing CCPS services **Optometry – 95% of practices providing WGOS1+2** All practices are currently providing WGOS 1&2	Apr-24 May-24	100% Meeting standard 13.7% Below standard (end Q1) 99% Above standard 100% Above standard	GDS contract value fulfillment 100% 80% 60% 40% 20% 0% Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Standard; % GDS contract
Cancer	**Single Cancer Pathway – 70% of patients to receive their first definitive treatment within 62 days by Q3, as per nationally submitted trajectory** In May 62.1% of patients received their first definitive treatment within 62 days. This was above our trajectory but we are still forecasting a drop in compliance with the SCP, due to pathology delays experienced through March, but aim to remain on trajectory to meet the Welsh Government ambition of 60% by December and 70% by March 2025.	May-24	62.1% Below standard	% cancer patients starting treatment withing 62 days 80% 70% 60% 50% 40% Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Trajectory; SCP performance

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Outpatient and Treatment waiting times	**Outpatient waiting times – Reduction in the number of patients waiting 52 weeks for a first outpatient appointment** In May there were 13,285 patients waiting 52 weeks for their first outpatient appointment. This is above the Welsh Government ambition. **Treatment waiting times – Reduction in the number of patients waiting 104 weeks for treatment** In May there were 3,018 patients waiting 104 weeks for treatment. This is above the Welsh Government ambition. We are currently reviewing our trajectories for reducing the number of long waiting patients aligned to our ongoing demand and capacity work	May-24	13,285 patients Above standard 3,018 patients Above standard	RTT > 52 weeks New Outpatient (chart: >52 Weeks New OP; Standard Sep-24) RTT > 104 weeks (chart: >104 Weeks; Standard Dec-24)
Diagnostics and Therapies	**Diagnostics – Reduction in the number of patients waiting over 8 weeks for a specified diagnostic** In May 15,245 patients were waiting over 8 weeks for a specified diagnostic, an increase from April and Welsh Government's ambition. A diagnostic update was brought to the most recent Board development session. **Therapies – No patients waiting over 14 weeks for Therapy – Q3** In May 491 patients were waiting over 14 weeks for therapies, a small increase from April and above our commitment for Q3.	May-24	15,245 patients Diagnostics Above standard 491 patients Therapies Above standard (Q3)	Patients waiting >8 weeks - Diagnostics (chart: Waiting over 8 Weeks) Patients waiting >14 weeks - Therapies (chart: Waiting over 14 Weeks; Standard Q3)

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Waiting times	**Cardiothoracic Surgery – Reduce wait for outpatients to <16 weeks Q2, reduce wait to treatment to <52 weeks Q2** In May there were 20 patients waiting over 16 weeks for a new outpatient appointment and 10 patients waiting over 52 weeks for surgery **Neurosurgery – Reduce wait for treatment to <40 weeks Q3, reduce wait for outpatients to <18 weeks Q4** In May there were 12 patients waiting over 18 weeks for a new outpatient appointment and 3 patients waiting over 40 weeks for surgery	May-24	20 Patients Above standard (Q2) 12 patients Outpatients Above standard (Q3) 3 patients Treatment Above standard (Q4)	16 week Outpatient waits - Cardiothoracics (>16 week new OP waits; Standard Q2) Outpatient and treatment waits - Neurosurgery (>18 week new OP waits; >40 week treatment; Standard)
Intensive Care Unit	**Delayed Transfers of Care – Reduce the % DTOC bed occupancy against the same period in 23/24** May saw another reduction in ITU DTOCs compared to March and April. However, this remained above our ambition to reduce from 23/24 levels due to increased operational pressures through the month.	May-24	8.9% Above standard	ITU - Delayed Transfers of Care (% DTOCs 24/25; Standard 23/24)

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C&V Priorities and Annual Plan Commitments

Priority	Performance Summary	Reporting Period	Performance against standard	Data
Paediatric waiting times	**New Outpatient waits – 0 patients waiting over 52 weeks for outpatients in Q1** In May there were 0 patients waiting over 52 weeks for a new outpatient appointment **Therapy waits – 0 patients waiting over 14 weeks for Therapies in Q3** In May there were 252 paediatric patients waiting over 14 weeks for Therapies (123 in Dietetics and 129 in Occupational Therapy)	May-24	0 Meeting standard 252 Above standard (Q3)	Paediatric patients waiting >14 weeks for therapies
Emotional Health and Wellbeing	**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 under 18s – 80% compliance with the Standard of <28 days in Q1** In May 95% of assessments were completed within 28 days **Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for under 18s – 80% compliance with standard in Q3** In May 14% of interventions were started within 28 days, this is below the standard for Q3 but in line with our improvement trajectory **Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard in Q3** In May 88% of patients had a valid Care and Treatment plan, above our ambition	May-24	95% Part 1a Above standard 14% Part 1b Below standard 88% Part 2 Above standard	LPMHSS assessments started 28 days < 18 years LPMHSS interventions started 28 days < 18 years Valid Treatment Plan < 18 Years
Neurodevelopment	**Neurodevelopment assessment - Reduce the longest wait to 140 weeks in Q4** In May the longest wait for a neurodevelopment assessment was 166 weeks, this is above our ambition for delivery in Q4 but is improved from 23/24	May-24	166 Above standard (Q4)	Neurodevelopment assessment weeks wait

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Mental Health Measures – Part 1a	**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 adults aged 18 years and over – 80% compliance with the Standard of <28 days in Q2** In May 19% of patients received their assessment within 28 days – this is in line with our forecast position but below the standard we are looking to achieve by the end of Q2. Referrals to the service remain high.	May-24	19% Part 1a Below standard (Q2)	LPMHSS assessments started 28 days - Adults
Mental Health Measures – Part 1b	**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 – 80% compliance with standard in Q1** In May 100% of therapeutic interventions were started within 28 days of assessment, above the standard and in line with our trajectory submitted to Welsh Government.	May-24	100% Part 1b Above standard	LPMHSS interventions started 28 days - Adults
Mental Health Measures – Part 2	**Percentage of patients with a valid Care and Treatment plan – 80% compliance with standard in Q3** In May 57% of patients had a valid Care and Treatment plan, a small decrease from April following focused work from the teams. Performance remains below the standard for Q3 – the RAMP protocol and Part 1 schemes have been approved though the Mental Health Liason Committee to support longer term improvements in compliance	May-24	57% Part 2 Below standard (Q3)	Valid Treatment Plan - Adults

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NHS Wales Performance Framework Measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
11.	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	2022/23	100%	**98.2%** Below standard	19/20: 93.4%; 20/21: 95.0%; 21/22: 96.5%; 22/23: 98.2%
12.	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Apr-24	Improvement compared to the same month in the previous year	**47.5%** Above standard	Jan-24: 45.20%; Feb-24: 46.10%; Mar-24: 46.90%; Apr-24: 47.50%
13.	Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Apr-May 24	A month on month increase towards a minimum of 30% contract value delivered by 30 September 2024 and 100% by 31 March 2025	**13.7%** Below standard	Apr-24: 4.90%; May-24: 13.70%
14.	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Apr-24	Increase compared to the same month in the previous year	**1,628** Above standard	Jan-24: 1452; Feb-24: 1724; Mar-24: 1649; Apr-24: 1628
15.	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 people aged under 18 years	May-24	80%	**95%** Above standard	Feb-24: 91%; Mar-24: 91%; Apr-24: 91%; May-24: 95%
16.	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	May-24	80%	**14%** Below standard	Feb-24: 19%; Mar-24: 23%; Apr-24: 24%; May-24: 14%
17.	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 adults aged 18 years and over	May-24	80%	**19.0%** Below standard	Feb-24: 91.0%; Mar-24: 53.9%; Apr-24: 16.1%; May-24: 19.0%
18.	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	May-24	80%	**100%** Above standard	Feb-24: 100.0%; Mar-24: 100.0%; Apr-24: 100.0%; May-24: 100.0%
19	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Jun-24	65%	**48%** Below standard	Mar-24: 54%; Apr-24: 51%; May-24: 52%; Jun-24: 48%
20.	Median emergency response time to amber calls	May-24	12 month reduction trend	**01:19:27** Above standard	Feb-24: 01:17:05; Mar-24: 01:14:44; Apr-24: 01:07:22; May-24: 01:19:27

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NHS Wales Performance Framework Measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
21.	Median time from arrival at an emergency department to triage by a clinician	Apr-24	15 minutes or less	**20** Above standard	Jan-24: 20; Feb-24: 21; Mar-24: 20; Apr-24: 20
22.	Median time from arrival at an emergency department to assessment by a clinical decision maker	Apr-24	60 minutes or less	**64** Above standard	Jan-24: 53; Feb-24: 61; Mar-24: 63; Apr-24: 64
23.	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	Jun-24	Improvement compared to the same month in the previous year, towards the national target of 95%	**62.8%** Below standard	Mar-24: 64.5%; Apr-24: 64.7%; May-24: 63.7%; Jun-24: 62.8%
24.	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	Jun-24	Reduction compared to the same month in the previous year, towards the national target of zero	**915** Above standard	Mar-24: 814; Apr-24: 829; May-24: 898; Jun-24: 915
25.	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Apr-24	12 month improvement trend towards a national target of 80% by 31 March 2026	**63.7%** Below standard	Jan-24: 64.4%; Feb-24: 60.8%; Mar-24: 62.3%; Apr-24: 63.7%
26.	Number of patients waiting more than 8 weeks for a specified diagnostic	May-24	0	**15,245** Above standard	Feb-24: 13908; Mar-24: 14454; Apr-24: 14835; May-24: 15245
27.	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional therapy	Apr-24	100%	**81.45%** Below standard	Jan-24: 79.74%; Feb-24: 77.94%; Mar-24: 77.99%; Apr-24: 81.45%
28.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	May-24	0	**491** Above standard	Feb-24: 1405; Mar-24: 1337; Apr-24: 485; May-24: 491
29.	Number of patients (all ages) waiting more than 14 weeks for audiology	May-24	0	**50** Above standard	Feb-24: 206; Mar-24: 0; Apr-24: 13; May-24: 50

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NHS Wales Performance Framework Measures

No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
30.	Number of patients waiting more than 52 weeks for a new outpatient appointment	May-24	0	**13,285** Above standard	Feb-24: 12310; Mar-24: 11759; Apr-24: 12695; May-24: 13285
31.	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Apr-24	Reduction compared to the same month in the previous year	**26,338** Below standard	Jan-24: 32644; Feb-24: 29685; Mar-24: 28020; Apr-24: 26338
32.	Number of patients waiting more than 104 weeks for referral to treatment	May-24	0	**3,018** Above standard	Feb-24: 3764; Mar-24: 2681; Apr-24: 2816; May-24: 3018
33.	Number of patients waiting more than 52 weeks for referral to treatment	May-24	Month on month reduction towards the national target of zero by 30 June 2025	**33,241** Above standard	Feb-24: 30757; Mar-24: 31124; Apr-24: 32436; May-24: 33241
34.	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Apr-24	80%	**20%** Below standard	Jan-24: 22%; Feb-24: 22%; Mar-24: 19%; Apr-24: 20%
35.	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Apr-24	80%	**62%** Below standard	Jan-24: 62%; Feb-24: 63%; Mar-24: 56%; Apr-24: 62%

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Productivity and Efficiency measures

Measure		Internal standard	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Trend
Outpatients	% DNAs - New appointments	5%	10.8%	9.7%	10.0%	11.0%	10.6%	10.4%	10.1%	10.1%	9.9%	10.9%	9.6%	9.3%	
	% DNAs - Follow-up appointments	5%	12.2%	11.5%	11.7%	11.8%	11.7%	11.6%	12.7%	12.3%	11.7%	13.0%	12.3%	12.3%	
Endoscopy	% room utilisation	90%	82%	95%	91%	95%	88%	87%	76%	70%	73%	83%	72%	84%	
	% utilisation (activity points available)	95%	74%	93%	83%	90%	82%	79%	69%	84%	94%	83%	83%	91%	
Theatres	Average turnaround time (minutes)	10	17.5	16.0	18.2	16.1	17.2	16.5	17.1	18.3	16.4	16.7	17.1	18.6	
	% of theatre session utilisation	95%	81%	81%	81%	83%	84%	88%	80%	75%	77%	73%	86%	86%	
	% in session utilisation	85%	77%	79%	78%	78%	80%	77%	77%	77%	80%	78%	79%	78%	
	<24 hour elective cancellations		274	229	219	197	257	285	269	239	226	212	243	289	
	% theatre activity as Daycase	TBC - will be added following confirmation of GIRFT dataset													
	High Volume Low Complexity' volume	TBC - will be added following confirmation of GIRFT dataset													
Waiting list	Total RTT waiting list volume	N/A	131664	134603	135686	136185	140725	141684	141828	142758	145810	147620	149805	150199	
Inpatient	Delayed pathways of Care - Mental Health	217	39	45	36	36	31	41	36	37	38	41	38	39	
	Delayed Pathways of Care - non-Mental Health		178	171	140	124	142	150	114	173	200	170	145	140	
	7 day LOS on Acute Wards (snapshot)	<40%		58.1%	58.9%	57.2%	59.3%	57.6%	56.5%	56.8%	59.2%	57.7%	56.8%	55.2%	
	21 day LOS on Acute Wards (snapshot)	<20%		31.3%	34.4%	33.7%	32.2%	28.7%	28.0%	29.8%	32.5%	32.9%	32.0%	29.3%	

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Priority	Performance Summary	Reported Period	Performance against standard	Data
Turnover	The overall trend is downwards since Jun-23; the rates have fallen from 13.00% at Jun-23 to 11.26% in May-24 UHB wide. This is a net 1.74% decrease, which represents 249 WTE fewer leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Work Life Balance', 'Voluntary Resignation - To undertake further education or training', 'Voluntary Resignation – Relocation'. 'Voluntary Resignation – Promotion' and 'Voluntary Resignation - Other/Not Known.	May-24		Turnover Rate
Sickness Absence	Rates remain high; although the rates appear to be the falling towards more 'normal' levels. The monthly sickness rate for May-24 was 5.16%. The 12-month cumulative rate has fallen steadily over the past 12 months to 6.21% (by comparison with May-23, which was 6.84%).	May-24		In-Month and Year to Date Sickness Rates
Statutory and Mandatory Training	The overall compliance rates rose for May-24 to 83.61%, 1.39% below the overall target. The compliance for All-Wales Genomics Services, Capital, Estates & Facilities, Clinical Diagnostics & Therapeutics, Children & Women's and PCIC are above the 85% target, and Corporate Executives, Mental Health and Specialist Services are above 80% compliance. The compliance with Fire training was 73.41% for May-23. All Wales Genomics Service have reached 86.57%, but the compliance for all of the other Clinical Boards is below the 85% compliance target.	May-24		Statutory & Mandatory e-Learning Compliance Rate Fire e-Learning Compliance Rate
Values Based Appraisal	VBA compliance fell marginally during May-24 to 81.85%. All Wales Genomics Service, Capital, Estates & Facilities and Children & Women's have exceeded the 85% target. PCIC, Surgical Services, Medicine and Corporate are over 80%.	May-24		VBA Compliance Rate

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Priority	Performance Summary	Reported Period	Performance against standard	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 12 months and the number of disciplinary cases is at the UHB Target. The People Services Team continue to analyse trends of employee relations cases to develop bespoke training packages or additional toolkits/support services where appropriate.	May-24		
Job Plans	The vast majority of clinicians have now engaged with job planning and have a job plan in the system, however only 32.12% have an agreed job plan that has been signed off within the past 12 months. A further 27.32% have an agreed job plan that was last reviewed and signed off before Jun-23.	May-24		
Medical Appraisals	The rate of compliance with Medical Appraisal has risen slightly for May-24, to 81.11%, but remains below the 85% target.	May-24		

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C&V Priorities and Annual Plan Commitments

Priority	Performance Summary	Reported Period	Performance against standard	Data
Staff in Post	The overall Health Board Staffing Numbers have increased in the last 12 months by 436 WTE, to 15,013.01 WTE. The change in the split between permanent and fixed-term as shown in the graph is largely due to validation of the ESR data held for staff contract type.	May-24		WTE Permanent and Fixed-Term Staff in Post Numbers
Variable Pay (Bank, Agency, Overtime..)	The trend of proportion of the pay bill spend on variable pay (Bank, Agency, overtime etc.) continues to fall. At Jun-23 the percentage was 9.65% of the total spend on pay, but in May-24 had fallen to 8.26%. It must however be borne in mind that the total pay bill is increasing.	May-24		Proportion of Total Pay Bill Attributable to Variable Pay
Monthly agency spend as % of total pay bill	The proportion of the total pay bill attributed to Agency continues to fall. At Jun-23 the percentage was 1.99% of the total spend on pay, but in May-24 had fallen to 0.93%. It must however be borne in mind that the total pay bill is increasing.	May-24		Agency Spend as % of Total Pay Bill

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Priority	Performance Summary	Reported Period	Performance against standard	Data
Time to Hire	The All-Wales target for recruitment Time to Hire (the time interval between vacancy creation and successful candidate ready for start date) is 71 days, and the NHS Wales average is 61 days. The figure for Cardiff & Vale uHB for May-24 was 84 days.	May-24		
Time to Shortlist	The All-Wales target for recruitment Time to Shortlist (the time interval between vacancy closure and shortlisting completion) is 3 days, and the NHS Wales average is 7 days. The figure for Cardiff & Vale uHB for May-24 was 6 days.	May-24		

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No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
36.	Percentage of sickness absence rate of staff	May-24	12 month reduction trend (6%)	**5.16%** Below standard	Feb-24: 6.41%; Mar-24: 5.90%; Apr-24: 5.79%; May-24: 5.16%
37.	Turnover rate for nurse and midwifery registered staff leaving NHS Wales	May-24	Rolling 12 month reduction against a baseline of 2019-20 (7-9%)	**11.26%** Above standard	Feb-24: 11.47%; Mar-24: 11.41%; Apr-24: 11.39%; May-24: 11.26%
38.	Agency spend as a percentage of the total pay bill	May-24	12 month reduction trend	**0.93%** Below standard	Feb-24: 1.39%; Mar-24: 0.60%; Apr-24: 0.91%; May-24: 0.93%
39.	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	May-24	85%	**81.80%** Below standard	Feb-24: 74.52%; Mar-24: 80.36%; Apr-24: 81.98%; May-24: 81.80%

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Concerns 30 day performance	**Welsh Government target for responding to concerns is 75% within 30 working days** **During April and May 24, the Health Board received :** • Received 718 Concerns • Closed 723 concerns • 80% closed within 30 working days (including Early Resolution) • 33 % closed under Early Resolution (within 2 days including day of receipt) • Received 238 Enquiries • Received 54 Compliments • We currently have 287 active concerns • Top 3 themes and trends • Concerns around appointments (waiting times/cancellations) • Communication • Clinical Treatment and Assessment	April and May 2024	80% Exceeding the 75% standard	% of concerns closed within 30 working days (including Early Resolution) Axis: 60–85; May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24
Duty of Candour	• Since April 1st 2023, 29,259 incidents have been reported by staff across the Health Board • Approximately 33% incidents regraded with clinical input and feedback to the reporter • Approximately 65 incidents reviewed per day by the Patient Experience Team • We continue to support DOC awareness sessions across Primary and Secondary care • Since April 1st 2023, we have triggered the DOC on 145 occasions • We have internally audited the process and compliance	To end of May-24	n/a	Incident grading changed following review Wales Genomics Service; Surgical Services; Specialist Services; Primary, Community and Intermediate Care; Other Organisations; Mental Health Services; Medicine Services; Executive and Corporate Services; Clinical Diagnostics and Therapeutic Services; Children and Women's Services; Capital, Estates and Facilities Axis: 0 1000 2000 3000 4000 5000 6000 7000 Yes / No

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Patient Feedback – Civica	The system went live on Friday 28th October 2022 and we are currently surveying up to 1000 patients daily via text, 600 chosen randomly from general hospital activity, 200 from EU activity and 200 from Mental Health activity. **Over the past 12 months, we have sent over 170,000 texts** and are seeing a response of 17%. In May, we sent 15,140 texts and had 2421 completions (16% response). Of those respondents who were discharged during April/May and answered the rating question using the scale of 0-10 where 0 is bad and 10 is excellent, 86% were satisfied with our service. Currently, our response rate overall is 17% and whilst it's our understanding that this is higher than many organisations, we will be focussing on improving this over the next year.	Mar/Apr-24 (Random) Mar/Apr-24 (MH) Mar/Apr-24 (EU))		
Patient Safety	Cardiff and Vale reported 7 NRIs to NHS Executive in May 2024 (by incident date). 13 closure forms were submitted to NHS Executive leaving us with 103 open NRIs (92 open in April) and 46 overdue (45 in April). Children and Women have the highest number of open NRIs due to the MBRRACE NRI reporting requirement, followed by Medicine and Mental Health Clinical Boards see chart opposite). Medicine and Mental Health also have the highest number of overdue NRIs. See top chart opposite for a break down of overdue NRIs per Clinical Board. The chart below shows that on average, 50% of C&V NRIs closures are completed on time. The above shows how Cardiff is positioned against other Health Boards for length of time NRIs remain open (more than 90 working days)			

INC_EXEC_01A - Number of NRIs Open at End of Last Month (CrosstabDB)

	No value	Total
Children and Women's Services	31	31
Clinical Diagnostics and Therapeutic Services	2	2
Executive and Corporate Services	3	3
Medicine Services	20	20
Mental Health Services	20	20
Primary, Community and Intermediate Care	1	1
Specialist Services	9	9
Surgical Services	17	17
Total	103	103

