Public Finance & Performance Committee

Wed 19 June 2024, 14:00 - 15:00

Virtual - MS Teams

Agenda

14:00 - 14:10
10 min

1. Standing Items

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 and Performance Committee meeting – 22 May 2024

John Union

1.4 Draft Finance and Performance Minutes 22.05.24 v1.0.pdf (4 pages)

1.5. Actions following the Finance and Performance Committee meeting held on 22 May 2024

John Union

1.5 Finance and Performance Action Log 19.06.24.pdf (1 pages)

1.6. Chair's Actions since previous meeting

John Union

14:10 - 14:40
30 min

2. Items for Review and Assurance

2.1. Finance Position Update – Month 2 Position & Savings Plan Progress

Catherine Phillips / Rob Mahoney / Andrew Gough

10 Minutes

2.1 Public Finance Committee SUMMARY Finance Position Report for Month 2 Final.pdf (12 pages)

2.2. Operational Performance

Adam Wright

15 Minutes

Regan,Nikki
17/06/2024 08:35:19

2.2 Operational Performance report cover paper.pdf (6 pages)
2.2a Integrated Performance Report.pdf (36 pages)

2.3. Decarbonisation Update

Ed Hunt

5 Minutes

- 2.3 - Q4 Decarbonisation Action Plan progress - Finance and Performance Committee.pdf (3 pages)
- 2.3a Q4 report - Finance and Performance Committee.pdf (8 pages)

14:40 - 14:50
10 min

3. Items for Approval / Ratification

3.1. Business Cases - Stroke Improvement

Adam Wright

10 Minutes

- 3.1 Stroke Business Case - F&P Committee Covering Report.pdf (4 pages)
- 3.1a Stroke Business Case 24-25.pdf (48 pages)

3.2. Business Cases - CAVHIS

- 3.2 CAVHIS Business Case - F&P Committee Covering Report.pdf (3 pages)
- 3.2a CAV Health Inclusion Business Case April 2024 update for SLB (1).pdf (49 pages)

14:50 - 14:50
0 min

4. Items for Information and Noting

4.1. End of Year Financial Report for the Regional Partnership Board

Meredith Gardner / Chris Markall

0 Minutes

- 4.1 RPB Funding Stream Q4 Report 2023-24.pdf (6 pages)

4.2. Monthly Monitoring Report

Robert Mahoney

0 Minutes

- 4.2 WG 2024 _25 month 2 MMR Covering Report.pdf (2 pages)
- 4.2a CV Financial Monitoring Returns 2024-25 - Month 2.pdf (8 pages)
- 4.2b 2024-25 MMR Template - Cardiff Vale UHB Month 2.pdf (5 pages)

14:50 - 15:00
10 min

5. Any Other Business

John Union

10 Minutes

15:00 - 15:00
0 min

6. Review and Final Closure

6.1. Items to be deferred to Board / Committee

John Union

Regan,Nikki
17/06/2024 08:30:29

6.2. To note the date, time and venue of the next Committee meeting: Wednesday 17 July 2024 via MS Teams

Regan,Nikki
17/06/2024 08:35:19

Unconfirmed Minutes of the Public Finance and Performance Committee Meeting
Held on 22 May 2024
Via MS Teams
Link to YouTube recording – click here

Chair:		
John Union	JU	Independent Member – Finance
Present:		
David Edwards	DE	Independent Member – Information Communication & Technology
Ceri Phillips	CP	UHB Vice Chair
In Attendance:		
Paul Bostock	PB	Chief Operating Officer
Marie Davies	MD	Interim Executive Director of Strategic Planning
Andrew Gough	AG	Deputy Director of Finance (Strategic)
Robert Mahoney	RM	Deputy Director of Finance (Operational)
Catherine Phillips	CP	Executive Director of Finance
Suzanne Rankin	SR	Chief Executive Officer
Jason Roberts	JR	Executive Nurse Director
Andrew Partridge	AP	Corporate Archivist & Records Management Manager
Secretariat:		
Nikki Regan	NR	Corporate Governance Officer
Apologies:		
Matt Phillips	CP	Director of Corporate Governance
Charles Janczewski	CJ	UHB Chair

Item No	Agenda Item	Action
FPC 22/05/001	**Welcome & Introduction** The Committee Chair (CC) welcomed everyone to the meeting.	
FPC 22/05/002	**Apologies for Absence** Apologies for Absence were noted. **The Finance and Performance Committee resolved that:** a) Apologies for Absence were noted.	
FPC 22/05/003	**Declarations of Interest** No Declarations of Interest were noted.	
FPC 22/05/004	**Minutes of the Finance and Performance Meeting held on 17 April 2024** The minutes of the meeting held on 17 April 2024 were received. **The Finance Committee resolved that:** a) The minutes of the Finance and Performance Committee meeting held on 17 April 2024, were held as a true and accurate record of the meeting.	
FPC 22/05/005	**Actions following the Finance and Performance Committee meeting on 17 April 2024** The Action log was received. **The Finance and Performance Committee resolved that:** a) The Action Log for the Finance and Performance Committee was noted.	

Regan, Nikki 17/06/2024 08:35:39

FPC 22/05/006	**Chairs Action since previous meeting** There had been no Chair's Actions taken since the last meeting	
FPC 22/05/007	**1) Financial Report – Month 1** The Financial Report – Month 1 was received. The ODDF gave a summary of the Financial Report for Month 1 and highlighted the following: • A deficit in month 1 of £1.325m, which was 1/12th of the £15.9m planned deficit • An over spend of £4.267m at the end of the month 1 • Due to the projected deficit, CAV would continue to fail the 3 year rolling performance requirements and therefore would not receive Ministerial approval for the UHB financial plan. • LHBs are obliged to confirm with WG that all inter NHS contracting arrangements have been concluded and agreed by 30 June 2024. Due to the approach of other health boards in Wales in not applying uplift funding to contracts in line with the 3.67% uplift provided by WG in Allocation Letters, this is unlikely to happen and may preclude the requirement to enter arbitration processes with commissioning organisations. This represents a £5.274m risk to the CAV financial plan which assumes a 3.67% baseline uplift to all Long-Term Agreements and Service Level Agreements within NHS Wales. Most commissioners have offered a far lower uplift with the balance being offered in return for additional service delivery by CAV. The CE noted a discussion took place at the NHS Leadership Board regarding the Executive Finance Director being clear in his expectation that uplifts on LTA's should be 3.67% in 2024-25. She questioned what the proposal was to ensure CAV receive the 3.67% of additional services. The ODDF explained that, as an example some commissioners have calculated non pay inflation as being 1.1% for 2024-25. CAV's position is that similar amounts have been added in previous years when non pay inflation was running at 11% or above. . He added that £5.2m was a risk but he believed this to be slightly lower since one LHB had changed its position since the report was written. The VC stated his perception that CAV didn't recover funding well through the LTAs and the position of commissioners offering 1.1% with the expectation that CAV does more was unfair. He thought WG has clearly stated their expectation that commissioners were committed to the 3.67% and CAV would need to stick to this line, and if necessary we may need to renegotiate the LTA downwards in terms of what could be provided for them even if this puts pressure on waiting lists targets. The ODDF noted the following points following VC's observations: • There was no previous debate over uplift rates which had followed WG uplifts to allocations • CAV expect the 3.67% per the clear guidance issued by WG • Updating the LTAs, some of which dated back more than 20 years would require joint agreement between parties, and wouldn't necessarily generate extra funding for CAV The ODDF noted the report and reflected on the different categories: • Table 2 reflected on the different pay income, non-pay categories and how CAV reached £4.26m overspend at Month1 • Table 3 displayed the same variance by clinical board • Additional funding offsetting variances will be allocated but hadn't been completed in month 1 so had been displayed separately in the table. • • The £47.2m Cost Reduction target underpins the plan and remains high risk. • As the year 2develops the ability of CAV to 'remain within the cash limit will come under pressure. At present the working assumption is that WG will support the £15.9m deficit set out in the draft plan. • CAV continued to work with NWSSP, Workforce and Operational Leads to try to minimise overpayments and act appropriately to reclaim salary overpayments. • Month 1 position was a cause for concern especially as CAV has yet to identify large parts of the £47.2m savings target.	