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Priority	Performance Summary	Reporting Period	Performance against standard	Data
Tier 1 Mortality	Inpatient Mortality The Crude Inpatient Mortality chart demonstrates continued inpatient mortality in line with the five year average for the same reporting period. 100% of patients that die as an inpatient now receive independent scrutiny from the medical examiner and plans are in place to start to review community deaths. All Cause Mortality Excess deaths have been observed across Wales and UK since late 2022. Work undertaken by Public Health Wales demonstrates the relative excess mortality by disease, where there is any mention of the disease on the death certificate as opposed to being the underlying cause of death. 94 deaths were recorded for Cardiff and the vale in week 9 compared 46.8 for the five year average for the same reporting week. This increase above the five year average has been consistent since January 2023	Mar-20 to Mar-24		Crude Mortality: Weekly Deaths In Hospital Number of in Hospital Deaths 100 0 Sum of Death
Infection Control	• In April 24, there were 22 cases of **C. difficile.** The current rate is 52.94 **cases per 100,000 population** which is **139% higher than the equivalent period in 2023/24.** The reduction expectation (RE) rate is unknown currently but based on previous 25 cases per 100,000 population, the current CAV rate is **111.76% below the RE**. CAV is currently the 4th across the 6 UHBS. • There were 15 cases of **S. aureus bacteraemia**. The current rate is **36.1 cases per 100,000 population** which is **36% higher than the equivalent period in 2023/24.** The reduction expectation (RE) rate is unknown currently but based on previous 20 cases per 100,000 population, the CAV rate is **80.5% over the RE**. CAV is currently joint 1st across the 6 UHBS. • There were 29 cases of **E. coli bacteraemia**. The current rate is **69.79 cases per 100,000 population** which is 20.5**% higher than the equivalent period in 2023/24.** The reduction expectation (RE) rate is unknown currently but based on previous 67 cases per 100,000 population, the CAV rate is 4.16% over **the RE.** CAV is currently joint 3rd across the 6 UHBs. • There were 14 cases of ***Klebsiella spp* bacteraemia** which is 7.6**% lower than the equivalent period last in 2023/24.** The current maximum number is unknown but based on previous reduction expectation of 58 cases, thus **CAV is 75.86% under the RE**. CAV current has the highest rate across the 6 UHBs. • There were 2 cases of ***P. aeruginosa* bacteraemia which is higher than the equivalent period in 2024/25 with 0 cases.** The current maximum number is unknown but based on previous reduction expectation of 18 cases, thus **CAV is 88.9% under the RE**. CAV current has 3rd highest rate across the 6 UHBs.	Apr-24		

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	Priority	Performance Summary	Reported Period	Data
Financial Performance	**Deliver 2024/25 Draft Financial Plan**	**Financial Plan Approved by Board and submitted to Welsh Government** • Brought forward underlying deficit of £60.9m • 2024/25 Demand and cost growth and unavoidable investments of £45.4m • Allocations and inflationary uplifts of £37.3m • Anticipated pass through funding on Long Term Agreements of £5.9m (3.67%) • A £47.2m Savings programme This results in a 2024-25 planning deficit of £15.9m. At month 2, the UHB is reporting an overspend of £8.821m. This is comprised of £1.557m operational overspend, a savings gap of £4.614m and the planned deficit of £2.650m (2 twelfths of the planned forecast year end deficit of £15.900m). The UHB expects to recover the month 2 operational & savings overspend to deliver the £15.900m planned deficit.	May. 24	See table below
	Achieve financial sustainability and recurrent financial balance by the end of 2025/26	The draft financial plan requires the UHB to meet its £47.2m Recurrent Savings target and deliver a balanced recurrent operational position to reduce the brought forward underlying deficit (ULD) from £60.9m to £15.9m at the end of 2024/25. At month 2, the UHB had identified £12.257m of recurrent green and amber savings In addition, it is assumed that 50% of the £5.134m of recurrent red schemes identified at month 2 will be delivered in year. and A £1.557m operational overspend was reported at month 2 and this will also need to be managed to a balanced position at year end to meet the target ULD. In summary, a further £32.376m of recurrent savings and a balanced operational position are required to enable the UHB to reduce its ULD to £15.9m at the end of March.	May. 24	Chart: Progress in Reducing the Underlying Deficity (ULD) from 60.9m to £15.9m
	Management of operational budget pressures	The UHB reported a £1.557m operational overspend at month 2, which is a deterioration of £1.060m from the £0.497m reported at month 1.	May 24	Chart: Planned Operational Position vs Month 2 Position

	Month 2 Position £m	Forecast Year-End Position £m
Planned deficit	2.650	15.900
Savings Programme	4.614	0.000
Operational position (Surplus) / Deficit	1.557	0.000
Financial Position £m (Surplus) / Deficit £m	**8.821**	**15.900**

Progress in Reducing the Underlying Deficity (ULD) from 60.9m to £15.9m

Operational Overspend
Shortfall Against recurrent Savings Target (assumes 50% of recurrent red schemes will deliver)
Planned Deficit
Target c/f UHB at Year End = £15.9m

Planned Operational Position vs Month 2 Position

Reported Operational Position
Planned Operational Position

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Priorities and Annual Plan Commitments

	Priority	Performance Summary	Reported Period	Data
	Delivery of recurrent £47.2m savings target	£20.989m Green and Amber schemes identified at month 2 of which £12.257m were recurrent.	May 24	**Progress in Identification of Savings Schemes** Monthly Progress of Identification of Schemes 0, 5,000, 10,000, 15,000, 20,000, 25,000, 30,000, 35,000, 40,000, 45,000, 50,000 Month 1, Month 2, Month 3, Month 4, Month 5, Month 6, Month 7, Month 8, Month 9, Month 10, Month 11 Green, Amber, Red, Unidentified
	Remain within Cash Limit	The UHB forecasts to remain within its 2024/25 cash limit, on the assumption that £15.900m of strategic cash support is provided for the forecast deficit.	June 24	Cumulative Cash drawn against Revenue and Capital Drawing Limit 0, 200, 400, 600, 800, 1000, 1200, 1400 Apr, May, Jun, Jul, Aug, Sep, Oct, Nov, Dec, Jan, Feb, Mar Cumulative Cash Drawings, Revenue & Capital Drawing Limit for year @ May 2024

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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	12 month improvement trend	**70%** Above standard	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 identification	Mar-24	90%	**0.7%** Below standard	Dec-23: 30.60%; Jan-24: 11.40%; Feb-24: 4.80%; Mar-24: 0.70%
42.	Percentage of calls ended following WAST telephone assessment (Hear and Treat)	Apr-24	17% or more	**16.1%** Below standard	Jan-24: 17.00%; Feb-24: 15.30%; Mar-24: 15.00%; Apr-24: 16.10%
43.	Number of Pathways of Care delayed discharges	May-24	12 month reduction trend	**179** Above standard	Feb-24: 238; Mar-24: 211; Apr-24: 183; May-24: 179
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	Apr-24	90%	**81.7%** Below standard	Jan-24: 85.3%; Feb-24: 88.0%; Mar-24: 83.6%; Apr-24: 81.7%
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	Apr-24	90%	**61.2%** Below standard	Jan-24: 54.4%; Feb-24: 54.0%; Mar-24: 55.2%; Apr-24: 61.2%
46.	Number of service user feedback experience responses completed and recorded on CIVICA	May-24	Month on month improvement	↑ **4681**	In May 2,000 more sms texts were sent and we send over 15,000 per month

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No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
47.	Cumulative number of laboratory confirmed bacteraemia cases: *Klebsiella* sp and; *Pseudomonas aeruginosa*	Apr-24	*Klebsiella sp* - 100 *P. aeruginosa* – 31	**14** **2** Below standard	Not on trajectory to achieve the reduction expectation number On trajectory to achieve the reduction expectation number
48.	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: *E.coli* and; *S.aureus* (MRSA and MSSA)	Apr-24	*E. coli* – 67 cases per 100,000 population *S. aureus* – 20 cases per 100,000 population	**69.79 cases per 100,000 population** **36.1 cases per 100,000 population** Above standard	On trajectory to achieve the reduction expectation rate Not on trajectory to achieve the reduction expectation rate
49.	Cumulative rate of laboratory confirmed *C.difficile* cases per 100,000 population	Apr-24	25 cases per 100,000 population	**52.94 cases per 100,000 population** Above standard	On trajectory to achieve the reduction expectation rate
50.	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset (>14 days after admission)	Apr-24	Reduction compared to the same month in the previous year	**30%** On standard	Ap-23: 30.90%; Apr-24: 30.00%
51.	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Feb-24	12 month improvement trend towards national target of 95%	**56.23%** Below standard	Nov-23: 55.21%; Dec-23: 55.50%; Feb-24: 56.26%; Feb-24: 56.23%
52	Number of ambulance patient handovers over one hour	Jun-24	0	**1728** Over standard	Mar-24: 1797; Apr-24: 1704; May-24: 1705; Jun-24: 1728
53.	Percentage of ambulance patient handovers within 15 minutes	May-24	Improvement compared to the same month in the previous year, towards the national target of 100% within 15 minutes	**16.25%** Below standard	Feb-24: 17.41%; Mar-24: 16.53%; Apr-24: 15.90%; May-24: 16.25%
54.	Number of National Reportable incidents that remain open 90 days or more	May-24	12 month reduction trend	↓ **5,649**	Second month reporting a reduction in this figure (March figure was 5,869, April 5,695 – 4% reduction since March).

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Report Title:	*Provision of Chimeric Antigen Receptor T Cell (CAR-T) Therapy Service – Phase 2*			Agenda Item no.	3.1
Meeting:	Finance and Performance Committee	Public	X	Meeting Date:	21.08.2024
		Private			
Status *(please tick one only)*:	Assurance		Approval	✓	Information	
Lead Executive Title:	Chief Operating Officer				
Report Author (Title):	Director of Operations, Specialist Services				

Main Report

Background and current situation:

Advanced Therapy Medicinal Products (ATMPs) are a new class of medicines offering potentially curative options for patients with chronic conditions, including cancer, where standard therapies have been exhausted. Unlike conventional medicines, these therapies aim to selectively remove, replace, repair or re-engineer a patient's own cells and/or genes to allow restoration of normal function or elimination of disease.

ATMPs are generally of three types:

- Gene ATMPs
- Cellular ATMPs
- Tissue engineered products (TEPs)

ATMPs may also be combined ATMPs, incorporating two or more of the above types.

In May 2018, Welsh Local Health Boards designated WHSSC (now the NWJCC) as the commissioner of all ATMPs for the Welsh population. ATMPs remain a high policy priority for Welsh Government and have been funded directly by Welsh Government from retained central allocation. This business case is aligned to the vision set out in the 'Delivery Plan for Advanced Therapies in Wales 2024-2029'. Therefore, the revenue requirement will be funded via the NWJCC from the WG central allocation and does not have a commissioner revenue impact for the LHBs.

Chimaeric Antigen Receptor T-cells (CAR-Ts) are cell-based gene ATMPs, also referred to as *ex vivo* gene ATMPs. CAR-T therapies were among the first in the pipeline of advanced cell therapies transitioning from 'bench to bedside' for both malignant and non-malignant disease. They are highly innovative personalised treatments offering potentially effective therapy with severe but manageable adverse events which require specialised monitoring and management.

The SWBMT Programme was among the first in the UK to be qualified as a CAR-T centre by Gilead-Kite on 31 December 2018. Immune Effector Cell (IEC) therapy, which includes CAR-Ts, was added to its JACIE accreditation following inspection in February 2019. Qualification by Novartis followed in early 2019.

Cardiff and Vale UHB was formally commissioned by WHSSC to deliver CAR-T therapies via the SWBMT Programme in September 2019. The first patient was referred in October 2019 and underwent CAR-T infusion on 6 December 2019.

At the time of commissioning, NICE had approved CAR-T therapy for adults with large B-cell lymphomas and for teenagers and young adults (TYAs) aged 16-25, with B-cell acute lymphoblastic leukaemia. WHSSC commissioned adults with lymphoma via the SWBMT Programme CAR-T service and TYAs with acute leukaemia via NHS England.

Demand for CAR-T therapy in adults with large B-cell lymphomas was estimated to be 10-15 per annum. The service was therefore sized and shaped to accommodate this demand, using clinical trial data which led to marketing authorisation ("licensing") to determine personnel and service requirements. The model adopted provided some elasticity to flex up to approximately 20 patient

referrals per annum so it was agreed from the outset that should referrals consistently exceed this number, there would be a need to submit a revised business case for right-sizing of the CAR-T service.

Since the original business case, NICE expanded CAR-T approvals, resulting in referrals above the threshold of 20 per annum over the past two financial years. Additionally, experience gained from delivering CAR-T therapies over the past 4½ years has shown that assumptions made from the clinical trial data which informed the original business case, underestimated requirements for parts of the patient pathway making current delivery unsustainable, even without accommodating these newer indications.

Compounding the above is the significant quality management and regulatory burden imposed by JACIE, HTA and MHRA standards as well as other conditions mandated by the manufacturer(s). Finally, no service is truly sustainable with a single-handed consultant, let alone one of this complexity, catering for circa 80% of the Welsh population and with a significant quality management and regulatory burden.

Additional investment to right-size the service would not only improve robustness and achieve sustainability, but would also allow the safe adoption of newer NICE approvals for adults as well as repatriation of TYAs aged 16-25 with B-cell acute lymphoblastic leukaemia from NHS England.

Benefits of repatriation include improved patient and family experience from being treated nearer to home, reduced patient and family cost associated with travel to and accommodation in England, a resultant reduction in the carbon footprint associated with the service, compliance with numerous Welsh Cancer Standards, and significant savings for NHS Wales given the considerable excess costs incurred when Welsh patients are treated by NHS England.

In acknowledgement of the above constraints, on 22 January 2024, WHSSC invited CVUHB (1) to resubmit a business case to address the capacity gap from 15 patients per annum to 25-27 patients per annum; (2) where outsourcing to NHS England is required, to re-cast the business case since expenditure by CVUHB up until the point of admission to a facility in NHS England is not reimbursed from the English CAR-T centre; and (3) to submit *"a revised business case and cost model for CAR-T to inform a renegotiation of the contract to better reflect capacity, costs of delivery and value for commissioners"*.

This business case therefore seeks additional investment into the CAR-T service within the South Wales Blood and Marrow Transplant (SWBMT) Programme to improve robustness, achieve sustainability and accommodate new approvals. Whereas the WHSSC invitation excluded the treatment of patients with B-cell acute lymphoblastic leukaemia, this Phase 2 business case also allows the repatriation of these patients whose CAR-T therapy is currently commissioned from NHS England, thereby further increasing value for NHS Wales.

The case seeks recurrent investment of £1,133,822 from the Welsh Government central allocation for ATMPs.

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

The business case as set out enables:

- Repatriation of work currently being outsourced to NHSE
- Capacity for new indications
- Service sustainability
- Regulatory compliance

If approved internally, funding would be sought from the Welsh Government allocation for ATMPs so there would be no commissioner impact for LHBs.

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Recommendation:

The Committee is requested to:

ENDORSE the CAR-T phase 2 business case with a **recommendation** to **BOARD** to **APPROVE** the CAR-T phase 2 business case for submission to NHS Wales Joint Commissioning Committee.

Link to Strategic Objectives of Shaping our Future Wellbeing: *Please place an "X" in the relevant box below **(this section must be completed)***			
1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	X
2. Deliver outcomes that matter to people	X	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	X
4. Offer services that deliver the population health our citizens are entitled to expect	X	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 place an "X" in the relevant box below **(this section must be completed)***									
Prevention		Long term	X	Integration	X	Collaboration	X	Involvement	

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

Approval/Scrutiny Route: ***Please insert any previous meetings where this paper has been received***	
Committee/Group/Exec	Date:

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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	Provision of Chimeric Antigen Receptor T Cell (CAR-T) Therapy Service – Phase 2
Clinical /Service Board or Department	Specialist Services Clinical Board Haematology, Immunology & Metabolic Medicine Directorate

Expected funding source (highlight/delete as appropriate)	NWJCC
Where a business case is with regard 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?	Jessica Castle, Director of Operations
Has this case been signed off by the Clinical Board / Corporate Departments finance and workforce business partners?	James Leaves, Assistant Director of Finance
Clinical Boards: Has the COOs office signed off this document? **Corporate Departments:** Has the relevant Executive sponsor signed off this document?	Adam Wright, Director of Operational Planning & Performance

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1. Executive Summary

This should provide an informative summary of the case. This section should be a summary of the subject, scope, proposal, resource implications, benefits and risks. It should clearly state the purpose of the business case.

Advanced Therapy Medicinal Products (ATMPs) are a new class of medicines offering potentially curative options for patients with chronic conditions, including cancer, where standard therapies have been exhausted. Unlike conventional medicines, these therapies aim to selectively remove, replace, repair or re-engineer a patient's own cells and/or genes to allow restoration of normal function or elimination of disease.

ATMPs are generally of three types:

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Demand for CAR-T therapy in adults with large B-cell lymphomas was estimated to be 10-15 per annum. The service was therefore sized and shaped to accommodate this demand, using clinical trial data which led to marketing authorisation ("licensing") to determine personnel and service requirements. The model adopted provided some elasticity to flex up to approximately 20 patient referrals per annum so it was agreed from the outset that should referrals consistently exceed this number, there would be a need to submit a revised business case for right-sizing of the CAR-T service.

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Since the original business case, NICE expanded CAR-T approvals, detailed in Section 2, resulting in referrals above the threshold of 20 per annum over the past two financial years (Table 1). Additionally, experience gained from delivering CAR-T therapies over the past 4½ years has shown that assumptions made from the clinical trial data which informed the original business case, underestimated requirements for parts of the patient pathway making current delivery unsustainable, even without accommodating these newer indications.

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Benefits of repatriation include improved patient and family experience from being treated nearer to home, reduced patient and family cost associated with travel to and accommodation in England, a resultant reduction in the carbon footprint associated with the service, compliance with numerous Welsh Cancer Standards, and significant savings for NHS Wales given the considerable excess costs incurred when Welsh patients are treated by NHS England.

Patients with haematological malignancies requiring CAR-T therapy are typically not in remission, i.e. they have active disease which is progressing. This poses a significant challenge to maintain patient fitness and keep the underlying disease under sufficient control for long enough to allow the patient to proceed to CAR-T infusion. Managing these patients necessitates intense triaging and treatment along the patient pathway. Despite this effort, there is still significant attrition along the treatment pathway with approximately 1 in 3 patients not achieving CAR-T infusion (Figure 6). It should be noted that even for the patients who do not ultimately receive CAR-T, significant time and resource is still expended and the workload associated with delivery of the entire pathway needs to be accounted for in right-sizing the service.

In acknowledgement of the above constraints, on 22 January 2024, WHSSC invited CVUHB (1) to resubmit a business case to address the capacity gap from 15 patients per annum to 25-27 patients per annum; (2) where outsourcing to NHS England is required, to re-cast the business case since expenditure by CVUHB up until the point of admission to a facility in NHS England is not reimbursed from the English CAR-T centre; and (3) to submit *"a revised business case and cost model for CAR-T to inform a renegotiation of the contract to better reflect capacity, costs of delivery and value for commissioners"*.

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Annual Revenue Requirement	**Current Year (£)**	**Recurrent (£)**
	£566,911	£1,133,822
Capital Requirement (£)		

2. Introduction and Background

This section should describe the setting and background to the business case and should serve to clarify the subject matter. What is the high-level aim / purpose and timeframe for this business case?

Historically, the foundations of cancer treatment were surgery, chemotherapy, and radiation therapy. Over the past several decades, targeted therapies such as imatinib (Gleevec) in chronic myeloid leukaemia and trastuzumab (Herceptin) in breast cancer, drugs that target cancer cells by homing in on specific molecular changes seen primarily in those cells, paved the way for other targeted therapies, cementing this modality of treatment as a fourth standard of care. More recently, "personalised medicine", whereby the power of a patient's own immune system is harnessed to detect and destroy tumours is emerging as a new standard of care being described by many in the cancer community as the "fifth pillar" of cancer treatment.

Advanced Therapy Medicinal Products (ATMPs) are new and emerging medicines with potential uses in treating forms of blindness, cancer, heart failure, liver disease, neurological conditions and rare paediatric diseases. ATMPs offer curative options for patients with chronic conditions, including cancer, where standard therapies have effectively 'run out'. Unlike conventional medicines these therapies aim to selectively remove, replace, repair and re-engineer a patient's own cells and/or genes to allow restoration of normal function and/or elimination of disease. There are already opportunities identified offering potential treatments for liver disease, arthritis, diabetic ischaemia, inherited conditions such as haemophilia and sickle cell disease and several types of cancers including haematological cancers within both the clinical trial setting and, with respect to haematological malignancies, for licensed commercial products.

Chimaeric Antigen Receptor T-cell (CAR-T) therapy, a cell-based (*ex vivo*) gene ATMP, is one type of ATMP that harnesses the power of the patient's immune system to direct tumour-specific T-cells to kill cancer cells. CAR-Ts have shown huge early promise in the treatment of haematological malignancies, potentially offering a chance of cure to patients who previously would have been facing end of life palliative care.

Key approvals by the National Institute for Health and Care Excellence (NICE) for CAR-T therapies in the haemato-oncology setting including approval dates and mode of access are summarised below. Note that due to uncertainties in the evidence at the time of initial approval, access is at first granted via the Cancer Drugs Fund (CDF) in England to allow for additional real-world evidence to be accrued before a final appraisal determination is made.