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	The SDDF noted the following points: • CAV were more progressed compared to last year but noted it was against a bigger target • Progress was being made but more work was needed by the organisation and needed to be identified by the end of Q1 to have any meaningful impact in the financial year. The ODDF further highlighted the following points: • Expect some of the Red CRP schemes to convert to Amber or Green during the year. • CAV's cash flow would be monitored • CAV are further advanced in identifying savings than in to 2023-24 and have a governance structure is in place with Exec / Clinical Board staff members, with a focus on the workforce reshaping. • CAV have put in place more enhanced recruitment controls from month 1, but there was still scope to reduce agency expenditure. The CC requested to have specific targets if this continued by next month. The ODDF explained that without knowing what the figure would be, the ability to pull it back in the short term would be challenging. The focus was on each clinical board and to see what costs could be avoided. The CE reassured the committee that the Sustainability Programme Board owned the savings plan and monitored the achievement. The escalation policy and scheme of delegation was reviewed for agency staff and also put a complete freeze on all new unfunded vacancies with effect from 16.05.24. The IMICT asked when would we see the line change on the trajectory. The EDF noted CAV didn't conclude the budget setting in the time set out and there was confusion in the clinical boards and wanted to ensure we had a clean position. Some assumptions were made and she was keen not to bring the problems here at this point in the year but would bring back later in the year The VC noted CAV need to be careful not to assume that by cutting costs in each clinical board that we will deliver overall savings. We may spend more money in one area that may generate savings in other areas. **The Finance and Performance Committee resolved:** a) The reported year to date over spend of £4.267m and the forecast deficit of £15.900m was noted and; b) Within this, the month 1 operational overspend against plan of £0.497m with a further £2.445m savings gap was noted and; c) The progress against the savings target, with £18.181m (39%) of green and amber schemes identified at Month 1 against the £47.2m target was noted and; d) That delivery of the forecast is also predicated on the confirmation of all expected income streams was noted.	
FPC 22/05/008	**Operational Performance** The COO presented the Operational Performance and highlighted the following: • New outpatient waiting list currently has 12k waiting for their first outpatient appointment • Some patients suffered waits of over 2 / 3 years particularly in Ophthalmology • CAV will meet the standard for Cancer but unable to meet the 75% • Concerns with Diagnostics as CAV was recorded of having wait times of over 8 weeks • Mental Health Clinical Board have a trajectory and currently tracking to where it should be with an expectation of 80% by September • Mental Health summit planned for June 2024 • CAV were required to reduce the 12 hr wait time in A&E The CC asked if the diagnostics wait was due to staff or equipment? The COO confirmed it was due to staffing issues. With non-Obstetrics ultrasound CAV were sending patients to a private hospital but stopped this in 2023 and plan to grow our own people & resources. He added there was no criteria for going on to the waiting list for ultrasound. The VC noted the demand continued for MH Clinical Board. He added that he had discussed using on line facilities more, which could be useful to reduce some of the demand within the MH Clinical Board, which had been done in Powys THB.	

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	The COO noted a solution was looked at for ADHD which would help give a diagnosis and help reduce waiting times. The CC asked who planned to attend the MH summit in September 2024? The COO explained the clinical summits were internal but attended by multi-disciplined teams. **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 was noted.	
FPC 22/05/009	**Monthly Monitoring Return – Month 12 & Month 1 (24/25)** The Monthly Monitoring Return for month 12 and 1 were for information and noting. **The Finance and Performance Committee resolved:** a) The monthly monitoring return for month 12 and month 1 (24/25) were noted.	
FPC 22/05/010	**Any Other Business** No other business was raised.	
	Date & time of next Meeting Wednesday 19th June 2024 via Teams	

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Public Action Log

Following Finance and Performance Committee Meeting
22 May 2024
(For the Meeting 19 June 2024)

Completed actions					
REF	**SUBJECT**	**AGREED ACTION**	**ACTIONED TO**	**DATE**	**STATUS/COMMENTS**
FPC 24/04/008	Savings Tracker 2024/25	Workforce Reshaping Work Update	Paul Bostock	19.06.2024	**COMPLETED** Added to Forward Plan for June meeting.
Actions referred to Board/Committees					

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Report Title:	Finance Report for the Period Ended 31st May 2024			Agenda Item no.	2.1
Meeting:	Finance Committee	Public	x	Meeting Date:	19th June 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 2 the UHB is reporting an overspend of £8.821m.

This is comprised of £4.614m unidentified savings, £1.557m of operational overspend and the planned deficit of £2.650m (two 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 2 operational and savings overspend to deliver the £15.900m planned deficit.

Table 1: Month 2 Financial Position 2024/25

	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**

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.

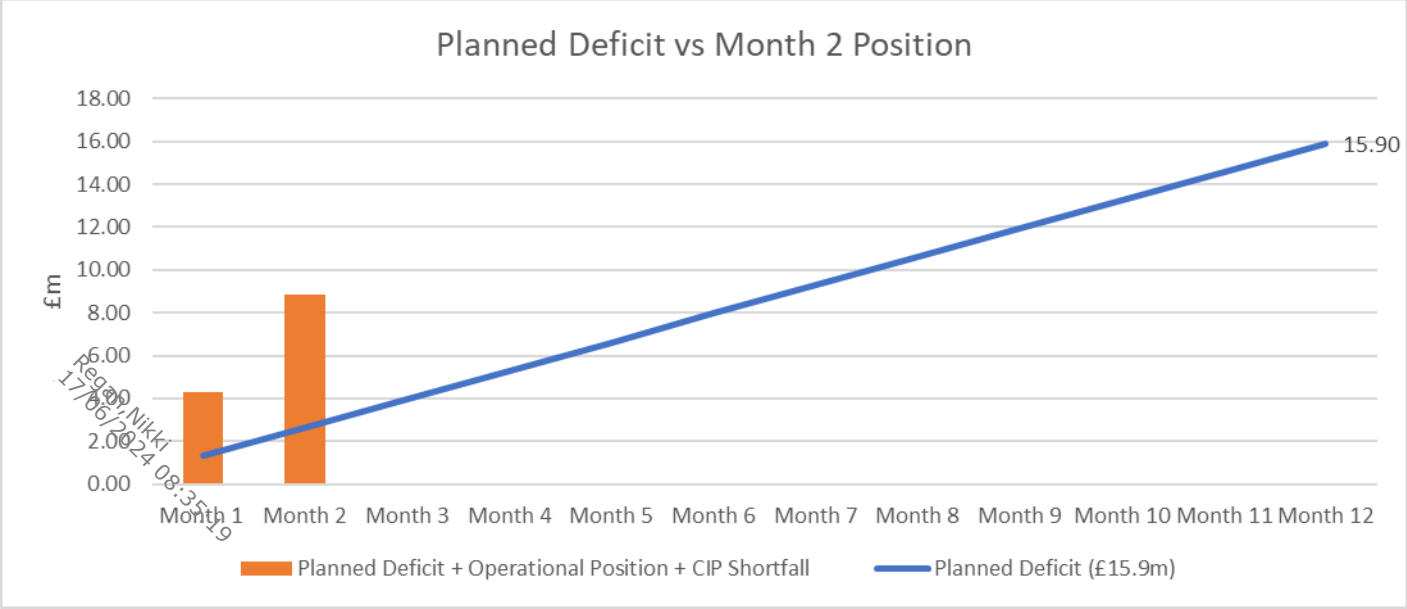
The submitted 2024-25 plan represents a failure of the UHB's statutory requirement to deliver a balanced financial plan over a three-year rolling period. The submitted financial plan has not been approved by Ministers and this will also represent the failure of a statutory financial duty if this situation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

Summary Financial Table
The following table analyses the £8.821m overspend at Month 2, between Income, Pay and Non-Pay.

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

Income/Pay/Non Pay	Memorandum Annual Budget £m	Current Period Actual £m	Total Variance (Fav)/Adv £m
In Month			
Income	(319.447)	(160.323)	0.029
Pay	150.410	76.198	0.601
Non Pay	169.037	87.353	2.599
Sub Total £m	0.000	3.229	3.229
2024/25 Planned Deficit	15.900	1.325	1.325
Variance to Plan £m	15.900	4.554	4.554
Cumulative			
Income	(319.447)	(320.282)	(0.836)
Pay	150.410	151.123	0.714
Non Pay	169.037	175.330	6.293
Sub Total £m	0.000	6.171	6.171
2024/25 Planned Deficit	15.900	2.650	2.650
Variance to Plan £m	15.900	8.821	8.821

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



Graph 1 shows the reported position at month 2 compared to the planned deficit. The actual position is £6.171m above the planned deficit because of the combined operational deficit and savings gap. The forecast position assumes that this will be recovered over the course of the year through management action to ensure that services operate within delegated budgets.

Long Term Agreements

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 offers, from a number of commissioners, which offer a lower percentage uplift than 3.67%. Commissioners have suggested that Cardiff and Vale UHB should provide additional activity and services if the UHB wishes to increase its overall income by 3.67%.

The current range of offers from commissioners could cause up to a £5.274m shortfall in the income anticipated in the UHB Financial Plan approved by the UHB Board

The Director of Finance is currently engaged in discussions with commissioner organisation colleagues to resolve this issue. Failure to resolve this disagreement may oblige the UHB to enter the Welsh Government arbitration process. This places the UHB at risk of a potential adverse judgment that would impact it's Financial Plan.

Financial Performance of Clinical Boards

Budgets were set to include £12m of operational pressures in addition to recognising non recurrent savings. Financial performance for Month 2 by Clinical Board is shown in Table 3.