Approvals for large B-cell lymphomas in 3L or later:

- Axicabtagene ciloleucel (Yescarta) for treating diffuse large B-cell lymphoma and primary mediastinal large B-cell lymphoma after two or more systemic therapies (TA559), 23 January 2019. *Access via the Cancer Drugs Fund (CDF) in England.*
- Axicabtagene ciloleucel (Yescarta) for treating diffuse large B-cell lymphoma and primary mediastinal large B-cell lymphoma after two or more systemic therapies (TA872), 28 February 2023. *Routine access (commercial in confidence).*
- Tisagenlecleucel (Kymriah) for treating relapsed or refractory diffuse large B-cell lymphoma after two or more systemic therapies (TA567), 13 March 2019. *Access via the CDF in England.*

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- Tisagenlecleucel (Kymriah) for treating relapsed or refractory diffuse large B-cell lymphoma after two or more systemic therapies (terminated appraisal) (TA933), 29 November 2023. *No decision since the company did not provide a complete evidence submission. No longer available for this indication via the CDF or routinely.*

Approval for large B-cell lymphomas in 2L:

- Axicabtagene ciloleucel (Yescarta) for treating relapsed or refractory diffuse large B-cell lymphoma after first-line chemoimmunotherapy (TA895), 7 June 2023. *Access via the CDF in England.*

Approval for mantle cell lymphoma:

- Brexucabtagene autoleucel (Tecartus) for treating relapsed or refractory mantle cell lymphoma (TA677), 24 February 2021. *Access via the CDF in England.*

Approvals for B-cell acute lymphoblastic leukaemia:

- Tisagenlecleucel (Kymriah) for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people aged up to 25 years (TA554), 21 December 2018. *Access via the CDF in England.*
- Tisagenlecleucel (Kymriah) for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people aged 25 years or younger (TA975), 15 May 2024. *Routine access (commercial in confidence).*
- Brexucabtagene autoleucel (Tecartus) for treating relapsed or refractory B-cell acute lymphoblastic leukaemia in people 26 years and over (TA893), 7 June 2023. *Access via the CDF in England.*

The Programme was initially commissioned to deliver CAR-T for adult patients with large B cell lymphomas after two or more systemic therapies, i.e., in third line (3L) or later. There is now sufficient "real-world" evidence from North America, Europe and the UK replicating the efficacy demonstrated in the pivotal trials that led to marketing authorisation ("licensing") with approximately 40% of patients surviving without disease in the long-term.

Additionally, 5-year follow-up data from the ZUMA-1 trial of axicabtagene ciloleucel (Yescarta) for third or later line treatment of relapsed or refractory LBCL showed that patients who remained disease-free as early as 1 year had no later relapses and had 5-year survival of over 90%, consistent with their population counterparts, suggesting that they had been cured (Jacobson et al. ASH 2021. Abstract #1764). To put this remarkable finding into context, data from the CORAL and LY.12 studies showed that patients with LBCL who received autologous haematopoietic stem cell transplantation (HSCT) in the second line, had to remain disease-free for 5 years before their survival approximated to that of their population counterparts (Assouline et al. *Blood Adv* 2020; 4:2011–2017), suggesting that CAR-T is a more potent therapy than autologous HSCT which has been the standard of care for the past three decades.

The delivery of CAR-T therapy is highly complex. Initially patients undergo apheresis to remove their T cells which are then shipped to an accredited facility for purification. The cells are then transduced with the genetically modified product of choice (the CAR) and expanded in culture. This may take place in the same or different facility from that which performed the initial purification step, i.e., the cells may have travelled from the place of care for the patient to a purification facility to a transduction facility before going to a further facility for testing and quality control. Finally, the cells are returned to the place of care for reinfusion into the patient (Figure 1). This entire process

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currently often crosses country boundaries within Europe and the USA and takes up to 6 weeks to complete depending on the product and company involved.

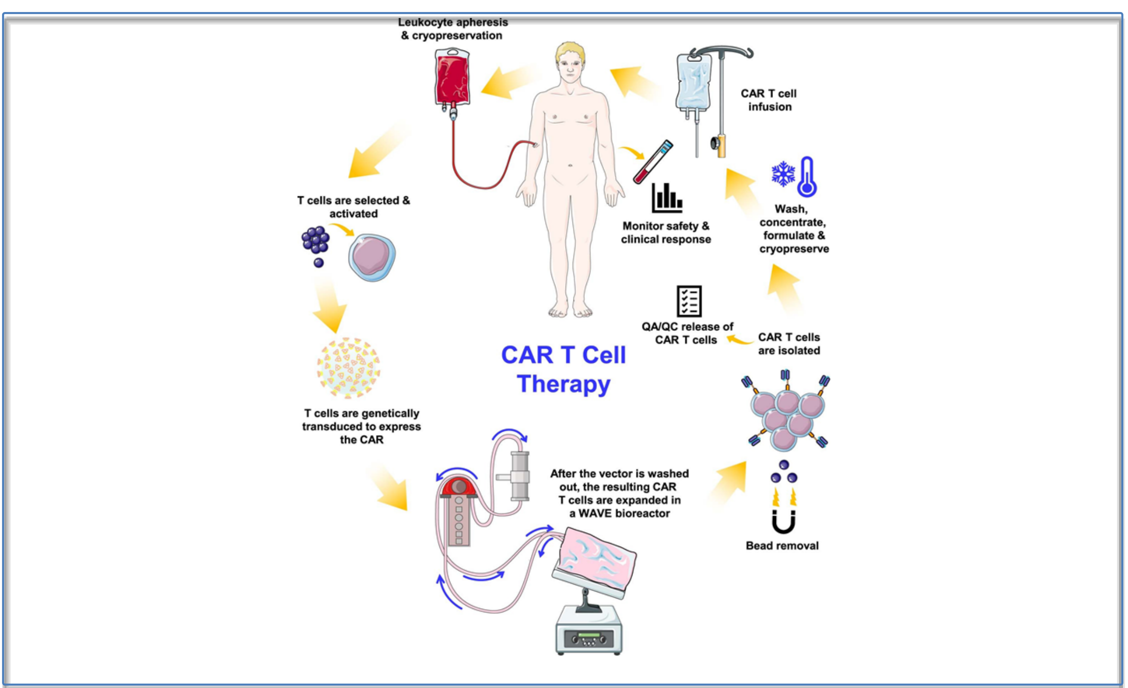

Figure 1: Process of CAR-T manufacture

Due to the newness and complexity of CAR-T therapy, there was always the intention that implementation would be phased to allow the necessary infrastructure to be put in place – both locally and nationally. It was also anticipated that, as indications expanded with new approvals, service provision would need to be revisited to ensure that arrangements remained adequate and fit for purpose.

Infrastructure provided with the Phase 1 investment included:

- A local CAR-T Multi-Disciplinary Team (MDT) for patient selection and submission to the National CAR-T Clinical Panel (NCCP), funded by NHS England, to formally approve treatment by confirming compliance with NICE recommendations
- Administrative support for the tracking of products and MDT support
- Nursing support for the monitoring of potential patients on the pathway from all customer LHBs and to strengthen the ambulatory programme to absorb CAR-T patients within the current footprint
- Identified ambulatory care accommodation to safeguard patients in the period following discharge from inpatient care
- Immediately available and resourced ITU capacity to receive patients as required following CAR-T therapy
- Clinical and administrative time to ensure compliance with HTA, MHRA and JACIE standards, as well as manufacturer-specific requirements
- MDT input to support work-up, monitoring and immediate response to AEs, alongside appropriate support for radiology, pathology, cardiology etc

The key risk associated with establishing this service was the lack of physical space and bed capacity to accommodate this new patient cohort. Increasing the capacity of the ambulatory care unit to accommodate more inpatients helped to mitigate but did not eliminate this risk since only one bed was provided, with transplant allocation reduced from 10 to 9 beds. There was therefore still a lack of surge capacity, considering that patients do not present evenly throughout the year.

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The impact of lack of surge capacity is shown in Figure 7 where on occasion up to 6 CAR-T patients were simultaneously in the treatment phase, including 4 as inpatients. Remembering that CAR-T patients are not in remission and cannot be postponed, accommodating all patients in need has had a negative impact on autologous HSCT, with some patients being transferred to NHS England for treatment. To accommodate additional CAR-T patients, the plan is to increase autologous HSCT activity at SBUHB to 50 per annum to allow for further expansion in bed capacity at CVUHB. Although this additional measure will provide further mitigation against insufficient bed capacity, until the realisation of the business case for a new facility, lack of surge capacity might still necessitate occasional transfer of autologous HSCT and/or CAR-T patients to NHS England for treatment, on safety grounds.

The Phase 1 business case was based on an anticipated initial demand of 10-15 patients per annum, which was interpreted by WHSSC (now JCC) as the number of patients infused, and funding was calculated on this basis. However, as shown in Figure 6, of the 72 patients referred between October 2019 and March 2024, 49 were infused representing an attrition rate of 32% along the patient pathway. Even from the point of NCCP approval of 64 patients, there was still an attrition rate of 23% (15 of 64 patients).

This attrition rate is significant since an inordinate amount of time and resource is invested in the early part of the pathway, even prior to approval by the NCCP. Further, it is common for referring haematologists to seek advice prior to referral and this activity is unrecorded since it takes place largely via telephone or email. This additional but necessary activity is not currently recognised or recompensed in the existing business case.
This Phase 2 business case therefore seeks to redress the imbalance between the larger number of patients referred and worked-up on the treatment pathway versus the smaller funded number who complete the pathway through to CAR-T infusion, given that resource is consumed from (and often before) the point of referral.

Secondly, experience gained from delivering CAR-T therapies over the past 4½ years has shown that assumptions made from the clinical trial data which led to marketing authorisation and informed the original business case, underestimated requirements for parts of the patient pathway making current delivery unsustainable. For example, the pivotal ZUMA 1 trial of axicabtagene ciloleucel (Yescarta) for the third or later line treatment of LBCL, reported a median stay, post CAR-T infusion, of 10 inpatient days. By contrast, as shown in Figure 8, for the CVUHB cohort of 49 infused patients, this was higher at 15 days. Moreover, the median post-infusion inpatient stay fluctuated widely from year to year, ranging from 12-23 days, applying unpredictable pressure to the system and frustrating forward planning. This Phase 2 business case therefore also seeks to address inadvertent omissions which characterised Phase 1.

Thirdly, since the initial LBCL Technology Appraisals (TA559, TA567) which led to the commissioning of the service, NICE has made further recommendations for CAR-T, thereby increasing the number of indications for treatment. This has had a predictable impact on personnel and bed requirements and now requires expansion of the CAR-T service to accommodate these additional patients.

Compounding the above is the significant quality management input necessary for maintenance of JACIE, HTA and MHRA standards, in addition to other conditions imposed by the manufacturer(s). This has proven more onerous than anticipated and all falls on the single CAR-T Lead Consultant. As is widely acknowledged, no service is truly sustainable with a single-handed consultant, let alone one of this complexity, catering for c.80% of the Welsh population and with a significant quality management and regulatory burden.

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Neither the CAR-T Lead Consultant nor the regional acute lymphoblastic leukaemia Lead Consultant (based at CVUHB) has available time or resource to comply with the WHSSC/JCC specification for delivery of CAR-T therapy for patients with relapsed or refractory B-cell acute lymphoblastic leukaemia in any of the NICE-approved age groups.

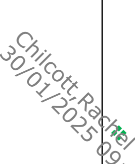
This Phase 2 business case therefore seeks additional investment to “right size” the CAR-T service to safely and sustainably deliver current NICE-approved indications for CAR-T therapy in relapsed or refractory LBCL and relapsed or refractory mantle cell lymphoma (MCL) and to use this opportunity of service expansion to repatriate the treatment of patients aged 16 and over with relapsed or refractory B-cell acute lymphoblastic leukaemia from NHS England.

Since the CAR-T service is unsustainable in its present configuration, this additional investment is required within the **current financial year 2024/25**, especially given the typical lag times associated with recruitment and training.

3. Strategic Context – Alignment to UHB strategic direction

Completion of the table below will evidence how this business case is supporting the four strategic objectives of the UHB and subsequent alignment to the UHB's current Integrated Medium-Term plan.

Objectives	How does this proposal support any of these objectives
Putting People First ❖ People will feel valued, developed, supported and engaged. ❖ We will have an inclusive culture, where the diversity of the health board’s people will be representative of the Health Board’s local populations ❖ Through our integrated population health improvement programme, we will enable and empower people to live healthy lives and reduce their risk of ill health	The Welsh Government ‘Quality Statement for Cancer’ states that services should deliver equitable, safe, effective, efficient, person-centred, timely care in the treatment of cancer in Wales. The service will ensure care closer to home, as described in the UHB’s Shaping our Future Wellbeing Strategy. The model will be sustainable and ensure equity of access across NHS Wales with patients able to access a range of treatment options. There are ongoing NHS England capacity issues therefore a sustainable model in Wales will ensure patients can access this complex treatment in timely manner.
Providing Outstanding Quality ❖ Focus on minimising inequity in healthy behaviours, preventative services, access to clinical services, and health outcomes, to reduce current unfair, unjust differences experienced by people in the health board’s communities ❖ Deliver outstanding quality of care every time - care that is personalised, timely, safe, accessible and effective. Achieve the best outcomes for patients in line with	The existing CAR-T service is JACIE accredited, HTA licensed and qualified by CAR-T manufacturers; this acknowledges the quality management programme and ensures pathways are of a high standard, and that patients can access excellent treatment. External KPI benchmarking by the CAR-T market leader demonstrates greater treatment pathway efficiency of the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what matters most to them, their families and carers ❖ Develop the Health Board's approach to continuous quality to improvement and make the best use of the health board's resources – people, assets (buildings and equipment) and money	CVUHB service compared with the national median. There is a financial benefit to UHB and NHS Wales, as delivering this treatment is more expensive outside of Wales. The service spans 6 of 7 UHBs in Wales. Aligns with Welsh Government vision to deliver Advanced Therapies in Wales.
Delivering in the Right Places ❖ 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. ❖ Refresh and deliver the Health Board's programme (Shaping Our Future Wellbeing in the Community) for creating integrated health and care facilities in our local communities where people can access the information and support they need under one roof ❖ With Cardiff University and NHS partners, develop the Health Board's plans for ensuring hospitals providing acute care are fit for the future (Shaping Our Future Hospitals). Develop more shared infrastructure with public and private sector partners to get best value for the health board's investment	The service will ensure care closer to home, as described in the UHB's Shaping our Future Wellbeing Strategy. Improved patient and family experience including reduced personal costs. Less patient and family travel, reducing the carbon footprint associated with delivery of CAR-T for Welsh patients. Compliance with cancer standards.
Acting for the Future ❖ Develop and expand the Health Board's research, teaching and innovation portfolios in collaboration with Cardiff University and other partners ❖ Contribute to the development of and adopt cutting-edge and novel treatment, techniques and technologies where they deliver improved patient outcomes and improved value ❖ Maximise the Health Board's contribution to the foundational economy ❖ 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	The model will be sustainable and ensure equity of access across NHS Wales with patients able to access a range of treatment options, ensuring the service is ready for expansion in Advanced Therapies. Less patient and family travel, reducing the carbon footprint associated with delivery of CAR-T for Welsh patients. The service will ensure care closer to home, as described in the UHB's Shaping our Future Wellbeing Strategy. Aligns with Welsh Government vision to deliver Advanced Therapies in Wales.

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4. Summary current service provision and case for change

This section should outline the current service provision – model / pathway, activity, existing workforce (skill mix and WTEs) and cost along with a case for change and how the proposal will help reduce strategic and operational risks.

The CAR-T patient pathway is summarised in Figure 2.

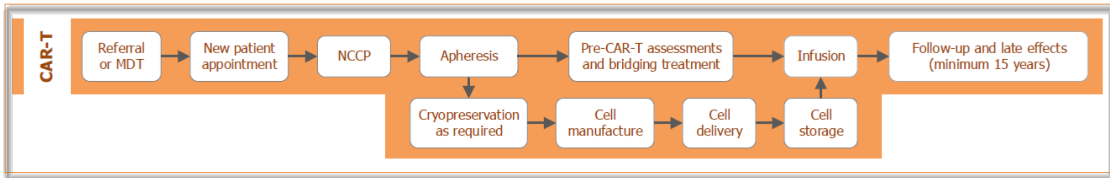

Figure 2: CAR-T patient pathway. NCCP, National CAR-T Clinical Panel

Potential CAR-T patients are identified either through the lymphoma MDT or by direct referral. All direct referrals are reviewed at the lymphoma MDT and potentially eligible patients are seen in the next available CAR-T new patient (NP) clinic. The MDT is held on Wednesdays and the CAR-T NP clinic on Fridays, so the minimum interval between MDT review and NP visit is 2 days.

Once eligibility is confirmed at the new patient appointment, patients are then listed for the next available meeting of the National CAR-T Clinical Panel (NCCP), hosted by NHS England. The NCCP meets on Tuesdays so the interval between the Friday CAR-T NP visit and NCCP review is always 4 days.

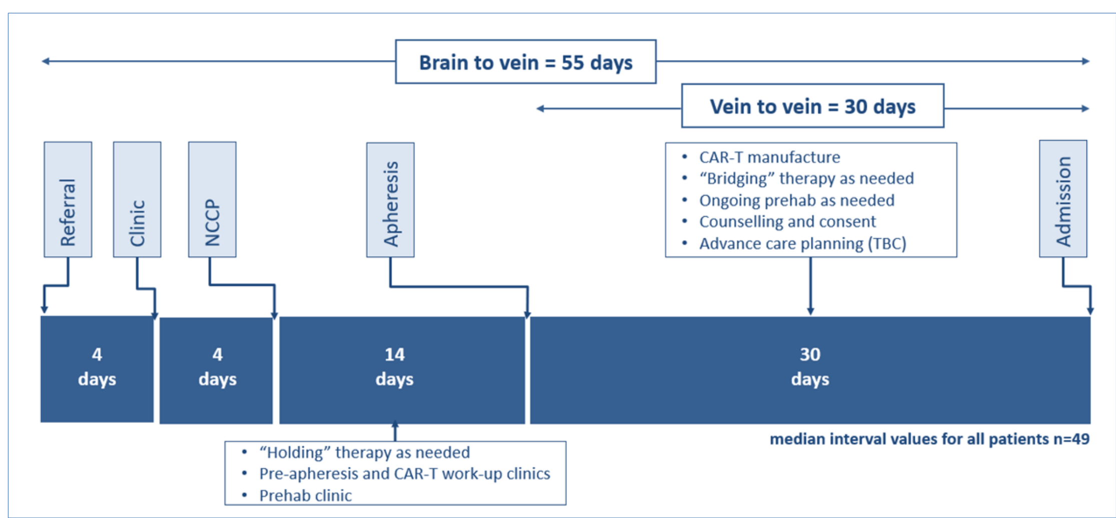

Figure 3. CAR-T pathway with timings for the first 49 patients infused by the SWBT Programme. All intervals are median times. Brain to vein, interval from referral to CAR-T infusion. Vein to vein, interval from apheresis to CAR-T infusion. NCCP, National CAR-T Clinical Panel.

The window between NCCP approval and apheresis is dependent on the patient's clinical condition, burden of disease and rate of disease progression. Consequently, "holding" radio-immuno-chemotherapy might have to be arranged and this is delivered either at CVUHB, Velindre Cancer Centre (radiotherapy) or the referring LHB, depending on the required therapy and capability at the referring LHB. This "holding" treatment must be carefully selected to not compromise the quality of the planned T-cell collection and, at any rate, minimum "wash-out" periods from end-of-treatment to apheresis apply. Additionally, the selected apheresis date must also coincide with the availability of a CAR-T manufacturing slot. Therefore, close oversight is required by the CAR-T team even (or especially) when the "holding" treatment is delivered outside of CVUHB. The current median interval from NCCP approval to apheresis is 14 days (Figure 3).

Between NCCP approval and apheresis several clinic reviews are conducted including a pre-apheresis clinic for operational requirements and regulatory compliance with the relevant JACIE, HTA and manufacturer-specific standards; a work-up clinic to perform the necessary baseline tests and assessments; and a prehabilitation clinic to optimise

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physical and mental fitness. During prehab patients get the benefit of physiotherapy, occupational therapy, dietetic, pharmacy and psychology assessment and intervention whilst simultaneously receiving key worker support from the CAR-T clinical nurse specialist. The CAR-T team therefore provides continued oversight during this interval. From apheresis to admission and CAR-T infusion, the "vein-to-vein" time, there might be the need for additional "bridging" radio-immuno-chemotherapy to prevent clinical deterioration whilst awaiting CAR-T manufacture. As with "holding" therapy, choice and timing must take anticipated CAR-T infusion dates into account since minimum wash-out periods also apply. During this window patients attend a consultant-led clinic for formal counselling and consent whilst continuing with relevant prehab interventions.

Given that approx. 60% of patients will fail CAR-T, there is a need for careful and sympathetic advance care planning. Patients have indicated that they prefer not to address these issues in any of the earlier clinics where the focus is on planning for CAR-T, recovery and possible cure. They revealed that they have found discussing curative and end-of-life palliative strategies by the same personnel in the same clinic setting both distracting and disconcerting. As a result of this feedback, a new and separate advance care planning clinic is proposed, led by a CAR-T nurse practitioner (new post) with consultant palliative care support (new investment). This will be offered within the "vein-to-vein" window which is currently a median of 30 days (Figure 3). Funding for this initiative is included in this Phase 2 business case.

For the whole cohort of 49 patients who completed the pathway to CAR-T infusion, the median interval from referral to infusion, the so-called "brain-to-vein" time, was 55 days. This compares favourably with the 74 days taken for the first 4 patients, who were treated before the entire CAR-T team was established. This emphasizes the importance of having the full complement of personnel with the requisite qualifications and training in place for delivering CAR-T with maximum efficiency. This is particularly important since patients need to access treatment before disease progression renders them ineligible to proceed.