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

Clinical Board	Operational Position (Surplus) / Deficit	Savings Position (Surplus) / Deficit	Total (Surplus) / Deficit	Prior Month (Surplus) / Deficit
	Variance	Variance	Variance	Variance
Cumulative	£m	£m	£m	£m
Clinical Diagnostics & Therapeutics	18	399	417	339
Children & Women	410	472	883	421
Capital Estates and Facilities	37	310	347	220
Executives	(119)	202	83	68
Genomics	(12)	0	(12)	(12)
Medicine	898	544	1,442	801
Mental Health	180	443	623	288
PCIC	1,098	656	1,754	673
Specialist	4	542	547	465
Surgery	35	715	750	466
Clinical Board budgets to be delegated	(883)		(883)	(952)
Sub-Total Delegated Position	**1,666**	**4,284**	**5,950**	**2,777**
Central Budgets	(110)	80	(30)	165
Commissioning	(0)	250	250	0
Cost Improvement Themes	0	0	0	0
Total (Surplus)/Deficit	**1,557**	**4,614**	**6,171**	**2,942**
Planned Deficit	2,650	0	2,650	1,325
Total Operational (Surplus)/Deficit	**4,207**	**4,614**	**8,821**	**4,267**

The UHB reported an overspend of £6.171m against the draft financial plan for the year to date.

The £4.614m deficit 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 position is expected to be recovered as further schemes develop during the financial year.

The pressures on operational positions, reported across delegated clinical boards, have been partially offset in Month 2 by a release of the majority of the £12m plan provision to support known brought forward operational pressures. £5.7 million remains un-allocated at present, as recovery actions are agreed, most notably in the Medicine Clinical Board. The year to date impact of this is within the Month 2 position (This is included in Table 3 in the row 'Clinical Board budgets to be delegated').

Clinical Boards are anticipating managing the operational financial risks that they face within their delegated budgets.

The most significant of these risks are

In addition to the challenge of delivering the savings targets for 2024-25, operational pressures are also particularly impacting in three clinical boards :-

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C&W : Driven by increased variable medical pay spend (£0.180m) combined with lower than expected income from Joint Committee (£0.100m formerly WHSSC). It is early in the financial year and contract performance may correct itself as the year progresses.

Mental Health : 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

(£0.215m). The high numbers of external placements has improved at the end of May 2024 and it is still anticipated that Mental Health will improve its position towards operational financial balance despite sustained demand contributing to a currently challenging position.

There have 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. These variable costs are borne by the Medicine and Children and Women's Clinical Boards.

PCIC : A new Optometry contract agreed between Welsh Government and community opticians in Wales has seen increased costs arising during implementation in 2024-25 without funding (£0.327m). The UHB's financial plan reshaped the funding framework for some PCIC urgent care initiatives which included the filling of community nursing posts (£0.291m). 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 2 positions and the robustness of actions to improve the financial outlook.

Welsh Government COVID 19 Allocations & Expenditure

The expenditure for Month 2 is summarised in Table 4 below.

Table 4: Summary of Month 2 COVID 19 Net Expenditure

	Month 2 £m	Forecast £m	Funded by WG £m	Variance to Plan/Funding £m
Health Protection/Vaccination & PPE	1.507	9.040	9.040	0.000
Long Covid	0.191	1.144	1.144	0.000
Sub Total WG Funded Covid Expenditure £m	**1.697**	**10.184**	**10.184**	**0.000**

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 not included in table 4 above and reported within delegated clinical board positions.

Welsh Government funded Health Protection, PPE and Long Covid expenditure is forecast to outturn in line with funding.

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 meet its planned deficit of £15.9m in 2024-25.