CAR-T is delivered in both ambulatory and inpatient settings (Figure 7) with subsequent outpatient follow-up once all acute toxicities have resolved. On d30 the CAR-T Lead Consultant and CNS hold a discharge planning review meeting with the patient to apprise them of the result of the d28 PET-CT scan. The patient is then returned to the care of the referring LHB with a clear management plan in place. For patients who have achieved a complete metabolic response (CMR), further routine outpatient follow-up takes place at d100 and months 6, 9, 12 and annually thereafter. Another planned initiative is for uncomplicated patients who have achieved a CMR to have this discharge review visit undertaken by the CAR-T nurse practitioner (new post) as currently obtains for HSCT recipients.

Despite care returning to the referring LHB from d30, in practice the CAR-T team remains heavily involved in patient management at the request of local consultants and indeed the patients themselves This is because although safe to be returned to the referring LHB at this point, the CAR-T patient's needs are not trivial and include monitoring and management of neutropenia (which can persist to d100), appropriate timing of the weaning of anticonvulsants in patients who had developed prior immune effector cell associated neurotoxicity syndrome (ICANS) and management of persistent hypogammaglobulinaemia which can extend to 18 months post CAR-T, resulting in intermittent but occasionally severe infection, the main cause of death in remission.

Although the current protocol is for patients to contact their local team for advice or if they become unwell, the CAR-T team remains available as a point of support. In practice, especially because of the rapport established with the CAR-T team, patients and their families continue to access the team through previously established lines of

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contact and in these circumstances, the CAR-T team often acts as a conduit between the patients and their local LHB. Additionally, the referring consultants themselves also contact the CAR-T team for advice and support.

For patients with residual or recurrent disease post CAR-T, optimal sequencing of subsequent treatment has not been defined. The current algorithm recommended by this centre is summarised in Figure 4. Although outside the remit of the CAR-T service, advice from and oversight by the CAR-T team is often sought with regard to subsequent lines of treatment, especially since cellular therapy might be later indicated. This unmet and unfunded need underscores the requirement for a regional lymphoma MDT.

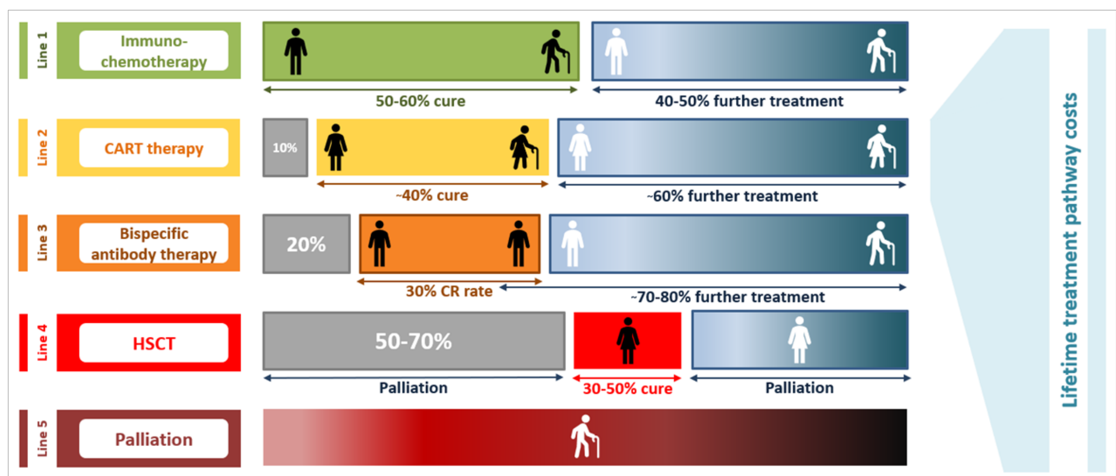

Figure 4: SWBMT Programme algorithm for treatment of patients with LBCL.

Clinical practitioners are understandably delighted at the prospect of having a multitude of therapeutic options at their disposal. However, as the following case histories exemplify, patients get emotionally drained from being constantly on a roller coaster of hope alternating with despair and this can lead them to make decisions that are not in their longer-term interests. Thus, it is essential to have comprehensive psychology and palliative care support throughout the treatment pathway.

> ***Case history 1***
> *A 36-year-old man was diagnosed with DLBCL in 2021. He attained a complete response to first-line immuno-chemotherapy but relapsed 16 months after completion of treatment. He proved refractory to second-line salvage chemotherapy rendering him ineligible for autologous HSCT. He then received bridging therapy prior to autologous CAR-T as third-line treatment in January 2023, two years following his initial presentation. Unfortunately, he failed to respond to CAR-T and received palliative radiotherapy from which he had an unexpectedly good response. He had a matched sibling so was offered an allogeneic HSCT which he declined, despite understanding that delay would inevitably result in further disease progression and uncertain subsequent survival.*
>
> *As anticipated, he suffered eventual disease progression and, having transferred to another health jurisdiction, received further radiotherapy followed by "off-the-shelf" allogeneic CAR-T infusion. The curative potential of this strategy is unknown in contrast to allogeneic HSCT, where there are several decades of data regarding its curative potential in this setting.*

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Case history 2
A 66-year-old woman was diagnosed with DLBCL in 2022, on a background of prior follicular lymphoma, diagnosed and treated to a complete response in 2015. Having proved refractory to two lines of therapy for DLBCL, she received bridging therapy followed by autologous CAR-T in January 2023. She failed CAR-T and received palliative radiotherapy achieving an unexpectedly good response which her local team consolidated with a 6-cycle course of immuno-chemotherapy.

Her current remission is not expected to be durable and potential options include NICE-approved bispecific antibody therapy and allogeneic HSCT. On learning this she indicated that it was "easier" to accept that she already had end-of-life treatment, enabling her to psychologically plan for whatever remission duration lay ahead. Finding the prospect of more options with uncertain cure too daunting, she elected to "enjoy the summer" and defer consideration of further treatment.

Patients who remain in continuous remission at 12 months post CAR-T have a projected 5-year survival of over 90% which is indicative of potential cure. However, due to uncertainties regarding longer-term toxicities, the MHRA has mandated minimum follow-up of 15 years. Now that the number of survivors is accruing, a nurse practitioner-led (new post) late effects clinic is planned to comply with this requirement starting from the month 12 consultant-led review. Funding for this service development is included in this Phase 2 business case.

In November 2023, the US Food and Drug Administration (FDA) posted a safety communication regarding T-cell malignancies, including CAR-positive lymphoma, in patients who received treatment with BCMA- or CD19-directed autologous CAR-Ts. The list of implicated products included all current NICE-approved CAR-Ts. These malignancies may occur as early as weeks following infusion and can prove fatal. In January 2024 the FDA updated its boxed warnings concerning CAR-Ts and on 18 April 2024 recommended that recipients of these products should be **monitored life-long** for secondary malignancies. [https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/fda-requires-boxed-warning-t-cell-malignancies-following-treatment-bcma-directed-or-cd19-directed, *accessed 06.2024*]

Should the MHRA follow suit and increase mandated follow-up from 15 years to lifelong, the CAR-T late effects treatment pathway would be updated to reflect this change. Depending on the recommended mode of monitoring and agreed shared-care arrangements, the updated late effects pathway may necessitate a Phase 3 revision of this business case.

5. Case for change - *The evidence*

*For the case to be considered this section **MUST** include*

- ***Demand** – analysis and trends of demand on the service,*
- ***Capacity** – analysis of the workforce, staffing levels, variations and actions being taken to address and, where necessary, improve efficiency.*
- ***Current performance** – summary of the achievement against the targets and efficiency indicators of the service.*
- ***Benchmarking** – proposed service change should be benchmarked against comparable providers / services.*

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Referrals

CAR-T for relapsed or refractory large B-cell lymphomas (LBCL) was approved by NICE in January 2019, initially through the Cancer Drugs Fund in England, for patients who had received at least two prior systemic therapies. The service in Wales was formally commissioned by WHSSC (now JCC) in September 2019 with provision via the South Wales Blood and Marrow Transplant (SWBMT) Programme, which was already Pharma-qualified as a CAR-T centre since December 2018.

It was anticipated that demand for the SWBMT Programme catchment area would be circa 10-15 per annum and the CAR-T service was sized accordingly with personnel requirements extrapolated from clinical trial data which led to CAR-T marketing authorisation. It was calculated from the onset that once referrals increased to around 20 per annum the service would need to be resized to cope with the additional workload.

Since the initial LBCL approval in January 2019, NICE approved CAR-T for relapsed or refractory mantle cell lymphoma (MCL) in February 2021 and, in June 2023, expanded the approval for LBCL to include treatment of patients in the second line, after a single prior course of chemo-immunotherapy, provided failure occurred within 12 months of treatment.

What was excluded from the outset, was the treatment of relapsed or refractory B-cell acute lymphoblastic leukaemia for patients aged 16-25 years, which had been NICE-approved in December 2018 and commissioned via NHS England. This indication was expanded in June 2023 to include older adults aged 26 and over.

Referral Indication	Financial Year					
	*2019/20	2020/21	2021/22	2022/23	2023/24	TOTAL
LBCL-3L	06	13	10	18	08	55
LBCL-2L	---	---	---	---	12	12
‡MCL	---	---	---	03	02	05
TOTAL	06	13	10	21	22	72

*Table 1: CAR-T referrals since inception of the service at CVUHB. LBCL, large B-cell lymphomas. 3L, treatment in third or later line (after two or more prior therapies); 2L, treatment in second line (after a single prior therapy). ‡MCL, mantle cell lymphoma (activity since November 2021). *2019/20 data from October 2019.*

Referrals for CAR-T therapy since inception of the service are summarised in Table 1. As was anticipated, demand increased as a result of both greater familiarity by referring clinicians as well as expanded NICE approvals. The current level of demand at over 20 patients per annum for the past two financial years, is unsustainable for a service initially tailored to cater for 10-15 patients per annum. As was indicated from the onset, crossing the threshold of 20 patients per annum would trigger a revision of the business case to right-size the service, hence this Phase 2 business case.

Demand analysis

There are epidemiological data to suggest that current referrals for LBCL, just over 20 per annum, have not yet reached the expected maximum, as summarised in Figure 5.

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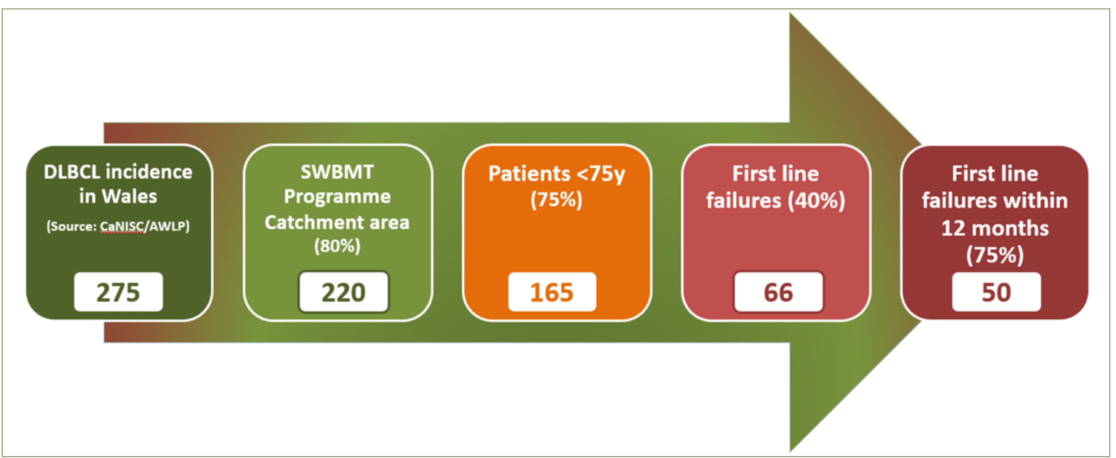

Figure 5: Estimate of patients with LBCL potentially eligible for second line CAR-T Therapy. DLBCL, diffuse large B-cell lymphoma. CaNISC, Cancer Network Information System, Cymru. AWLP, All-Wales Lymphoma Panel.

Data from CaNISC, confirmed by the All-Wales Lymphoma Panel (AWLP) who centrally reviews all new lymphoma diagnoses, reveal that c.275 patients are newly diagnosed with DLBCL per annum. Of this, the SWBMT Programme catchment area accounts for ~80% equating to 220 patients per annum.

UK NCCP data of DLBCL patients who received CAR-T in the third line setting between 2019 and 2021, showed that only 7 of 300 (2.5%) recipients were aged 75 and over (A. Kuhnl, personal communication 2022), despite this age group accounting for 25% of all DLBCL patients. Provisionally excluding this age group would result in 165 (75% of 220) patients.

Sixty per cent of patients with DLBCL will be cured with first line treatment resulting in 40% failures (n=66) of whom 75% (n=50) will fail within 12 months and be potentially eligible for second line CAR-T therapy. This therefore represents the potential ceiling of DLBCL referrals for CAR-T in the second line. However, not all patients would have the requisite fitness so the proportion of the maximum of 50 patients who should be referred is unknown.

To address this uncertainty, the SWBMT Programme is in the early phase of setting up a service evaluation to review the treatment and response of all Welsh patients diagnosed with DLBCL since January 2022 – the population potentially eligible for second line CAR-T since NICE approval in June 2023. This will answer the question of whether patients are being appropriately identified and referred, or if postcode affects provision, the so-called “postcode lottery”. At any rate, the data would further inform the need for a regional lymphoma MDT to ensure patients are adequately treated at all stages along the treatment pathway regardless of residence.

Large B-cell lymphoma (LBCL) is an umbrella term encompassing several subtypes of aggressive “high grade” lymphomas not all of which were listed in the original NICE TA; however, many are now routinely approved by the NCCP given that biologically they (and their response to CAR-T) are similar. These include Richter’s transformation of chronic lymphocytic leukaemia/small lymphocytic lymphoma, LBCL with secondary central nervous system involvement and post-transplant lymphoproliferative disorder (PTLD). These “additional” LBCLs would account for an extra 0-4 patients per annum.

Although it is unclear what proportion of the ceiling of 50-54 LBCL patients per annum would be candidates for CAR-T, the 22 referrals received in 2023/24 would suggest that all eligible LBCL patients are not yet being referred. By contrast, the referral of

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five patients with mantle cell lymphoma since this indication was NICE-approved in February 2021 is consistent with anticipated demand of 0-3 per annum.
Right-sizing the CAR-T service would provide opportunity for repatriation of patients with relapsed or refractory B-cell acute lymphoblastic leukaemia who currently receive CAR-T therapy in NHS England in contravention of numerous cancer standards, at significant additional cost to NHS Wales and with a negative patient and family experience including additional personal cost. There is no current capacity to comply with the WHSSC/JCC specification for delivery of this service, where the need is similar to (if not greater than) that described for the management of patients with lymphoma.

The estimated new demand, in terms of **referrals**, resulting from extended NICE approvals for large B-cell lymphomas, mantle cell lymphoma and B-cell acute lymphoblastic leukaemia is **25-27** per annum, which represents an **80% increase** over the initial 10-15 that were estimated at the commencement of the CAR-T service. This number may further increase as a result of the planned service evaluation but the current estimate represents known demand.

Treatment pathway

The pathway for CART patients is complex, with multiple steps to be navigated from the point of referral to eventual CAR-T infusion. As shown in Figure 6 there is significant attrition along the pathway with 32% (23/72) not progressing to CAR-T infusion from initial referral.

From the point of NCCP approval the attrition rate is lower but still significant at 23% (15/64), which is comparable to the UK average of 25% where, between 2019 and 2021, for the first two years of CAR-T delivery, 300 of the 404 patients approved by the NCCP proceeded to eventual CAR-T infusion.

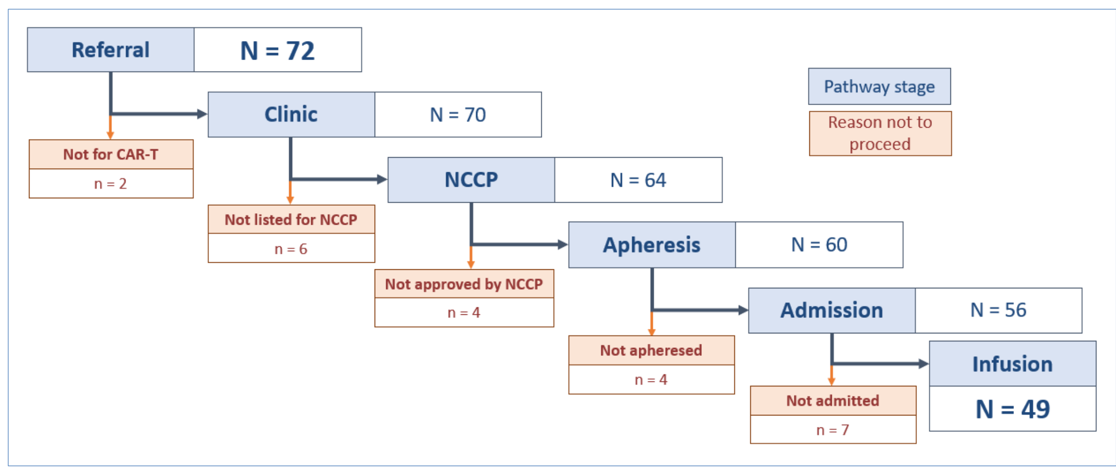

Figure 6. CAR-T pathway details for the first 72 patients referred between October 2019 and March 2024. Reason and timing of attrition shown. NCCP, National CAR-T Clinical Panel.

Treatment delivery and capacity

The CAR-T service was commissioned for delivery via the SWBMT Programme. To accommodate this initiative, one BMT bed was sacrificed, reducing the complement from ten to nine. To offset this loss, ambulatory care provision was strengthened to accommodate more routine haemato-oncology patients as well as parts of both the autologous and allogeneic HSCT pathways. However, even with this arrangement, it was acknowledged that there would remain a lack of surge capacity, occasionally necessitating transfer of autologous HSCT and/or CAR-T patients to NHS England on patient safety grounds.

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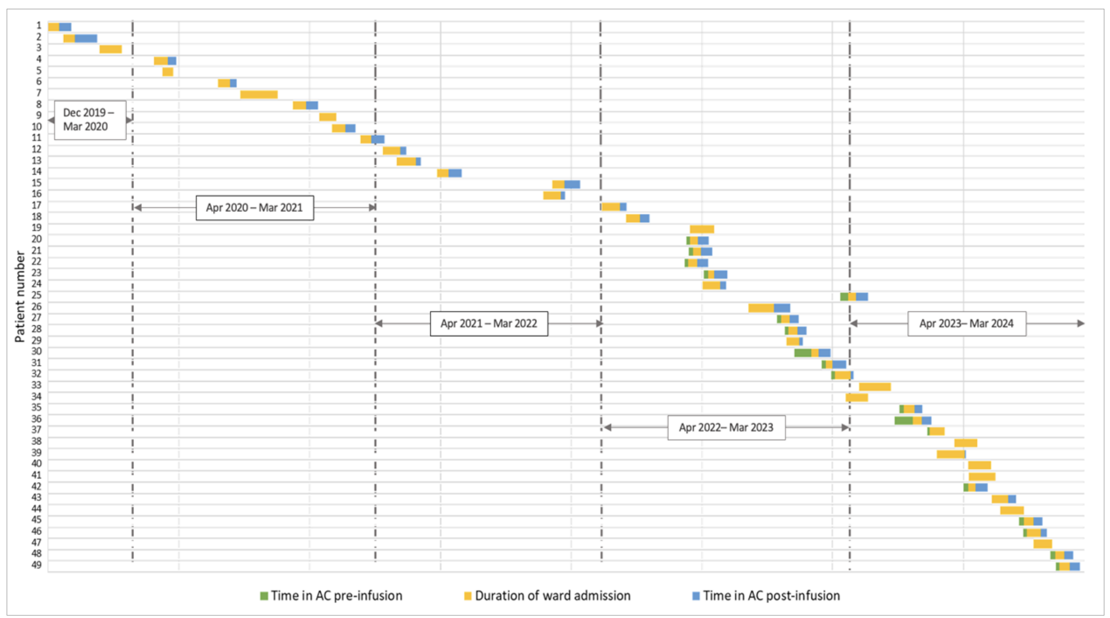

Figure 7. Bed utilisation data for CAR-T patients infused between December 2019 and March 2024 showing time spent as an inpatient (yellow bars) and in ambulatory care (AC) both before (green bars) and after (blue bars) CAR-T infusion. Each composite bar represents a single patient episode.

Figure 7 shows the increasing use of the ambulatory care unit since the start of the CAR-T service, expanding from only the post-infusion period (blue bars) to now include lymphodepletion where chemotherapy is delivered prior to CAR-T infusion (green bars). Despite this increased use of ambulatory care, as also shown in Figure 7, where each bar represents a single patient treatment episode, patients do not present evenly throughout the year. Consequently, there were occasions where up to 6 patients were simultaneously on the CAR-T treatment pathway including up to 4 patients occupying inpatient beds, underscoring the need for surge capacity.

Despite the obvious advantage provided by the ambulatory care unit in relieving pressure on inpatient beds, real-world experience of delivering CAR-T therapy over the past 4½ years has shown that assumptions made from the clinical trial data which informed the original business case, underestimated this requirement. In contrast to the pivotal ZUMA 1 trial of axicabtagene ciloleucel (Yescarta) which reported a median inpatient stay of 10 days post CAR-T infusion before being discharged to ambulatory care, this was higher for the CVUHB cohort of 49 infused patients who spent a median of 15 days (Figure 8). Moreover, this fluctuated widely from year to year, ranging from 12-23 days, applying unpredictable pressure to the system thereby frustrating forward planning. Indeed, only 2 of the 49 (4%) patients, spent 10 or fewer days as an inpatient following CAR-T infusion before being able to be discharged to ambulatory care (Figure 8). Compounding this negative impact on capacity was the consumption of more resource than anticipated.

CAR-T eligible patients are, by definition, not in remission and their treatment therefore cannot be postponed. The lack of surge capacity within the SWBMT Programme necessitates ongoing and intense triaging of patients on both the BMT and CAR-T pathways, consuming significant staff resource. If triaging cannot overcome the impact of demand surge, patients may need to be transferred elsewhere for treatment outside NHS Wales, to prevent deterioration whilst on the waiting list.

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Since the commissioning of the CAR-T service, this lack of surge capacity has resulted in transfer of one CAR-T and three autologous HSCT patients to NHS England for treatment on clinical safety grounds. A business case for a new facility at CVUHB to address capacity and quality deficiencies is awaiting approval to progress to the OBC/FBC stage. Until this is realised, a further mitigation is to increase autologous

HSCT activity at SBUHB to 50 patients per annum. Any implications for the SBUHB service will be the subject of a separate business case submission.

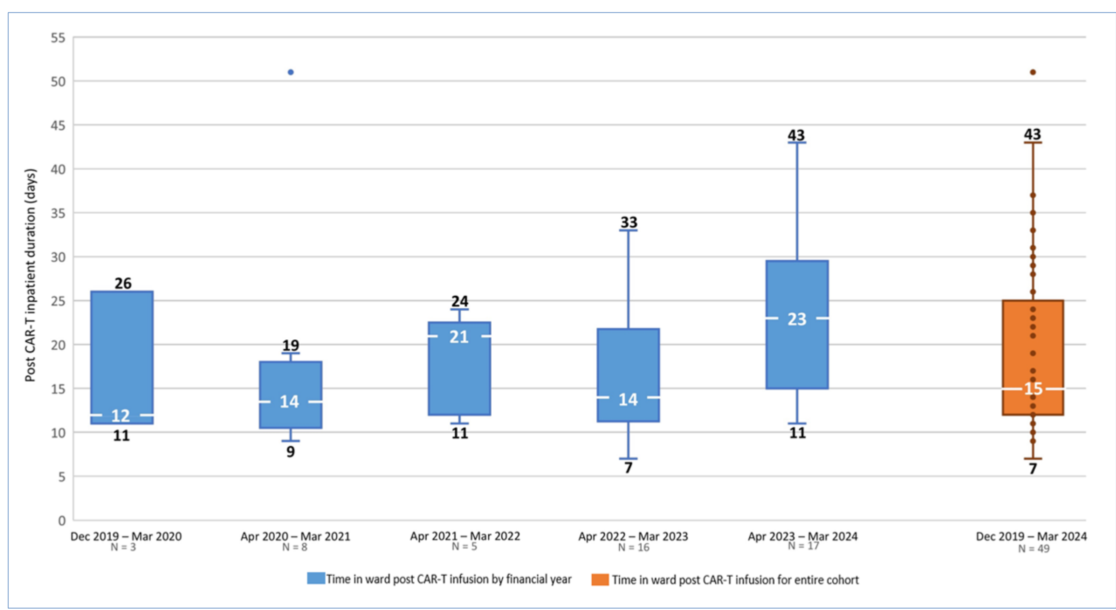

Figure 8. Box and whisker plot of inpatient bed use post CAR-T infusion by financial year (blue bars) and for the entire infused cohort of 49 patients (orange bar). Bars represent interquartile ranges with medians shown in white; whiskers represent upper and lower limits. Individual patients are shown as filled in circles, including a single outlier who spent 52 days.

In addition to right-sizing the service to accommodate demand, there is also the need to redress the imbalance of insufficient staff allocation to some aspects of the treatment pathway. These inadvertent omissions and/or underestimates were the result of differences in real-world experience from the clinical trial data which led to marketing authorisation and subsequent shaping and commissioning of the service. Experience gained from 4½ years of CAR-T delivery has revealed which gaps in provision make the current service unsustainable, even without consideration of increased demand. These additional requirements, with the rationale, are detailed in Section 7.

Performance and benchmarking

Despite the constraints imposed by lack of adequate physical facilities and an over-stretched workforce, assessment of key performance indicators (KPIs) shows that the CAR-T team performs at or above the UK average. However, this accomplishment has been at the expense of staff exhaustion and burnout, making the current service delivery model unsustainable.

Through education of referring teams in the Cancer Network, leading to better patient selection and timelier referral, and by continual finessing of the treatment pathway, the attrition rate has fallen over the 4½ years that the SWBMT Programme CAR-T team has been in operation. In the first 2½ years of operation (October 2019 to March 2022), 55% (16/29) of referred patients completed the pathway through to CAR-T infusion, improving to 77% (33 of 43 patients) for the latter 2 years (April 2022 to March 2024). Thus, the programme managed a larger number of patients with greater efficiency.

Data from Gilead-Kite regarding the use of axicabtagene ciloleucel (Yescarta) for the treatment of LBCL showed that pathway KPIs for the SWBMT Programme CAR-T service compared favourably with national figures as illustrated in Figure 9.

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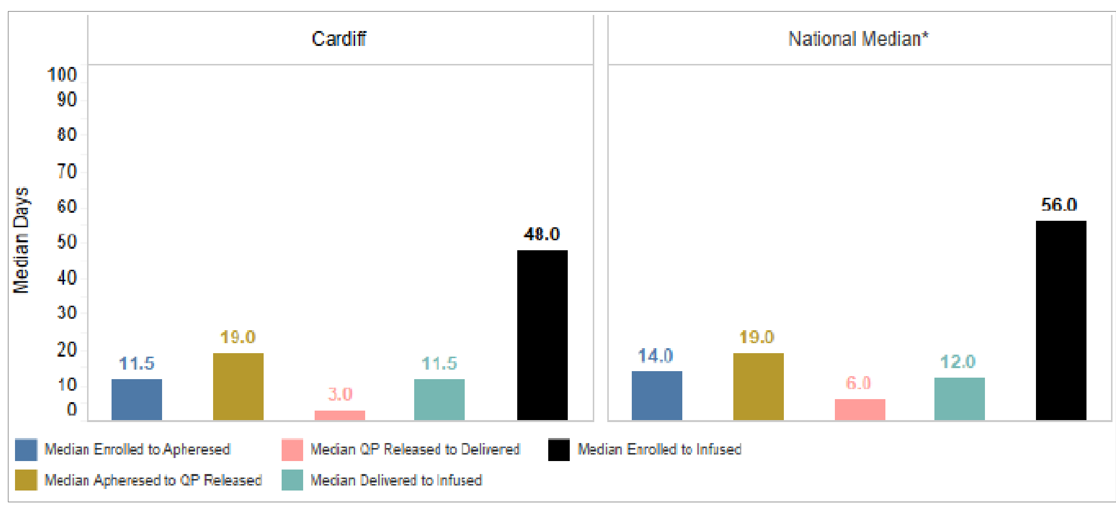

Figure 9. LBCL CAR-T treatment pathway KPIs for the 12-month period to 8 March 2024. Dataset restricted to use of axicabtagene ciloleucel (Yescarta). [Source: Gilead-Kite]

Due to efficiencies gained along the treatment pathway, for the 12-month period to 8 March 2024, patients treated by the SWBMT Programme CAR-T service spent a median of 48 days from registration on "Kite Konnect" to CAR-T infusion, compared to the UK median of 56 days.

Unlike the case for haematopoietic stem cell transplantation (HSCT), the BSBMTCT (British Society for Blood and Marrow Transplantation and Cellular Therapy) does not yet provide centrally benchmarked CAR-T survival data. The Cardiff service is therefore dependent on data published or presented by the NCCP which includes all UK centre data, and therefore that also of Cardiff. Thus, the comparison is with the UK average as opposed to "the rest" of the UK (i.e., excluding Cardiff) as occurs for benchmarked HSCT data provided by the BSBMTCT.

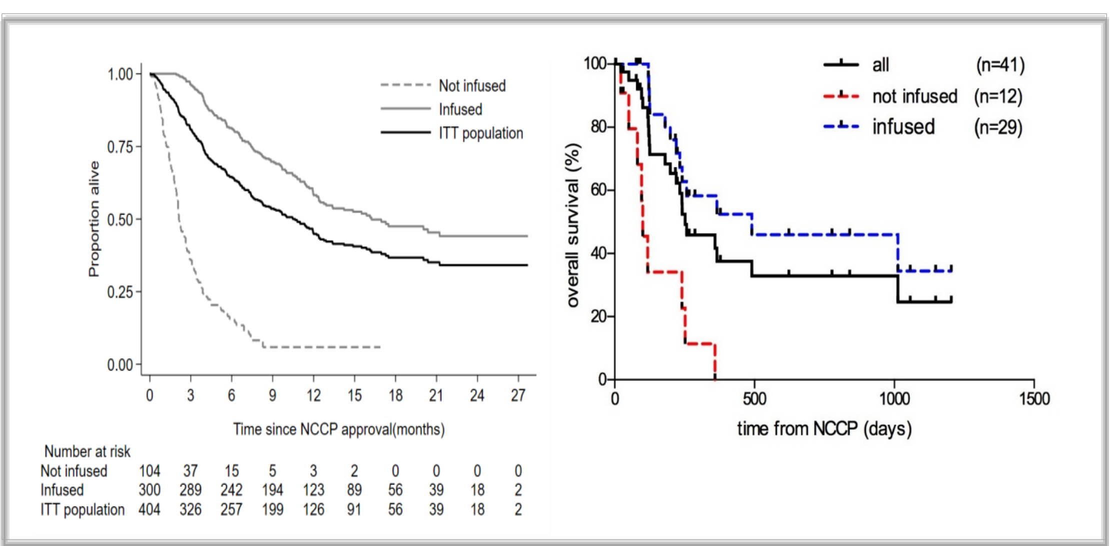

Figure 10. Comparison of overall survival between the SWBMT Programme and UK cohorts of patients approved by the NCCP to receive CAR-T for LBCL in third or later line of therapy. Data cut-off February 2023.

Figure 10 shows overall survival of patients with LBCL who were approved by the NCCP to receive CAR-T in third or later line (data cut-off February 2023) by treatment status (infused versus not). Data are shown for the SWBMT Programme cohort (data internally compiled) and the UK national dataset (compiled by the NCCP).

Results from both cohorts are equivalent and comparable to clinical trial and other "real-world" data, showing a survival plateau of approximately 40%.

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Value for Money Benchmarking

The initial phase 1 CAR-T investment which provided the infrastructure for up to 15 infusions has a 24/25 funded baseline of £1,552,883 which includes the staffing infrastructure, non-pay consumables and support services.
At this funding level the inferred cost per case would be £103,522 per completed infusion.

The comparable NHSE tariff paid by the NWJCC to NHS England providers when the Cardiff centre capacity is reached ranges between £108,819 (University Hospital Bristol) and £121,892 (Kings College) this excludes any critical care or accommodation expenses which will be charged to commissioners on top of the tariff.

The NHSE tariff is under review as there is a number of years real data available from operating CAR-T services; recognising the attrition rate for referrals that do not fully complete the infusion process and how time intensive this is for clinical teams, and the premium incurred by lower volume centres whilst building capacity.

In 2023/24 the Cardiff service over performed against the funded baseline and delivered 19 cases, the reimbursement from commissioners for the additional 4 cases only covers the cost of the non-pay consumables, therefore the cost per case for welsh commissioners was £85,051. However, this is not sustainable without the capacity investment outlined in this case.

6. Option Appraisal

This section should provide the details of the options considered. In developing the options, a do-nothing or do-minimum option must be retained. Do nothing may not be feasible but in this event should act as the baseline.

In some cases, where there is clearly only one realistic way forward, this should be explained, giving the reasons. In other cases, a range of options exist. These should be set out and then explored via a value for money appraisal whereby costs, benefits and risks of each option are compared.

The recommended option is then carried forward into section 7

The following case history, currently live within NHS England, amply exemplifies the imperative of designing a safe and sustainable service and puts the option appraisal of this business case in the appropriate context.

The upper limits of patient activity described in each option have been defined by what is clinically safe and sustainable, with due regard for staff welfare, within the funding envelope provided. What has been specifically avoided is the temptation to reset the baseline to what might have been unsustainably and unsafely achieved at the expense of staff wellbeing. Each option therefore represents the **best value** attainable for the associated expenditure.

Case history 3
In the early phase of the COVID-19 pandemic, when it was unclear what impact this would have on transplant beds, access to intensive care, ability to readmit unwell patients, etc, a central HSCT Programme Directors' Group was formed, initially meeting weekly, to discuss capacity and other issues to ensure that patients across the UK had equitable access to transplant beds, evolving treatments and COVID vaccines.

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CARING FOR PEOPLE, KEEPING PEOPLE WELL

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

These meetings were funded by NHS England and hosted by the Anthony Nolan, the first unrelated donor stem cell registry worldwide, and the largest such registry in the UK. Supporting the work of the central group were regional hubs who reported into the central Programme Directors' Group. Wales was a member of, and co-chaired, the Wales and SW England hub, having joined at the request of WHSSC.

When the impact of the pandemic subsided, the regional hubs were largely disbanded, but the central Programme Directors' group continued to meet (albeit at a reduced frequency) due to the advantage of the immediacy of effective lines of communication across the entire UK transplant community, additionally benefitting from the ongoing presence NHS England from a commissioning standpoint, with the Anthony Nolan acting as secretariat.

At the Programme Directors' Group meeting on 20 June 2024, it was revealed that the paediatric allogeneic HSCT centre in Bristol had closed for an initial 6 months with effect from April 2024. This was largely due to inadequate staffing, mainly at consultant level, leading to near miss events even though these did not result in patient harm. The Bristol paediatric allogeneic HSCT programme routinely performed c.33 procedures p.a. The existing consultant complement which was deemed inadequate comprised one substantive and one locum post.

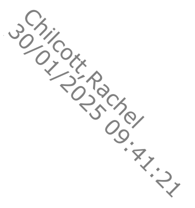
As a consequence of the closure, centres (including Wales) that typically refer paediatric patients into Bristol, have been linked to other NHS England centres, but with the clear understanding that this does not guarantee capacity at the new centre at the time that transplantation is required. Instead, these new centres will simply act as "hubs" and attempt to find capacity for referred patients elsewhere within NHS England, as needed.

At the time of writing there is a Welsh paediatric patient who ordinarily would have had an allogeneic HSCT in Bristol but who is an inpatient in Sheffield.

Despite the plan to reassess the situation at 3 and 6 months, the prevailing view was that the programme would remain closed at the end of the initial 6-month period.

Significant drawbacks associated with the closure of the Bristol allogeneic HSCT programme include but are not restricted to:

a. *Increased patient and family travel*
b. *Increased patient and family expenditure associated with travel and accommodation costs*
c. *Poorer patient and family experience*
d. *Earlier repatriation of patients back to referring centres since most other paediatric allogeneic HSCT programmes in NHS England do not have the option of housing patients until d100 post-HSCT as occurred in Bristol*
e. *For the Welsh patient currently in Sheffield, the plan is to repatriate the patient to Wales on discharge, despite the tariff including care to d100 post-HSCT. Thus, NHS Wales would be paying twice for costs incurred between discharge and d100*
f. *Lack of an agreed strategy for readmission between discharge and d100 post-HSCT, putting patients at risk of being readmitted to facilities without the requisite expertise to effectively manage these complications*



The autologous CAR-T service provided at Bristol remains unaffected since this is delivered by the adult HSCT programme.

Although the above case history involves allogeneic HSCT rather than autologous CAR-T provision, the risks and consequences of staffing levels inadequate for the delivery of complex services are identical as already described in this business case and following options.

Important take-home lessons include:

- Patients' lives are put at risk when staffing levels are inadequate
- Staff are unable to work unsustainably over prolonged periods
- Rather than expect staff to work in an unsustainable manner, the decision was taken to close the service on patient safety (and presumably also staff health and welfare) grounds
- The correct response to inadequate staffing is to close the affected service rather than expect staff to "stretch" further and continue to work unsustainably
- Capacity is not guaranteed within NHS England
- The responsibility for resolution rightly rests with the commissioner (NHS England in this specific case) rather than the provider

Option 0: Do nothing

The service is unsustainable in its existing format and cannot simultaneously cope with current demand and compliance with the requisite quality and regulatory burden. Staff have already manifested evidence of exhaustion and burnout, and this cannot be allowed to continue, on employee health and welfare grounds.

If this Phase 2 business case is not supported, the CAR-T service will have to revert to the originally commissioned **10-15 referred** patients, equating to **10 infusions**, based on an attrition rate of 33%. This is because flexing to a ceiling of 20 referrals (up to 13 infusions) as was originally proposed, has proven to be unsustainable due to the inadvertent omissions from the Phase 1 business case. Referring LHBs would be advised that once this threshold is reached, additional patients would need to be referred **directly** to NWJCC.

Experience gained from using the WHSSC Outsourcing Framework (August 2016) showed that using the *Primary provider to provider* outsource option places a significant administrative burden on clinical staff, the expenditure for which was not reimbursed. This is not sustainable or feasible given the constraints already described. The Cancer Network would therefore be advised that the only viable outsource strategy would be the *WHSSC to provider* option, because the CAR-T team would not have capacity to be involved in or assist with patients not receiving treatment within the service.

The following risks/disadvantages are associated with Option 0:

- More patients would be treated in NHS England where benchmarked waiting times from manufacturer registration to CAR-T infusion are longer.
- Capacity in NHS England cannot be guaranteed, and this patient group needs to be treated with minimum delay.
- Patients and their families would have a worse experience including increased personal travel and housing costs.
- There would be non-compliance with the MHRA regulatory requirement for a minimum follow-up of 15 years to collect post-marketing adverse event data since there would be no capacity for the proposed nurse-led late effects clinic.
- The proposed advance care planning clinic will not open.
- Adult and TYA patients with relapsed or refractory B-cell acute lymphoblastic leukaemia will continue to be treated in NHS England.

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- This option is associated with more travel and a larger carbon footprint.
- This arrangement is financially disadvantageous to NHS Wales
- There is potential reputational risk for Wales, Welsh Government and CVUHB.

Option 1: Do minimum

With the "do minimum" option, the CAR-T service would be right-sized for the originally commissioned demand of 10-15 referrals per annum and accommodate the originally proposed ceiling of 20 referrals equating to a maximum of 10-13 infusions per annum. This will address the inadvertent omissions from the Phase 1 business case, allow the delivery of a sustainable service, whilst incorporating the needed initiatives based on patient feedback.

Advantages of Option 1:

- Achievement of a sustainable service with reduced risk of staff burnout.
- Patients would benefit from advance care planning.
- An MHRA-compliant late-effects monitoring service would be established.

The following risks/disadvantages would remain with Option 1:

- Capacity would not be increased so outsourcing to NHS England would still be required with the associated risks of uncertain capacity.
- Outsourced patients would wait longer for treatment and potentially experience worse clinical outcomes.
- There would be a worse patient experience for outsourced patients including the associated increased travel and housing costs.
- Patients with relapsed or refractory B-cell acute lymphoblastic leukaemia will continue to be treated in NHS England.
- The carbon footprint associated with this option would remain significant.
- This arrangement will remain financially disadvantageous to NHS Wales.
- The potential for reputational risk will remain.

Option 2: Preferred option

The preferred option, the subject of this Phase 2 business case, is to right-size the CAR-T service for existing and future demand anticipated as a result of the planned service evaluation, and for the repatriation of adult and TYA patients with relapsed or refractory B-cell acute lymphoblastic leukaemia from NHS England.

Investing in Option 2 would increase referral capacity by 80% from 10-15 per annum at the start of the CAR-T service to 25-27 per annum. This equates to 20-22 infusions per annum since, as a result of increased pathway efficiency, 77% of referred patients now complete the pathway through to CAR-T infusion, compared with 67% in the early years of the service. The level of work acuity demanded to maintain pathway efficiency at its current 77% would only be sustainable with this Phase 2 investment.

Right-sizing the service would create genuine elasticity to accommodate further patients identified by the planned service evaluation without recourse to additional staff resource; but would be limited by physical capacity constraints.

Advantages of the preferred option:

- All advantages of Option 1.
- Potential to accommodate additional LBCL patients identified via the planned service evaluation (dependent on number of additional referrals generated).
- Repatriation of adult and TYA patients with relapsed or refractory B-cell acute lymphoblastic leukaemia from NHS England.
- Reduction in waiting times for patients.
- Improved patient and family experience including reduced personal costs.

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- Less patient and family travel, reducing the carbon footprint associated with delivery of CAR-T for Welsh patients.
- Compliance with cancer standards.
- Financially advantageous for NHS Wales – recouping of current excess costs of outsourcing would significantly subsidise this option.
- Capacity to use *Primary provider to provider* option whenever the outsource option is required.
- Reduction of reputational risk.
- Potential to repatriate autologous HSCT in patients with multiple sclerosis from NHS England with delivery at SBUHB.

Residual risks with the preferred option:

- Model dependent on SBUHB consistently performing c.50 autologous HSCT procedures per annum (already funded for this level of activity so low risk).
- Until the new build is realised, significant demand surges might still necessitate occasional outsourcing to NHS England.

7. The Preferred Option

The preferred option will achieve right-sizing of the existing service to improve safety, achieve sustainability, increase capacity to accommodate expanding NICE approvals for CAR-T therapy in LBCL and MCL and additionally allow the repatriation of patients with relapsed or refractory B-cell acute lymphoblastic leukaemia from NHS England.

In addition, by increasing throughput at SBUHB to fully-funded capacity, this option would also allow repatriation of autologous HSCT in patients with multiple sclerosis from NHS England to Wales, with these procedures performed at SBUHB.