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Table 5: Financial Risk Register at May 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. However 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 which has a deficit of £15.9m in 2024-25 and break even positions in FY 2026 and FY 2027 which the Minister is not able to approve. Support for the one year 2024-25 financial plan will be required Welsh Government has not confirmed its support at the present time. Enhanced Monitoring meetings with 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 following 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 with Welsh Government maintain discussions over progress towards a financially balanced three year IMTP .
Achievement of Capital statutory breakeven duty The Health Board has a capital allocation, which it should not exceed on a three year rolling basis.	8	The current 2024-25 UHB Capital Plan is structured to remain within 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 with the submitted £15.9m deficit plan for 2024-25	20	The period to Month 2 has reported financial pressures against the £47.2m savings target and operational pressures within 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 Reviews with each Clinical Board : Monthly Finance meetings with all Clinical Boards and COOs Office : weekly Savings meetings of delegated budget holders, bi weekly 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 with any savings which 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 2, only £17.5m of Green and Amber schemes against the £47.2m target have been identified as recurrent in nature. A CIP pipeline tracker is in place with a weekly monitoring progress across the organisation. Monthly Financial Clearance Meeting include specific focus on CIPs. Further focus is provided in Executive / Clinical Board Performance Reviews, bi weekly Sustainability Boards and weekly Savings meetings. Governance reporting and monitoring arrangements through the Finance Committee and Board.
2024-25 LTA framework in NHS Wales.	15	The UHB 2024-25 Financial Plan anticipated a 3.67% inflationary uplift for its LTA contracts with WHSSC and commissioning health boards as a provider of services as well as 'business to business' Service Level Agreement contracts with other NHS organisations. This is in line with WG planning guidance . The uplift is expected per WG cash allocation letter. WHSSC and Health Boards have a deadline of 30th June to confirm. Not receiving the planned inflationary uplift will impact the UHB's ability to meet it's 24/25 planned deficit.
Remain within Cash limit	15	The UHB will require cash support from WG for the 24/25 planned deficit of £15.9m alongside working 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 forward the point of the year when cash controls will require consideration. Cash controls will 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

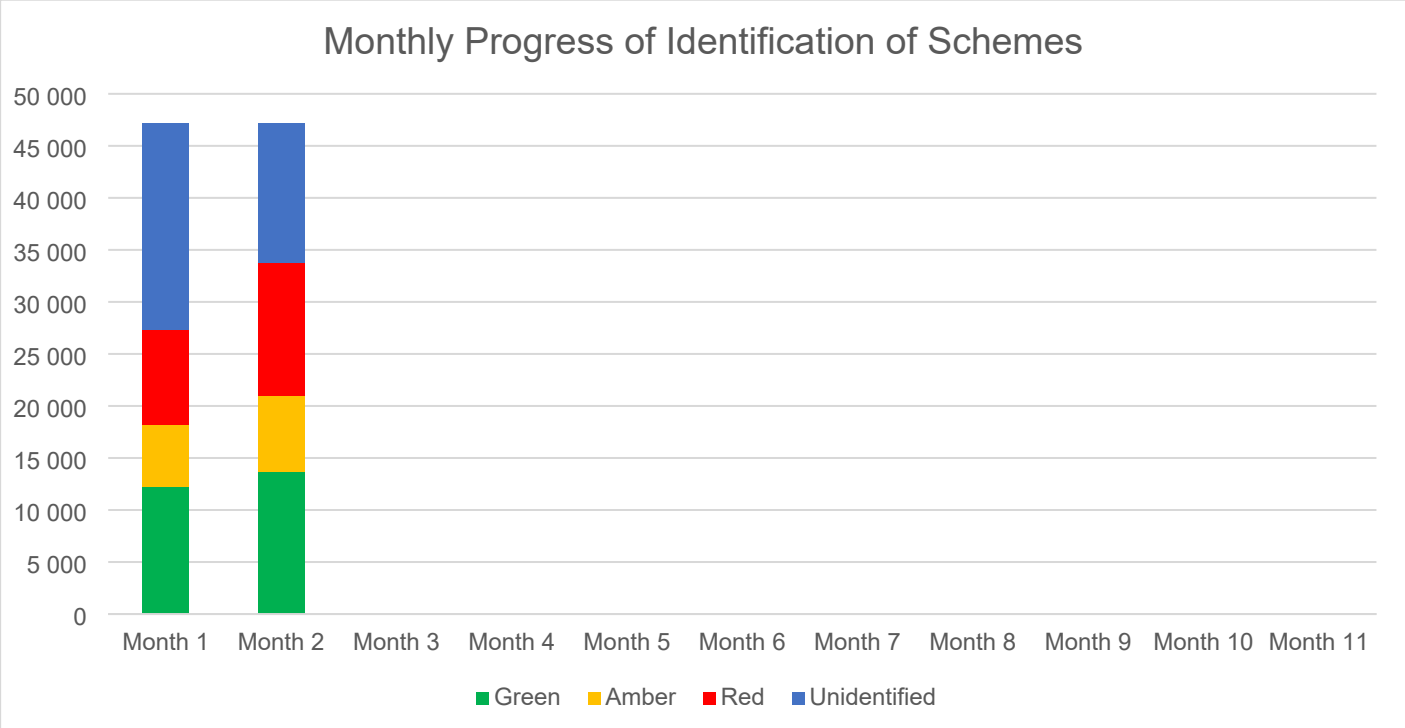
At month 2, £20.989m of green and amber savings had been identified towards the £47.2m savings target. £11.323m of these schemes are recurrent. This represents an increase of £2.809m from Month1 and identifies 44% of the annual target.