What the Bristol NHS England experience exemplifies is that failure to address safety and sustainability concerns puts patients at risk and exposes staff to burnout. Note that delay in addressing these deficiencies result in a worse patient experience, increased personal cost to patients and families, additional pressure on other service providers and increased overall cost of delivering the service. In summary, such an approach does not represent financial prudence or value for money.

Quality management

The quality management system (QMS) of the SWBMT Programme is based on three pillars:

1. **Personnel**
   Maintenance of an adequate number of appropriately qualified and trained personnel.

2. **Processes**
   Processes need to be validated and shown to be effective. The Programme has identified “key” processes which the Programme seeks to “control” to ensure that they remain fit for purpose and consistently achieve desired outcomes. These key processes are essentially the **patient pathways** and underpinning **supporting protocols** of the Collection and Processing Facilities. The adult clinical pathways are listed below:

   a. The autologous HSCT patient pathway
   b. The allogeneic HSCT patient pathway
   c. The sibling HSCT donor pathway
   d. The autologous CAR-T patient pathway (the subject of this business case).

3. **Premises**
   This term is generically applied to physical facilities, procurement and supplies. The state of the premises of the adult programme at CVUHB was severely criticised by the JACIE Inspectorate at two prior inspections, being described as *"shabby and behind the curve"* in 2013, deteriorating to *"the worst ever seen"* at the follow-up inspection in 2019. The Inspectorate made it clear that unless significant improvement is made by the time of the next inspection (scheduled for 2025) our JACIE accreditation would be at risk.

   The premises have been on the CVUHB risk register at the highest level of reportable risk since January 2010. Mitigation to date has been insufficient since the premises are incapable of meeting JACIE standards, despite refurbishment. The only remedy is a new build as part of the planned UHW2. As an interim solution, a business case for a new cellular therapy unit has been submitted to Welsh Government and is currently awaiting approval to proceed to the OBC/FBC phase.

In contrast to the state of the **premises**, the quality management **processes** of the SWBMT Programme have been externally validated and found to be excellent. During the CAR-T centre qualification process in 2018, the QMS was described as *"the best in Europe"*, whilst in February 2019 the JACIE Inspectorate described it as *"the best ever seen"*. In 2021, when the HTA was deciding which Tissue Establishments should have virtual or onsite inspections due to COVID restrictions, the SWBMT Programme was described as a *"low risk Tissue Establishment"* and allocated a virtual inspection.

It is therefore imperative that, on patient safety grounds, the quality bar is not lowered, and the requirements identified in this business case implemented in full. This will benefit patients with relapsed or refractory LBCL and mantle cell lymphoma, who receive CAR-T therapy via the SWBMT Programme, as well as patients with relapsed or refractory B-cell acute lymphoblastic leukaemia whom this business case proposes to repatriate from NHS England.

Inpatient capacity

Surge capacity constraints have been partially mitigated by the ambulatory care service and will be further mitigated by increasing autologous HSCT activity at SBUHB to 50 per annum. This will also allow patients with multiple sclerosis to undergo autologous HSCT in SBUHB. This has been on the BSBMTCT indications list since 2013 and approved by Health Technology Wales in 2020. However, these procedures are still not performed in Wales on capacity grounds, with eligible patients treated by NHS England at significant cost and negative patient and family experience. Any financial implications for the SBUHB service would be subject to a separate business case submission.

Until the new build at CVUHB is realised, capacity constraints will not be fully mitigated and there will be a residual, albeit reduced, risk of needing to outsource patients to NHS England during periods of extreme demand surges.

NEW PERSONNEL REQUIREMENTS

Medical staffing requirements

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a. **Consultant – CAR-T programme**

A single-handed consultant-led service is inherently unsafe and unsustainable. Further it is impossible for a single person to oversee the demands of compliance with

JACIE, HTA, MHRA and manufacturer-specific standards for a programme of any size, let alone one with a catchment area of ~80% of the Welsh population.

An additional **1.0 WTE** consultant is needed to oversee the acute lymphoblastic leukaemia pathway including delivery of CAR-T. This person will make it feasible to meet the WHSSC/JCC specification for the delivery of CAR-T for this indication and will share the regulatory demands of the overarching CAR-T service. The provision of cross-cover between the two CAR-T consultants would add robustness and to the service, improve sustainability and reduce existing staff exhaustion and burnout.

b. Consultant – Palliative Care

No provision was made for palliative care in the Phase 1 business case. As previously described, 60% of patients will fail CAR-T so there is a need to establish an advance care planning clinic and support patients through the emotional challenge of repeated treatment offering uncertain cure. Palliative care input would be critical for the success of these initiatives. The requirement is for **0.2 WTE.**

c. CAR-T Fellow – Lymphoma and Leukaemia

There is a need for **1.0 WTE** middle grade cover to assist with the day-to-day management of patients as well as provide out-of-hours cover. This would be analogous to the improvement provided by the BMT Fellow in the HSCT programme.

Nursing requirements

d. CAR-T Nurse Practitioner

This post is required to oversee the entire CAR-T service (lymphoma and repatriated leukaemia patients). The nurse practitioner would lead the advance care planning and late-effects clinics and take responsibility for discharge planning of uncomplicated patients. The postholder would also contribute to staff training, quality and regulatory compliance. The requirement is **1.0 WTE Band 7**.

e. Apheresis Clinical Nurse Specialist – CAR-T Programme

The initial Phase 1 allocation was 0.5 WTE Band 6 apheresis operator to assist with procedures and absorb increased requirement. Experience from the initial 4½ years of running the CAR-T service has shown that the apheresis procedures have stabilised with CAR-T used second line in LBCL replacing autologous HSCT. The greater requirement is a lead for this component of the apheresis service due to the disproportionate regulatory burden and the associated training requirements, with the postholder still contributing to the operational requirement. The new requirement is for **1.0 WTE Band 7** (uplifted from 0.5 WTE Band 6).

f. CAR-T Clinical Nurse Specialist – Leukaemia

This post is required to enable repatriation of patients with B-cell acute lymphoblastic leukaemia from NHS England. This post is analogous to the existing CAR-T CNS Lymphoma post and the postholders would provide cross-cover for each other. The requirement is **1.0 WTE Band 6**.

Allied Health Professionals

g. Physiotherapist

No provision was made for physiotherapy in the Phase 1 business case. Adoption of a prehabilitation programme has resulted in significant improvement in the condition of potential patients enabling greater fitness prior to admission. This is particularly important because these patients are not in remission and typically receive holding and bridging radio-immuno-chemotherapy whilst awaiting apheresis and subsequent CAR-T manufacture.

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Due to the known debilitating effects of treatment, adequate physiotherapy input in the pre-CAR-T phase is critical to maximising the number of patients who regain and retain fitness for treatment, thereby reducing attrition on the CAR-T pathway. This input continues during the inpatient and post-discharge phases to shorten the rehabilitation period. The requirement is **1.0 WTE Band 6**.

h. Dietitian

The Phase 1 allocation was 1.0 WTE Band 6. However, due to the complexity of the patient group, the short window to effect improvement and ongoing dietetic needs post treatment, the appropriate banding for this post is Band 7. The requirement is therefore upgraded to **1.0 WTE Band 7** (uplifted from Band 6).

i. Clinical Psychologist

The Phase 1 allocation was 1.0 WTE Band 8a, the same as allocated to the BMT programme. To provide robustness and sustainability, the services merged to provide seamless provision. Despite this initiative, the service struggled to cope with demand, due to the high level of distress in this patient group, making it challenging to cope with NICE recommendations on psychology provision.

Compounding the above was the frequent staff turnover resulting in repeated service disruption. It was later explained that clinical psychologists at Band 8a are in the post-qualification stage of training and often change posts every 12-18 months until securing a higher banded permanent post. This is clearly unsatisfactory for a patient group facing repeated uncertainty regarding survival as previously described.

To address these challenges, the Macmillan psychology service at CVUHB has designed a new model to provide more stability whilst allowing for career progression. It also needs to be appropriately banded given the acute lymphoblastic leukaemia cohort of patients start at age 16. The additional requirement is **0.6 WTE Band 8c and 0.24 WTE Band 5**.

Clinical and Biomedical Scientists

j. Processing Facility

No provision was made for the Stem Cell Processing Unit (SCPU) in Phase 1. This was a significant oversight since the SCPU plays a pivotal operational role in the pre-manufacture stage with a significant JACIE, HTA and manufacturer-specific regulatory burden. On receipt of the CAR-T product, MHRA regulations apply since the ATMP returns as a drug. The regulatory burden is disproportionate to the number of patients being agnostic of clinical activity. The requirement is **1.0 WTE Band 7** Biomedical scientist and **1.0 WTE Band 4** for administrative and quality management support.

k. Neurophysiology

There was provision in Phase 1 for consultant neurology and neurophysiology support of the CAR-T service. However, no provision was made for technician support to perform the EEGs needed at baseline or to assist in the management of ICANS. The requirement is for **0.5 WTE Band 6** EEG technician.

Administrative, clerical and other supporting roles

l. IT support officer

The lack of a validated database was identified as a regulatory risk by both the HTA and JACIE inspectorates. Following a competitive tender process, CVUHB invested in StemSoft, a configurable database specific for cellular therapy programmes. The SWBMT Programme is still in the configuration and validation phases, but this will be an ongoing requirement as regulatory standards are tightened, software updates introduced, and service developments implemented. Prior to investing in StemSoft,

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the HTA described the system of depending on Excel spreadsheets as, "user-intensive, user-dependent and obsolete".

In addition to StemSoft, all controlled documents are stored on QPulse, a document control repository that is compliant with regulatory standards.

Due to the wide catchment area of the SWBMT Programme shared-care arrangements are in place to facilitate treatment nearer to home when desirable. To this end all treatment protocols were located on the CVUHB intranet with open access via any NHS Wales computer. CVUHB recently discontinued support for the Oracle system on which the intranet was based, switching to SharePoint. This immediately rendered protocols invisible to customer LHBs, posing a clinical risk. IT support is needed to create new "web pages" to facilitate NHS Wales-wide access thereby reducing the risk associated with this change. There will be an ongoing need for maintenance of SharePoint as documents are updated with changes in service delivery.

For all the above initiatives, ongoing IT support will be essential. The requirement is for **1.0 WTE Band 6** IT Support Officer.

m. CAR-T pathway coordinator – Leukaemia
It has already been demonstrated that the CAR-T pathway is very complex with numerous hurdles to be overcome as the patient traverses the treatment pathway. To facilitate timely referral, access to CAR-T therapy and assistance with data collection and analysis for regulatory compliance, a coordinator would be needed to support the entire B-cell acute lymphoblastic leukaemia pathway, including CAR-T delivery. The requirement is for **1.0 WTE Band 4** CAR-T/ALL pathway coordinator.

n. Secretarial support
This post is required to support the new consultant and other clinical staff to be appointed as a result of this business case. The requirement is for **0.5 WTE Band 4** secretary.

Workforce Requirements

Area of Investment	Band	Phase 2 (wte)	24/25 PYE	FYE	Comment
Consultant CAR-T and acute lymphoblastic leukaemia (ALL)	Cons	1.00	£75,988	£151,975	The consultant would provide cross cover to the existing CART consultant who is single handed but also allow us to bring in ALL CART to Cardiff
Consultant Palliative Care	Cons	0.20	£15,198	£30,395	No Phase 1 allocation. Clear need for advance care planning, MHRA-compliant late-effects clinic and ongoing palliative care provision along treatment pathway
CAR-T Fellow	CF	1.00	£54,516	£109,032	To support lymphoma and ALL pathways including out-of-hours service
CAR-T Nurse Practitioner	7	1.00	£32,061	£64,123	New post. Required to oversee combined lymphoma and leukaemia CAR-T delivery and to support Phase 2 nurse-led initiatives: discharge reviews, advance care planning, late-effects clinic.
Apheresis CNS	6	0.50	£18,460	£36,919	Uplift from 0.5wte Band 6 to 1.0 Band 7 - Initial requirement was to increase apheresis capacity but greater need is to lead the CAR-T component of the apheresis

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					service, given the regulatory burden, including training and documentation to maintain regulatory compliance whilst still contributing to operational workforce.
CAR-T and ALL CNS	6	1.00	£27,204	£54,407	New post. To support repatriation of patients with B-cell acute lymphoblastic leukaemia from NHS England and to provide cross-cover to lymphoma CAR-T CNS.
AHP - Physiotherapy	6	1.00	£27,204	£54,407	No Phase 1 allocation. Significant input received in prehab to get patients fit for CAR-T and maintenance in later stages on pathway.
AHP - Dietetics	7	0.00	£4,858	£9,715	Revision of Phase 1 allocation from 1.00wte band 6 to 1.00wte band 7 - The new banding reflects the significant prehabilitation requirement given patients often receive holding and bridging therapy whilst awaiting CAR-T manufacture and admission. Improving and maintaining dietetic health is paramount to achieve and maintain fitness along the pathway
AHP - Psychology	8C	0.60	£26,474	£52,947	New model needed due to the significant turnover with previous allocation - Revised banding allocation across Psychology provision would provide stability and career progression
AHP - Psychology	5	0.24	£5,269	£10,538	As above
Clinical Scientist – Stem Cell Processing Unit	7	1.00	£32,061	£64,123	No allocation in phase 1 - Pivotal operational role at pre-manufacture stage with significant, disproportionate regulatory burden. Post-manufacture storage needs to be MHRA-compliant.
Quality administration support	4	1.00	£17,394	£34,787	Needed for administrative and quality management support for the Stem Cell Processing Unit.
Neurophysiology technician	6	0.50	£13,602	£27,204	No allocation in phase 1. Required to provide EEG service given the increased demand and with 40% of patients experiencing ICANS. No technician time included in phase 1 and demand greater than anticipated
IT Support Officer	6	1.00	£27,204	£54,407	No allocation in phase 1. Need to address regulatory risk identified by the HTA and JACIE. The SWBMT Programme has invested in a database, StemSoft. This will require ongoing configuration, validation and upgrades to continue to meet the needs of the service.
Clinical pathway co-ordinator	4	1.00	£17,394	£34,787	New post. Required to support repatriation and delivery of ALL CAR-T and to facilitate regulatory compliance
Secretarial support	4	0.50	£8,697	£17,394	New post. Essential to cover new consultant appointee and related administrative and regulatory duties

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Sub-total pay		11.54	£403,581	£807,161	

Non-pay		Cost per patient	No. pnts p.a.	24/25 PYE	FYE	Comment
Clinical supplies		£5,638	7	£19,731	£39,463	Baseline amended from 15 to 22 Infusions
Drugs		£1,128	7	£3,946	£7,893	Baseline amended from 15 to 22 Infusions
Pathology laboratories		£22,776	7	£79,715	£159,429	Baseline amended from 15 to 22 Infusions
Radiology		£1,128	7	£3,946	£7,893	Baseline amended from 15 to 22 Infusions
Sub-total non-pay		**£30,668**		**£107,339**	**£214,677**	
TOTAL				**£510,920**	**£1,021,838**	

	24/25 PYE	FYE	Comment
Accommodation for patients	**£4,900**	**£9,800**	Funding for a fortnight's stay at £100 per night for each patient (should this be necessary).
Overheads	**£51,092**	**£102,184**	
Combined cost	**£566,911**	**£1,133,822**	

The outcome of the option appraisal should be stated here along with:

- *Assessment of the +/- impact of this option on other services*
- *Any dependencies (internal and external) that this option relies upon*

Impact on other services

SWBMT Clinical Programme: Positive impact from right-sizing, improving staff welfare by reducing exhaustion and burnout due to understaffing

SWBMT Collection Facility: Positive impact from right-sizing to facilitate compliance with HTA, JACIE, MHRA and manufacturer-specific standards

SWBMT Processing Facility: Positive impact from right-sizing to deal with operational workload and to facilitate compliance with HTA, JACIE, MHRA and manufacturer-specific standards

Palliative Care: Positive impact from funding to allow introduction of advance care planning and late-effects monitoring which currently do not exist. Secure funding will remove current ad hoc input along the treatment pathway

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Neurology: Positive impact since this Phase 2 allocation would allow for repatriation of autologous HSCT for multiple sclerosis from NHS England to Wales and will be delivered at SBUHB

Physiotherapy: No prior funding allocation. Positive impact from funding to address prehab and maintenance needs for this population who need to progress to treatment with minimal delay. Current provision is from the BMT service at the expense of the BMT patient population

Dietetics: Positive impact from right-sizing to cope the increased demands associated with this patient population to ensure appropriate level of care

Psychology: Positive impact from right-sizing to provide a more stable service and reduce staff turnover. Current post has been vacant since August 2023 and unable to recruit due to inadequate model. This has been to the detriment of this patient group as exemplified in the case histories.

Neurophysiology: Positive impact from provision of 0.5 WTE Band 6 technician to perform EEGs as clinically indicated. Previous allocation was for consultant input to read scans and advise on treatment but not for the actual performance of the scans.

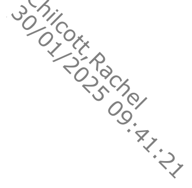
No negative impact on other services deployed with the Phase 1 allocation since these were remain right-sized.

Dependencies on other services

Ambulatory Care Unit: This expansion will demand a pro rata increase in ambulatory care activity. There is adequate staffing but there is a risk relating to capacity since the footprint is limited. Demand has not yet exceeded capacity but this would need to be kept under review.

Clinical Transplant Programme, SBUHB: This Phase 2 proposal is dependent on the Clinical Programme at SBUHB performing c.50 procedures per annum to release an additional BMT bed at CVUHB to facilitate the increased number of CAR-T patients. It is also dependent on facilitating the repatriation of autologous HSCT from NHS England to Wales which will be financially advantageous to NHS Wales.

SBUHB is already funded to perform 50 procedures per annum and their physical facilities are superior to those at CVUHB and meet JACIE standards, leading to a better inpatient experience for transferred patients. However, there is not the same level of allied health professional (AHP) input to ensure that patients experience the same level of care. This is already under review and may result in a separate business case submission to right-size for the AHP aspect of service provision at SBUHB.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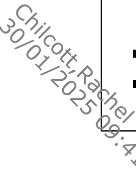
7.1 Benefits

This section must outline both the quantifiable and non-quantifiable benefits associated with the proposal. The measures by which quantifiable benefits will be tracked should be included.

Quantifiable benefits	***Non-quantifiable benefits***
Key Performance Indicators (KPIs): In compliance with JACIE standards, KPIs are presented annually to stakeholders, including the commissioners. Meetings are recorded and data circulated on request. The KPIs associated with the benefits of the Phase 2 investment are listed below. Where these apply to a specific CAR-T indication this will be indicated. **Pathway benefits:** ▪ Increase in referral capacity from 10-15 per annum to 25-27 per annum. ▪ Sustained increase in pathway efficiency from 67% to 77% of referred patients proceding to CAR-T infusion. ▪ Reduction in CAR-T pathway timelines: “Brain-to-vein” and “vein-to-vein” times will be benchmarked and presented annually. ▪ Increase in CAR-T infusions from 10-13 per annum to 20-22 per annum. ▪ Repatriation of TYA patients aged 16-25 with ALL to Wales. ▪ Repatriation of adult patients aged 26 and over with ALL to Wales. ▪ Repatriation of autologous HSCT in multiple sclerosis to Wales. ▪ Introduction of advance care planning clinic. ▪ Introduction of late-effects clinic. ▪ Maintenance of regulatory compliance. **Patient outcome benefits:** ▪ Increase in survival due to increased CAR-T infusions: 40% for LBCL patients who receive CAR-T compared to <10% for patients who do not (Figure 10). ▪ Potential increase in cure rate due to increased CAR-T therapy: Patients with LBCL in remission 1 year post CAR-T have 5-year survival of >90%, implying cure. This will be presented annually. ▪ Improved patient fitness due to prehab. ▪ Reduced length of stay due to prehab.	▪ Improved patient experience ▪ Less patient travel ▪ Reduced patient and family costs ▪ Improved patient and family wellbeing from psychology and palliative care ▪ Improved staff training and retention ▪ Improved nursing and AHP career progression opportunities ▪ Less staff burnout ▪ Improved staff morale ▪ Reduced carbon footprint ▪ Reduction in reputational risk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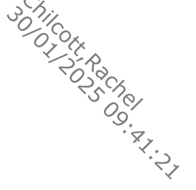
CARING FOR PEOPLE, KEEPING PEOPLE WELL
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

7.1.1 Benefits tracker

This section must see the benefits realisation tracker (below) completed for all quantifiable beneifits. Where cases are approved this will form a key part of future review meetings with IG and provide assurance as to how benieifts are being tracked.

Benefit	Metric	Baseline	Target	Timeline / Ambition
Increased capacity for LBCL referrals	Number of new patients seen annually Number of patients outsourced to NHS England	10-15	20-25	Within 6 months of investment
Increased pathway efficiency	Percentage of referred patients who proceed to CAR-T infusion	67%	75-77%	Within 6 months of investment
Reduction in pathway timelines	Brain-to-vein time Vein-to-vein time	Median 55 days Median 30 days	At or below UK median (where available) At or below UK median (where available)	Within 6 months of investment. Expected to be variable and may be different for different CAR-T indications and with patient volume. Where available, benchmarked data to be presented at annual review meetings, otherwise internal year-on-year comparisons would be used.
Repatriation of patients with ALL from NHS England	Number of new patients seen annually	0	0-3	Within 3 months of appointment of CAR-T consultant
Availability of prehab	Number of NCCP-approved patients who get prehab	>90%	>90%	Immediately following investment
Psychology assessment	Number of NCCP-approved patients assessed by psychology team	Initially 100% falling to 0% since August 2023 due to lack of staff retention	100%	Within 6 months of investment and establishment of new model
Advance care planning	Percentage of referred patients who attend advance care planning clinic	0	>80% of patients approved by NCCP	Within 3 months of investment
Late effects monitoring	Number of patients who attend late effects clinic	0	>80% of patients surviving in remission for more than 1 year	Within 3 months of investment
Regulatory compliance	Relevant JACIE, HTA and MHRA standards	Full compliance. Maintenance of JACIE accreditation and HTA licensing	Full compliance. Maintenance of JACIE accreditation and HTA licensing	Immediately following investment. Some aspects of JACIE accreditation are outside the control of the team (e.g. facilities)
Repatriation of autologous HSCT in patients with multiple sclerosis to Wales	Number of patients who receive autologous HSCT for multiple sclerosis	0	0-5	Within 6 months of investment



7.2 Risk

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

Risk Title	Descriptor	Probability (1-5)	Impact (1-5)	Total risk score (PxI)	Mitigating Action	Owner
Impact of increased patient numbers on the overall BMT/CAR-T patient pathway including bed availability	Increased numbers of both LBCL patients and the addition of patients with ALL receiving CART. These patients are complex and managing their pathway needs significant input with decisions sometimes needing to be made rapidly. Risk of the number of complex patients that are needing to be admitted for treatment at the same time and not having the capacity to house them will be ongoing and need significant management. **The long-term management and resolution of this risk will depend on a separate business case (in-progress) for a new and expanded ward to house patients treated with cellular therapies and is not included in this business case.**	4 Probable	3 Medium	12 Major (significant impact on patients who cannot be acomodated in CVUHB)	Implementation of the ambulatory model at all applicable parts of the pathway for eligible patients. Maintenance of minimum pathway duration to minimise requirement for inpatient beds. Optimisation of the autologous HSCT pathway to increase the number of procedures at SBUHB to 50 p.a.. Agreement with King's College Hospital in London with an agreed pathway for CAR-T patients who cannot be accomodated in CVUHB due to extreme demand surges.	Haematology directorate
Impact on BMT/CAR-T clinical workforce	Increased numbers of patients with lymphoma and the addition of patients with leukaemia repatriated from NHS England would increase overall patient acuity with a higher number of patients experiencing adverse events simultaneously. This requires increased staffing resource at all levels with a richer skillmix including consultant, clinical fellow specialist registrar and specialist nurse input in and out-of-hours.	3 Possible	3 Medium	9 Moderate	Addition of consultant as well as a clinical fellow in this business case will reduce dependency on a single-handed consultant. The additional consultant will lead on the leukaemia CAR-T pathway with cross-cover to/from the lymphoma CAR-T consultant increasing the robustness of the overall service. The Nurse Practitioner-led initiatives in discharges, advance care planning and late-effects monitoring (with palliative care consultant support would reduce reliance on the CAR-T consultants, increasing sustainability of the service. The addition of an apheresis lead nurse for CAR-T would increase capacity for increased collections and provide regulatory oversight for apheresis.	Haematology directorate
Impact on BMT/CAR-T non-clinical workforce	Increased numbers of patients with lymphoma and the addition of patients with leukaemia repatriated from NHS England to increase in thwould increase the downstream requirements associated with the service and negatively impact on scientific and administrative staff of the Stem Cell Progessing Unit which is operating at capacity to dleiver the	2 Unlikley	4 High	8 Moderate	Increased staffing both at senior and administrative level allows for improved capacity to handle complex CAR-T pathway for aphersis prodcuts and manufactured CAR-T products. Compliance with JACIE, HTA, MHRA and manufacturer-specific standards are mandatory.	Laboratory medicine and Haematology Directorate

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	transplant programme. No provision was made for the increased workload and associated regulatory burden inherent in introducing the CAR-T service.					
Impact on supporting specialties to be able to have the capacity to respond appropriately, e.g. rapidly for post infusion complications	As above, increased numbers of both DLBCL patients and the addition of patients with ALL following the pathway to CAR-T. Increased numbers will need potential neurology input/review, incresed numbers of EEGs, ITU input/review/bed days, palliative care input, physiotherapy input.	3 Possible	3 Medium	9 Moderate	This business case includes resource for several suupporting specialities noting that the pathway and delivery of CAR-T relies on a signifcant mix of specalist input usually within very short time-frames. This increase should allow the CAR-T pathway numbers to be able to be increased safely.	Cardiff and Vale UHB

Key: 5 x 5 matrix

5x5 RISK MATRIX

PROBABILITY					
Highly Probable	5 Moderate	10 Major	15 Major	20 Severe	25 Severe
Probable	4 Moderate	8 Moderate	12 Major	16 Major	20 Severe
Possible	3 Minor	6 Moderate	9 Moderate	12 Major	15 Major
Unlikely	2 Minor	4 Moderate	6 Moderate	8 Moderate	10 Major
Rare	1 Minor	2 Minor	3 Minor	4 Moderate	5 Moderate
	Very Low	Low	Medium	High	Very High

IMPACT

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7.3 Total Cost - Resource Implications and Affordability

This table should be the sum of annex a,b and c which provides the detailed break.

	Year 1 £	Year 2 £	Year 3 £
TOTAL RECURRENT (not formula driven - complete)	£566,911	£1,133,822	£1,133,822
TOTAL NON-RECURRENT (not formula driven - complete)			

Assumed start date	01/10/24
Funding Source Revenue:	JCC
Funding Source Capital:	

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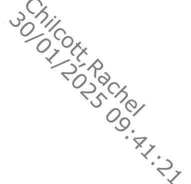
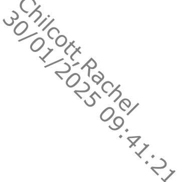
The below table illustrates the uplift required in phase 2 in relation to the phase 1 infrastructure investment and the overall cost per referral:

	Phase 1	Phase 2	Total
Area of Investment	**WTE**	**WTE**	**WTE**
Consultant - BMT	1.00		1.00
Consultant CAR-T and acute lymphoblastic leukaemia		1.00	1.00
Consultant Palliative Care		0.20	0.20
CAR-T Fellow		1.00	1.00
Consultant – Neurologist / Neurophysiologist	0.20		0.20
Consultant - Radiologist	0.20		0.20
Consultant – Haematologist (lymphoma/leukaemia)	0.20		0.20
Consultant - ITU	0.10		0.10
Consultant - Histopathology	0.10		0.10
Consultant - Immunology	0.10		0.10
Sub Total Medical Staff	**1.90**	**2.20**	**4.10**
Clinical Nurse Specialist	1.50	1.50	3.00
CAR-T Nurse Practitioner		1.00	1.00
Nursing (ward)	4.23		4.23
Practice Educator	1.00		1.00
Sub Total Nursing Staff	**6.73**	**2.50**	**9.23**
Medical secretary	0.50	0.50	1.00
Administration & MDT Co-ordinator	1.00		1.00
Quality Manager	1.00		1.00
Quality administration support		1.00	1.00
Data Manager	1.00		1.00
IT Support Officer		1.00	1.00
Clinical pathway co-ordinator		1.00	1.00
Sub Total Admin & Support Staff	**3.50**	**3.50**	**7.00**
Clinical Scientist		1.00	1.00
Neurophysiology technician		0.50	0.50
Pharmacist	1.00		1.00
Occupational Therapist	1.00		1.00
AHP - Physiotherapy		1.00	1.00
Dietician (uplift to 7)	1.00		1.00
Psychologist	1.00	0.84	1.84
Sub Total Allied Health Professional Staff	**4.00**	**3.34**	**7.34**
Total Staffing Infrastructure Requirement	**16.13**	**11.54**	**27.67**
Revenue Requirement £	1,093,663	807,161	1,900,824
Estimated Referrals	15	12	27
Staffing Cost Utilisation per Referral £	72,911	67,263	70,401



REVENUE	WTE	Band/ Scale	Recurrent/ Non-Rec	Cost Year 1 Part Year	Cost Year 2	Cost Year 3
Direct Pay Costs - Staff Type	**WTE**		**R / NR**	**£**	**£**	**£**
Consultant CART and ALL	1.00	Cons	R	£75,988	£151,975	£151,975
CART Fellow	1.00	Cons	R	£54,516	£109,032	£109,032
Consultant Palliative Care	0.2	Cons	R	£15,198	£30,395	£30,395
CAR-T Nurse Practitioner	1.00	B7	R	£32,061	£64,123	£64,123
Apheresis Nurse (uplift from 0.5 B6)						
CAR-T and ALL CNS	1.00	B6	R	£27,204	£54,407	£54,407
SCPU						
Clinical Scientist	1.00	B7	R	£32,061	£64,123	£64,123
Quality administration support	1.00	B4	R	£17,394	£34,787	£34,787
AHP						
Physiotherapy*	1.00	B6	R	£27,204	£54,407	£54,407
Dietician (Uplift from B6)	0.0	B7	R	£4,858	£9,715	£9,715
Psychology	0.60	8C	R	£26,474	£52,947	£52,947
	0.24	B5	R	£5,269	£10,538	£10,538
Clinical pathway co-ordinator	1.00	B4	R	£17,394	£34,787	£34,787
Neurophysiology Technician	0.50	B6	R	£13,601	£27,204	£27,204
IT Support Officer	1.00	B6	R	£27,204	£54,407	£54,407
Clinical pathway co-ordinator	1.00	B4	R	£17,394	£34,787	£34,787
Secretarial support	0.50	B4	R	£8,697	£17,394	£17,394
TOTAL PAY	**11.54**			**£403,581**	**£807,161**	**£807,161**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REVENUE	WTE	Band/ Scale	Recurrent/ Non-Rec	Cost Year 1 Part Year	Cost Year 2	Cost Year 3
Direct Non-Pay	**WTE**		**R / NR**	**£**	**£**	**£**
Clinical Supplies			R	£19,731	£39,463	£39,463
Drugs			R	£3,946	£7,893	£7,893
Pathology laboratories			R	£79,715	£159,429	£159,429
Radiology			R	£3,946	£7,893	£7,893
Accommodation for patients			R	£4,900	£9,800	£9,800
Overheads			R	£51,092	£102,184	£102,184
Impact on Support Departments						
Pharmacy						
Therapies						
Outpatients/Medical Records						
Radiology						
Medical Physics						
Laboratory Medicine						
Theatres						
Anaesthetics						
Facilities - catering, domestics, waste, linen						
xx						
Other - specify including overheads (inc finance/HR etc.)						
xx						
Infrastructure						
Estates Maintenance/Premises						
Utilities						
Rates						
Information Technology/Telecoms						
Revenue Consequence of Capital spend below						
TOTAL PAY				**£163,330**	**£326,661**	**£326,661**

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this should be identified and detailed and, if known, whether this is agreed as part of the UHB's Capital Programme.

CAPITAL	Year 1	Year 2	Year 3
	£	£	£
xx			
xx			
xx			
TOTAL	0	0	0

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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.**

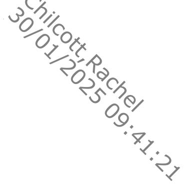
For 2023 this means:

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



Report Title:	2024-25 Month 3 Monthly Financial Monitoring Return			Agenda Item no.	4.1	
Meeting:	Finance Committee	Public	X	Meeting Date:	21 August 2024	
		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 (2024) 026 - Welsh Government 2024/25 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 C3), to provide the Committee with transparency on the submission made to the Welsh Government.

A copy of the June 2024/25 MMR is attached.

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

The extracts from the UHBs Monthly Financial Monitoring Return are provided for information and assurance.

Recommendation:

The Board / Committee is requested to:

NOTE the extracts from the UHBs Monthly Financial Monitoring Returns.

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.

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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:	

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THE WELSH GOVERNMENT FINANCIAL COMMENTARY

FINANCIAL POSITION FOR THE THREE MONTH PERIOD ENDED 30th JUNE 2024

INTRODUCTION

The Health Board submitted an initial draft financial plan to Welsh Government at the end of March 2024.The draft plan incorporated: -

- Brought forward underlying deficit of £60.9m
- 2024/25 Demand and cost growth and unavoidable investments of £45.4m
- Additional Allocations of £37.3m
- Anticipated pass-through funding on Long Term Agreements of £5.9m (3.67%)
- A £47.2m Savings programme

This results in a 2024/25 planning deficit of £15.9m.

The draft plan assumes that the 2024/25 cost of the RLW, being paid to staff directly employed by the UHB will be funded through the 2024-25 pay award funding in addition to non recurrent funding for the impact of the policy on the social/third sector.

At Month 3 the UHB is reporting an overspend of £11.564m.

This is comprised of £5.151m unidentified savings, £2.438m of operational overspend and the planned deficit of £3.975m (three twelfths of the annual planned deficit of £15.9m set out in 2024-25 financial plan approved by the UHB Board and submitted to Welsh Government).

BACKGROUND

The Board agreed and submitted a draft financial plan to Welsh Government at the end of March 2024. A summary of the draft financial plan submitted is provided in Table 1.

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Table 1: 2024/25 Draft Plan

	£m	
	2024/25	2025/26
Planned Opening Deficit	**16.5**	15.9
Non Recurrent Welsh Government (WG)Funding 2023/24	17.2	
Shortall on 2023/24 Recurrent Savings	15.2	
Recurrent Operational Pressures	12.0	
Estimated Demand Growth / Inflationary Pressures	40.4	40.0
Essential service investments	5.0	5.0
Gross Deficit £m	**106.3**	**60.9**
WG Core Uplift	(37.3)	(24.0)
WG Core Uplift - pass through funding on LTAs	(5.9)	
Savings Target	(47.2)	(36.9)
Planned Financial Position £m	**15.9**	**0.0**

This represents the draft financial plan of the Health Board.

These financial monitoring returns have been prepared within the framework of the UHB's submitted Draft Financial Plan, which includes a planning deficit of £15.9m for 2024-25. This report details the financial position of the UHB for the period ended 30th June 2024.

A full commentary has been provided to cover the tables requested for the month 3 financial position.

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

Table A sets out the draft financial plan and latest position at month 3 for which the following should be noted:

- The UHB's 47.2m 2024/25 savings target is reported on lines 8 & 9.
- It is assumed that LTA inflation of £5.9m (3.67%) will be passed to the UHB from other Health Boards.
- The bought forward underlying deficit is £60.9m as outlined in the draft financial plan.

The identification and delivery of the £47.2m recurrent savings target is key to delivery of the planned in year and underlying position.

The forecast carry forward underlying deficit at year end 2024/25 is reported at £15.900m and reflects the forecast included in the 2024/25 Draft Financial Plan.

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OVERVIEW OF KEY RISKS & OPPORTUNITIES (TABLE A2)

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

The UHB's Financial Plan was based on the clear planning instructions from Welsh Government that all LTAs and SLAs should reflect uplifts in line with the general 2024-25 funding uplift provided in the 2024-25 Allocation Letter of 3.67%. The UHB has received and agreed offers, from a number of commissioners, which offered a range of percentage uplifts some of which were lower than 3.67% and proposed additional delivery of services from C&V UHB. Elements of income will be contingent on improved LTA outturn performance and this remains a risk for the UHB.

In addition, the exposure to additional operational pressures has increased from £2m to £4m. This reflects the following:

- Significant numbers of mental health patients having to be accommodated in out of area placements due to in patient demand and lack of capacity within the UHB's own facilities.
- The new Optometry contract agreed between Welsh Government and community opticians in Wales which has seen increased costs arising during implementation in 2024-25 where the UHB is awaiting confirmation of additional funding.
- Increased specialling costs arising from the additional mental health support needed in respect of complex behavioural patients on a number of medical wards across UHW and UHL
- Residual costs of additional capacity programmes where non recurrent funding has now ceased.

The following opportunities to curtail expenditure and recover additional income and funding will continue to be reviewed as the year progresses:

- Management of the operational pressures
- Efficacy and delivery of savings programmes
- Recovery of planned care overspend
- LTA Performance
- Slippage against specific expenditure programmes

ACTUAL YEAR TO DATE (TABLE B AND B2)

Table B confirms the year to date deficit of £11.564m which is an in month deterioration of £2.743m. The year to date deficit and the forecast deficit of £15.900m is shown in Table 2.

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Table 2: Summary Financial Position for the period ended 30th June 2024

	Month 3 Position £m	Forecast Year-End Position £m
Planned deficit	3.975	15.900
Savings Programme	5.151	0.000
Operational position (Surplus) / Deficit	2.438	0.000
Financial Position £m (Surplus) / Deficit £m	**11.564**	**15.900**

The month 3 deficit of £11.564m comprised of the following:

- £3.975m planned deficit
- £5.151m unachieved CRP gap
- £2.438m adverse variance against plan.

It is anticipated that the adverse operational variance of £2.438m and unachieved CRP gap at month 3 can be recovered as the year progresses and that the UHB will deliver its planned deficit position of £15.900m.

A central focus of Executive / Clinical Board Performance Reviews and sustainability meetings is on ensuring operational pressures are addressed and managed and that further progress is made in identifying and delivering recurrent savings schemes that in turn will de-risk the draft financial plan.

The UHB plan provides funding to cover both inflationary pressures incurred in 2023/24 and COVID consequential costs predominately relating to an increased bed base including Lakeside Wing. Continuing operational pressures were reported against medical staff budgets, specialing costs, continuing healthcare, planned care additional capacity and the revised national Optometry Framework in month 3. Progress in managing these costs will be closely monitored as the year progresses.

SOCNE / SOCNI Movement (Table B1)

An explanation of significant movements in the Forecast Income and Expenditure Categoris is provided in the response to queries arising from the previous monitoring return submission.

PAY & AGENCY (TABLE B2)

The UHB recorded Agency costs of £0.513m in month primarily due to nursing pressures. £0.370m of the costs recorded in June related to registered nursing and midwifery.

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COVID 19 ANALYSIS (TABLE B3)

At month 3, Table B3 reports forecast outturn expenditure due to COVID-19 to be £10.184m. This includes expenditure related to the Covid funding for Health Protection and PPE (£9.040m) and Long Covid (£1.144m) allocations.

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

Table 3: Summary of Forecast COVID 19 Net Expenditure

	Month 3 £m	Forecast £m	Funded by WG £m	Variance to Plan/Funding £m
Health Protection/Vaccination & PPE	2.260	9.040	9.040	0.000
Long Covid	0.286	1.144	1.144	0.000
Sub Total WG Funded Covid Expenditure £m	**2.546**	**10.184**	**10.184**	**0.000**

The Business Plan for the continuing Covid Programmes remains subject to review and the UHB expects to revise the profile of expenditure included in Table B3 in due course. The UHB plan assumes that any underspends against Covid funding will be retained by the UHB.

The UHB forecast is in line with the confirmed Welsh Government COVID Funding totaling £10.184m.

SAVINGS PROGRAMME 2024-25 (TABLE C, C1, C2 & C3)

At month 3, the UHB had identified £28.750m (61%) of green and amber savings to deliver against the £47.2m savings target leaving a further £18.450m schemes unidentified. This represents an increase of £7.761m from the £20.989m identified at month 2 and provides the UHB with some assurance that further schemes will continue to be identified and progressed to reduce the danger of not meeting the planned target. In addition, there are a further £12.497m of red schemes in the pipeline which will reduce the shortfall to £5.954m if delivered in year.

Overall performance in the identification of savings schemes (including red schemes) is outlined in table 4 below:

Table 4: Savings Schemes

	Total Savings Target £m	Total Savings Identified £m	Total Savings (Unidentified) £m
Total Identified Savings (green, amber & red) £m	47.200	41.246	(5.954)

The £5.151m deficit reported against the £47.2m savings plan is due to the straight-line phasing of the gap against the target over months 1 to 12. The

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position is expected to be recovered as further schemes develop over the financial year. The reported gap includes red schemes which are excluded from the Monthly Monitoring Returns savings tables, in accordance with the Welsh Government instruction. However, a proportion of red schemes are expected to deliver in 2024/25. At a 50% delivery level an additional £6.248m of savings schemes for 2024-25 would be reported as identified at Month 3.

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

INCOME/EXPENDITURE ASSUMPTIONS (TABLE D)

NHS organisations are expected to have concluded discussions and signed contracts (Long Term Agreements and Service Level Agreements) between each other by the end of June 2024. Failure to do so obliges parties to submit arbitration briefs to Welsh Government to deliberate on and make a ruling.

The UHB's Financial Plan was based on the clear planning instructions from Welsh Government that all LTAs and SLAs should reflect uplifts in line with the general 2024-25 funding uplift provided in the 2024-25 Allocation Letter of 3.67%. This uplift was reflective of the increased cost of providing healthcare and delivering services by provider organisations.

The UHB has received and agreed offers, from a number of commissioners, which offered a range of percentage uplifts some of which were lower than 3.67% and proposed additional delivery of services from C&V UHB.

Discussions were concluded without the need to resort to arbitration and with most LTAs being uplifted in line with the Welsh Government guidelines. Some settlements will recover the necessary income to support the anticipated plan position with improved output and productivity.

INCOME ASSUMPTIONS 2024/25 (TABLE E)

Table E outlines the UHB's 2024/25 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 draft financial plan assumes that the Directors of Finance agreement on LTAs is upheld by all parties in NHS Wales.

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It is understood WG included a sensitivity assumption in the Allocation of funding to support the Optometry contract reform. The revised Allocation has rebased historic funding with baselines linked in-part to activity projections. Cardiff and Vale may be more advanced in the current delivery and projections for Optometry and this is currently presenting a notable financial risk. It is assumed and anticipated that further allocation funding will be made available in-year to support contract reform and delivery and this is included in Table E assumptions at a forecast of £2m.