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 £6.402m of savings schemes for 2024-25 would be reported as identified at Month2.

The total of green, amber and red schemes (£33.794m) represents 72% of the annual target.

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

Graph 2 - Progress in Identification of Schemes



Further detail of the progress by Clinical Boards and Improvement Themes is provided in Table 7.

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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	518	307	825	202	1,027
Clinical Diagnostics and Therapeutics	1,199	458	209	667	9	676
Corporate Executives	501	166	0	166	1,099	1,265
Medicine	1,379	134	150	284	150	434
Mental Health	1,079	58	343	401	56	457
Primary, Community and Intermediate Care	2,423	358	1,067	1,425	635	2,060
Specialist Services	1,482	411	601	1,011	0	1,011
Surgical Services	1,689	402	537	939	173	1,112
Subtotal - Grip and Control	**12,000**	**3,203**	**3,476**	**6,679**	**2,424**	**9,103**
Medicines Management	4,530	1,105	2,078	3,182	712	3,894
Reducing Length of Stay	3,500	2,856	0	2,856	459	3,315
Optimising Planned Care	1,000	0	0	0	1,000	1,000
Income Generation	1,000	426	173	599	248	846
Continuing Healthcare	2,500	0	475	475	1,335	1,810
Facilities and Estates / Service Reconfiguration	500	0	0	0	606	606
Value/Clinical Variation	0	0	0	0	0	0
Procurement	5,000	2,888	534	3,421	566	3,987
Recording Patient Care	1,500	0	0	0	150	150
Other Digital Benefits	0	0	0	0	50	50
Workforce - Temporary Pay	7,403	2,757	400	3,157	4,953	8,111
Workforce Reshaping	8,268	458	162	620	301	922
Subtotal Cost Improvement Themes	**35,200**	**10,490**	**3,821**	**14,311**	**10,380**	**24,691**
Total Savings Position	**47,200**	**13,693**	**7,297**	**20,989**	**12,804**	**33,794**

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 2, £12.257m of the identified green and amber schemes and £5.134m of red schemes were recurrent.

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The reported gap includes red schemes, 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 50% delivery, £6.4m additional savings would be delivered.

Cash Flow Forecast

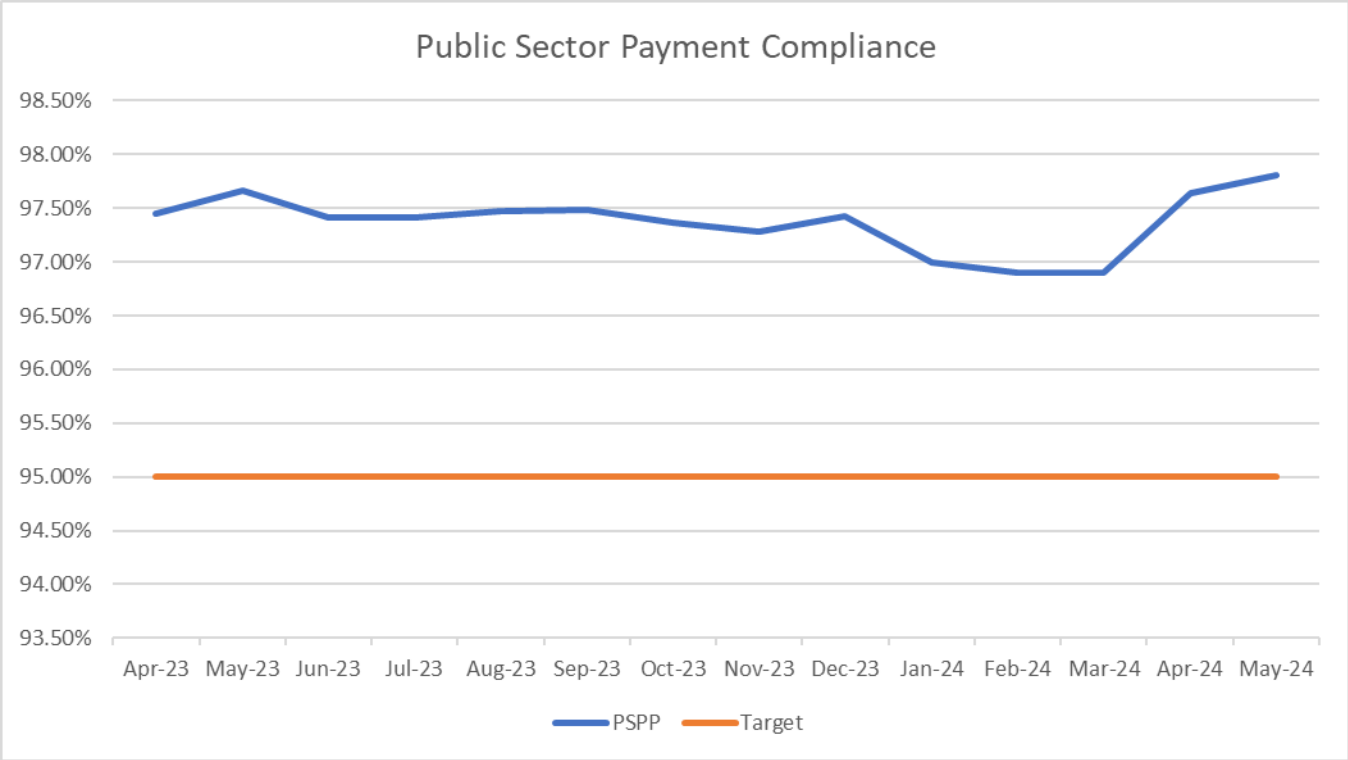
The closing cash balance at the end of May, was £6.691m.