This risk was not assumed in the UHB's financial plan being an agreement between Welsh Government and the Optometry profession within Wales. In addition the costs incurred by Cardiff and Vale relate to patients of optometrists based in the C&V area who are not necessarily UHB residents.

BALANCE SHEET (TABLE F)

The opening balances at the beginning of April 2024 reflect the closing balances in the 2023/24 Draft Accounts.

MONTHLY CASFLOW FORECAST (TABLE G)

The closing cash balance at the end of June, was £2.181m.

The cashflow forecast projects a £15.900m deficit at year end in line with the UHBs planning deficit.

In due course, the UHB expects to seek Finance Committee and Board approval to request £15.900m strategic cash support from Welsh Government to cover the cash shortfall arising from the forecast deficit.

PUBLIC SECTOR PAYMENT PERFORMANCE (TABLE H)

The UHB's public sector payment compliance performance is above the target of 95%. Performance for the month to the end of June was 97.8%.

CAPITAL RESOURCE LIMIT, IN YEAR SCHEMES & DISPOSALS (TABLES I, J & K)

Of the UHB's approved Capital Resource Limit, 5% has been expended to date.

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The Mortuary scheme is slightly behind forecast year to date due to additional survey requirements however this is expected to deliver within year as are all other schemes.

Planned expenditure for the year reflects the CRL received from Welsh Government dated 20th June 2024 - £33.942m.

AGED WELSH NHS DEBTORS (TABLE M)

On the 31st of June 2024 there was 1 invoice raised by the UHB against other Welsh Government which had been outstanding for more than 17 weeks. The invoice has now been paid.

RING FENCED ALLOCATIONS (TABLE P)

Assumed funding and forecast expenditure in respect of Ring Fenced Allocations is reported in Table P. A balanced position is forecast and reported in year.

IFRS 16 (TABLE Q)

Lease costs, Interest, depreciation and dilapidations are reported at table Q.

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 next available meeting of the Finance Committee for information.

CONCLUSION

The UHB submitted a draft financial plan at the end of March 2024 which included a forecast deficit of £15.900m.

The UHB is committed to achieving in year and recurrent financial balance as soon as possible. The UHB currently has a draft financial plan for 2024-25 which aims to deliver financial stability and ensure that the underlying position is maintained. The plan includes a savings target of £47.2m.

The reported financial position for the first three months is a reported overspend of £11.564m which is £7.589m above the £3.975m straight line profile of the planned deficit.

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……………………………………….
SUZANNE RANKIN
CHIEF EXECUTIVE

11th July 2024

……………………………………….
ROBERT MAHONEY
DEPUTY DIRECTOR OF FINANCE

11th July 2024

Chilcott,Rachel
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Cardiff & Vale ULHB Period : Jun 24

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

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

		In Year Effect	Non Recurring	Recurring	FYE of Recurring	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	-60,900	0	-60,900	-60,900	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-15,225	-60,900
2	Cost Pressures (Non Covid-19) (Negative Value)	-45,400	-45,400			-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-11,350	-45,400
3	Planned Expenditure For Covid-19 (Negative Value)	-10,184	-10,184			-822	-822	-848	-837	-837	-837	-837	-882	-882	-882	-849	-850	-2,493	-10,184
4	Allocation Letter Revenue Funding Uplift / (Reduction)/ WG RRL / WG Income Uplift / (Reduction/ Non-Covid)	37,300	37,300			3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	9,325	37,300
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	10,184	10,184			822	822	848	837	837	837	837	882	882	882	849	850	2,493	10,184
6	Other Income Uplift / (Reduction)	5,900	5,900			492	492	492	492	492	492	492	492	492	492	492	492	1,475	5,900
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0	821	336	-125	194	-398	-126	-185	-49	-51	-50	-75	-291	1,032	0
8	Planned (Finalised) Green and Amber Savings Plan	20,272	8,928	11,344	13,549	890	1,348	1,805	1,485	2,076	1,805	1,730	1,773	1,775	1,774	1,799	2,014	4,042	20,272
9	Planned (Finalised) Net Income Generation	717	492	226	236	38	65	71	71	71	71	204	25	25	25	25	25	174	717
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0													0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0															0	0
12		0	0															0	0
13	Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	26,211	0	26,211	31,215	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	6,553	26,211
14	**Opening IMTP / Annual Operating Plan**	**-15,900**	**7,220**	**-23,120**	**-15,900**	**-1,326**	**-1,325**	**-1,324**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-3,975**	**-15,900**
15	Reversal of Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	-26,211	0	-26,211	-31,215	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-6,553	-26,211
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)	0	0															0	0
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0															0	0
18	Other Movement in Month 1 Planned & In Year Net Income Generation	-5	0	-5	0	0	-57	200	9	5	5	-155	-2	-2	-2	-2	-2	143	-5
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-390	-323	-67	-271	52	-389	72	464	-23	-36	-46	-89	-66	-69	-109	-150	-265	-390
20	Additional In Year Identified Savings - Forecast	7,765	4,980	2,786	2,949	0	0	1,771	628	623	676	699	702	688	636	623	718	1,771	7,765
21	Variance to Planned RRL & Other Income	0	0															0	0
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 plus virements (Positive Value - additional)	0	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0															0	0
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	0	0			0	0	0	0	0	0	0	0	0	0	0	0	0	0
25	In Year Accountancy Gains (Positive Value)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	0	0															0	0
27	Savings Gap / Savings Gap Recovery	13,689	0	13,689	28,536	-90	239	-397	1,083	1,579	1,540	1,686	1,573	1,565	1,620	1,672	1,618	-248	13,689
28	Operational Ovespend / Recovery	5,151	5,151		0	-719	-838	-881	843	843	843	843	843	843	843	843	843	-2,438	5,151
29		0	0															0	0
30		0	0															0	0
31		0	0															0	0
32		0	0															0	0
33		0	0															0	0
34		0	0															0	0
35		0	0															0	0
36		0	0															0	0
37		0	0															0	0
38		0	0															0	0
39		0	0															0	0
40	**Forecast Outturn (- Deficit / + Surplus)**	**-15,900**	**17,028**	**-32,927**	**-15,900**	**-4,267**	**-4,554**	**-2,743**	**-482**	**-482**	**-482**	**-482**	**-482**	**-482**	**-482**	**-482**	**-482**	**-11,564**	**-15,900**
41	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**				**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
42	**Operational - Forecast Outturn (- Deficit / + Surplus)**	**-15,900**				**-4,267**	**-4,554**	**-2,743**	**-482**	**-482**	**-482**	**-482**	**-482**	**-482**	**-482**	**-482**	**-482**	**-11,564**	**-15,900**

Chilcott, Rachel 30/01/2025 09:

Cardiff & Vale ULHB

Period : Jun 24

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

This Table is currently showing 0 errors

#	Category	Line	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	YTD as %age of FY *YTD variance as %age of YTD*	Assessment Green £'000	Assessment Amber £'000	Full In-Year forecast non recurring £'000	Full In-Year forecast recurring £'000	Full-Year Effect of Recurring Savings £'000
1	Pay	Budget/Plan	466	585	582	652	823	777	773	815	789	788	813	813	1,634	8,678		0	115			
2		Actual/F'cast	497	399	911	1,116	932	936	942	945	931	875	862	957	1,807	10,301	17.54%	10,040	261	4,813	5,488	6,345
3		Variance	30	(186)	329	463	109	158	169	130	141	86	48	144	174	1,623	*10.62%*	10,040	146			
4	Non-Pay	Budget/Plan	259	479	810	508	727	594	601	601	629	629	629	845	1,548	7,311		6,229	1,083			
5		Actual/F'cast	287	259	2,184	971	1,058	914	908	908	933	933	928	1,120	2,730	11,404	23.94%	10,338	1,066	7,982	3,422	3,695
6		Variance	28	(219)	1,374	463	331	320	307	307	304	304	299	275	1,183	4,093	*76.42%*	4,109	-16			
7	Primary Care - Drugs & Appliances	Budget/Plan	105	106	106	106	106	106	106	106	106	106	106	106	317	1,268		1,268	0			
8		Actual/F'cast	105	170	174	197	197	197	212	212	212	212	212	212	449	2,311	19.44%	2,219	92	0	2,311	2,928
9		Variance	(0)	64	69	91	91	91	106	106	106	106	106	106	132	1,043	*41.78%*	951	92			
10	Secondary Care Drugs	Budget/Plan	14	133	260	171	161	238	161	161	161	161	161	161	406	1,940		1,940	0			
11		Actual/F'cast	8	85	326	205	183	260	183	183	183	183	174	157	419	2,133	19.66%	2,133	0	280	1,853	2,271
12		Variance	(6)	(48)	66	35	23	23	23	23	23	23	14	(4)	13	194	*3.22%*	194	0			
13	CHC/FNC	Budget/Plan	45	45	48	48	260	90	90	90	90	90	90	90	138	1,075		565	510			
14		Actual/F'cast	45	45	52	89	307	137	137	137	137	137	137	137	142	1,498	9.50%	801	697	510	988	988
15		Variance	0	0	5	41	47	47	47	47	47	47	47	47	5	423	*3.47%*	236	187			
16	Primary Care Contractor	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Healthcare Services Provided by Other Healthboards	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
20		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
22	Non-healthcare Services Provided by Other Healthboards	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
23		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
24		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
25	Other Private & Voluntary Sector	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
26		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
27		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
28	Joint Financing & Other	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
29		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
30		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
34	Total	Budget/Plan	890	1,348	1,805	1,485	2,076	1,805	1,730	1,773	1,775	1,774	1,799	2,014	4,042	20,272		10,001	0			
35		Actual/F'cast	942	959	3,648	2,577	2,676	2,444	2,382	2,386	2,397	2,340	2,313	2,582	5,548	27,647		25,531	2,116	13,585	14,062	16,228
36		Variance	52	(389)	1,843	1,092	600	640	653	613	622	567	514	568	1,506	7,375		15,530	2,116			
37		Variance in month	5.89%	(28.85%)	102.13%	73.58%	28.91%	35.44%	37.72%	34.58%	35.03%	31.95%	28.60%	28.20%	37.27%							
38		In month achievement against FY forecast	3.41%	3.47%	13.19%	9.32%	9.68%	8.84%	8.62%	8.63%	8.67%	8.47%	8.37%	9.34%								

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Table C1- Savings Schemes Pay Analysis

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000			£'000	£'000	£'000	£'000	
1	Pay - General & Substantive	Budget/Plan	167	230	227	233	404	404	399	442	416	415	440	440	624	4,216	0	115			
2		Actual/F'cast	167	211	498	635	468	464	456	456	454	447	447	555	876	5,257	4,996	261	1,011	4,246	5,064
3		Variance	0	(19)	271	402	64	61	56	14	38	32	7	115	252	1,040	4995.566683	146			
4	Pay - Variable	Budget/Plan	299	355	355	419	419	373	373	373	373	373	373	373	1,009	4,462	0	0			
5		Actual/F'cast	330	188	413	481	464	471	486	490	477	428	415	402	931	5,045	5,045	0	3,803	1,242	1,281
6		Variance	30	(167)	58	61	45	98	113	116	103	54	41	28	(78)	583	5,045	0			
7	Pay - Agency	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	Total	Budget/Plan	466	585	582	652	823	777	773	815	789	788	813	813	1,634	8,678	0	115			
11		Actual/F'cast	497	399	911	1,116	932	936	942	945	931	875	862	957	1,807	10,301	10,040	261	4,813	5,488	6,345
12		Variance	30	(186)	329	463	109	158	169	130	141	86	48	144	174	1,623	10,040	146			

Table C2- V&S Saving Categories

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast
			Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000		
1	Workforce	Budget/Plan	466	585	582	652	823	777	773	815	789	788	813	813	1,634	8,678
2		Actual/F'cast	497	399	911	1,116	932	936	942	945	931	875	862	957	1,807	10,301
3		Variance	30	(186)	329	463	109	158	169	130	141	86	48	144	174	1,623
4	Medicines Management	Budget/Plan	119	239	365	276	266	343	266	266	266	266	266	266	723	3,207
5		Actual/F'cast	113	255	500	402	380	457	395	395	395	395	386	368	869	4,444
6		Variance	(6)	16	135	126	114	114	129	129	129	129	120	102	145	1,237
7	Procurement & Non-pay	Budget/Plan	259	479	810	508	727	594	601	601	629	629	629	845	1,548	7,311
8		Actual/F'cast	287	259	2,184	971	1,058	914	908	908	933	933	928	1,120	2,730	11,404
9		Variance	28	(219)	1,374	463	331	320	307	307	304	304	299	275	1,183	4,093
10	CHC	Budget/Plan	45	45	48	48	260	90	90	90	90	90	90	90	138	1,075
11		Actual/F'cast	45	45	52	89	307	137	137	137	137	137	137	137	142	1,498
12		Variance	0	0	5	41	47	47	47	47	47	47	47	47	5	423
13	Pathway	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Other - Commissioning	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	Other - Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
22	Total	Budget/Plan	890	1,348	1,805	1,485	2,076	1,805	1,730	1,773	1,775	1,774	1,799	2,014	4,042	20,272
23		Actual/F'cast	942	959	3,648	2,577	2,676	2,444	2,382	2,386	2,397	2,340	2,313	2,582	5,548	27,647
24		Variance	52	(389)	1,843	1,092	600	640	653	613	622	567	514	568	1,506	7,375

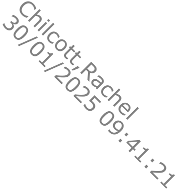

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Table C3 - Tracker

	£'000	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Full-year forecast	Non Recurring	Recurring	FYE Adjustment	Full-year Effect
Savings (Cash Releasing & Cost Avoidance)	Month 1 - Plan	890	1,348	1,805	1,485	2,076	1,805	1,730	1,773	1,775	1,774	1,799	2,014	4,042	20,272	8,928	11,344	2,206	13,549
	Month 1 - Actual/Forecast	942	959	1,876	1,949	2,053	1,768	1,683	1,683	1,709	1,704	1,690	1,864	3,777	19,882	8,605	11,277	2,002	13,279
	Variance	52	(389)	72	464	(23)	(36)	(46)	(89)	(66)	(69)	(109)	(150)	(265)	(390)	(323)	(67)	(204)	(271)
	In Year - Plan	0	0	1,776	617	618	670	701	704	690	638	625	720	1,776	7,760	4,975	2,786	163	2,949
	In Year - Actual/Forecast	0	0	1,771	628	623	676	699	702	688	636	623	718	1,771	7,765	4,980	2,786	163	2,949
	Variance	0	0	(5)	11	6	6	(2)	(2)	(2)	(2)	(2)	(2)	(5)	5	5	0	(0)	0
	Total Plan	890	1,348	3,581	2,102	2,694	2,475	2,431	2,477	2,464	2,412	2,424	2,735	5,818	28,032	13,903	14,129	2,369	16,498
	Total Actual/Forecast	942	959	3,648	2,577	2,676	2,444	2,382	2,386	2,397	2,340	2,313	2,582	5,548	27,647	13,585	14,062	2,165	16,228
	Total Variance	52	(389)	67	475	(17)	(31)	(48)	(91)	(68)	(71)	(111)	(152)	(270)	(385)	(318)	(67)	(204)	(271)
Net Income Generation	Month 1 - Plan	38	65	71	71	71	71	204	25	25	25	25	25	174	717	492	226	10	236
	Month 1 - Actual/Forecast	38	8	271	79	75	75	49	23	23	23	23	23	317	713	492	221	15	236
	Variance	0	(57)	200	9	5	5	(155)	(2)	(2)	(2)	(2)	(2)	143	(5)	0	(5)	5	0
	In Year - Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	In Year - Actual/Forecast	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total Plan	38	65	71	71	71	71	204	25	25	25	25	25	174	717	492	226	10	236
	Total Actual/Forecast	38	8	271	79	75	75	49	23	23	23	23	23	317	713	492	221	15	236
	Total Variance	0	(57)	200	9	5	5	(155)	(2)	(2)	(2)	(2)	(2)	143	(5)	0	(5)	5	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	928	1,413	1,875	1,555	2,147	1,875	1,934	1,798	1,800	1,799	1,825	2,040	4,216	20,989	9,420	11,570	2,216	13,785
	Month 1 - Actual/Forecast	980	967	2,147	2,028	2,128	1,843	1,733	1,707	1,732	1,728	1,714	1,887	4,094	20,595	9,097	11,498	2,017	13,515
	Variance	52	(446)	271	473	(19)	(32)	(201)	(92)	(68)	(72)	(111)	(153)	(122)	(395)	(323)	(72)	(199)	(271)
	In Year - Plan	0	0	1,776	617	618	670	701	704	690	638	625	720	1,776	7,760	4,975	2,786	163	2,949
	In Year - Actual/Forecast	0	0	1,771	628	623	676	699	702	688	636	623	718	1,771	7,765	4,980	2,786	163	2,949
	Variance	0	0	(5)	11	6	6	(2)	(2)	(2)	(2)	(2)	(2)	(5)	5	5	0	(0)	0
	Total Plan	928	1,413	3,652	2,173	2,765	2,546	2,635	2,503	2,490	2,437	2,450	2,760	5,992	28,750	14,395	14,355	2,379	16,734
	Total Actual/Forecast	980	967	3,918	2,657	2,752	2,519	2,432	2,409	2,420	2,364	2,337	2,606	5,865	28,360	14,077	14,283	2,180	16,464
	Total Variance	52	(446)	266	484	(13)	(26)	(203)	(94)	(70)	(74)	(113)	(155)	(127)	(390)	(318)	(72)	(199)	(271)

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
All Service Areas	9,130	12,590	355	**22,075**	713	0
Scheduled Care	0	1,041	0	**1,041**	0	0
Unscheduled Care	0	1,004	0	**1,004**	0	0
Mental Health	0	0	0	**0**	0	0
Community Services	0	0	0	**0**	0	0
Primary Care	1,171	2,356	0	**3,527**	0	0
Commissioned Services - CHC	0	0	0	**0**	0	0
Commissioned Services - Specialised Services	0	0	0	**0**	0	0
Other Commissioned Services	0	0	0	**0**	0	0
Clinical Support	0	0	0	**0**	0	0
Non Clinical Support	0	0	0	**0**	0	0
Executive / Corporate Areas	0	0	0	**0**	0	0
Total	**10,301**	**16,991**	**355**	**27,647**	**713**	**0**

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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	132,945	118,770	92,640	101,335	123,960	96,476	106,966	115,576	101,186	105,251	104,376	77,505	1,276,986
2	WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only	1,180	1,180	420	995	2,005	1,160	1,160	1,160	1,160	1,160	1,160	1,160	13,900
3	WG Revenue Funding - Other (e.g. invoices)	3,185	1,319	1,307	1,298	1,298	1,298	1,298	1,298	1,298	1,298	4,490	4,490	23,878
4	WG Capital Funding - Cash Limit - LHB & SHA only	10,000	4,000	2,000	2,080	2,000	1,980	1,980	1,980	1,980	1,980	1,980	6,314	38,274
5	Income from other Welsh NHS Organisations	40,964	47,167	44,602	44,684	36,025	40,894	39,338	41,638	39,434	41,436	41,478	46,156	503,815
6	Short Term Loans - Trust only													0
7	PDC - Trust only													0
8	Interest Receivable - Trust only													0
9	Sale of Assets													0
10	Other - (Specify in narrative)	4,368	12,334	6,857	15,758	7,759	10,401	15,651	7,610	7,332	15,513	7,332	9,470	120,386
11	**TOTAL RECEIPTS**	**192,642**	**184,770**	**147,825**	**166,150**	**173,047**	**152,209**	**166,393**	**169,262**	**152,390**	**166,639**	**160,816**	**145,096**	**1,977,240**
	PAYMENTS													
12	Primary Care Services : General Medical Services	6,787	6,329	7,770	6,590	6,560	8,090	6,560	6,560	8,090	6,560	6,560	8,090	84,546
13	Primary Care Services : Pharmacy Services	215	140	125	124	150	150	150	150	300	600	300	300	2,704
14	Primary Care Services : Prescribed Drugs & Appliances	8,718	18,833	0	9,099	18,430	0	9,215	18,430	0	9,215	9,215	9,215	110,370
15	Primary Care Services : General Dental Services	2,354	2,429	2,380	2,368	2,385	2,385	2,385	2,385	2,385	2,385	2,385	2,385	28,612
16	Non Cash Limited Payments	2,112	2,077	2,270	2,136	2,190	2,190	2,190	2,190	2,190	2,190	2,190	2,190	26,115
17	Salaries and Wages	70,344	70,347	70,084	70,490	70,084	69,890	70,339	70,041	69,923	70,134	70,667	70,495	842,839
18	Non Pay Expenditure	80,837	87,303	68,961	70,536	71,250	67,523	73,573	67,523	67,523	73,573	67,523	66,008	862,135
19	Short Term Loan Repayment - Trust only													0
20	PDC Repayment - Trust only													0
21	Capital Payment	12,675	1,730	1,015	2,985	2,000	1,980	1,980	1,980	1,980	1,980	1,980	6,314	38,600
22	Other items (Specify in narrative)													0
23	**TOTAL PAYMENTS**	**184,043**	**189,188**	**152,605**	**164,327**	**173,049**	**152,209**	**166,393**	**169,260**	**152,392**	**166,637**	**160,820**	**164,997**	**1,995,920**
24	Net cash inflow/outflow	8,599	(4,418)	(4,780)	1,823	(2)	1	1	2	(1)	2	(3)	(19,902)	
25	Balance b/f	2,780	11,379	6,961	2,181	4,004	4,001	4,002	4,003	4,005	4,004	4,005	4,002	
26	Balance c/f	11,379	6,961	2,181	4,004	4,001	4,002	4,003	4,005	4,004	4,005	4,002	(15,900)	

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