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 Compliance

The UHB's public sector payment compliance performance is above the target of 95%. Performance for the month to the end of May was 97.8% for the year to date as illustrated in Graph 2 below.

Graph 3 – Public Sector Payment Compliance



Capital

The UHBs approved capital resource limit is £33.942m in line with the latest CRL received from Welsh Government on the 14th May 2024. This comprises of £13.564m discretionary funding and £20.288m towards specific projects (including decarbonisation schemes, Interventional Neuroradiology Equipment, Mortuary, UHW Lift Refurb and upgrade).

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.

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Table 7: Finance - Key Performance Indicator Dashboard at May 2024

	STATUS REPORT				
Measure	**May 2024**	**RAG Rating**	**Latest Trend**	**Target**	**Time Period**
Deliver 2024/25 Draft Financial Plan	£8.821m deficit at month 2 being £2.650m forecast deficit, £4.614m savings gap and £1.557m operational overspend.	R	↓	Deliver 2023/24 £15.900m Revised Planned Deficit	M2 2024-25
Return to Financial Balance and approved IMTP status	Achieve financial sustainability and recurrent financial balance by the end of 2025/26	R	↓	Reduce c/f underlying defict to £15.900m at year end	M2 2024-25
Management of operational budget pressures	The UHB reported a £1.557m operational overspend at month 1.	R	↓	Operational Spend to be maintained within Budgets	M2 2024-25
Delivery of recurrent £47.2m savings target	£20.984m Green and Amber schemes identified at month 2 of which £12.257m were recurrent.	R	⊖	£47.2m	M2 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	⊖	To remain within Cash Limit	M2 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 2 position is a reported overspend of £8.821m, which is £6.171m above the £2.650m straight line profile of the planned deficit.

As at month 2 £20.989 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.

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

Recommendation:

At Month 2 the Committee are requested to:

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- **NOTE** the reported year to date overspend of £8.821m and the forecast deficit of £15.900m.
- **NOTE** the month 2 operational overspend against plan of £1.557m with a further £4.614m savings gap.
- **NOTE** the progress against the savings target, with £20.989m (44%) of green and amber schemes identified at Month 2 against the £47.2m target.
- **NOTE** that delivery of the forecast is also predicated on the confirmation of all expected income streams.

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:

Reed, Nikki
13/08/2024 08:13:19

Finance Committee	Date: 19th June 2024

Regan,Nikki
17/06/2024 08:35:19

Report Title:	Operational Performance Report			Agenda Item no.	2.2
Meeting:	Finance and Performance Committee	Public	✔	Meeting Date:	19/06/24
		Private			
Status *(please tick one only):*	Assurance ✔	Approval		Information	
Lead Executive:	Chief Operating Officer				
Report Author (Title):	Head of Performance				

Main Report
Background and current situation:

Background and current situation:

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

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

The report has been refreshed in line the 24/25 National Performance framework and recent KPIs identified by the Cabinet Secretary. The updated IPR will be shared at the Board Development session this month and then used for this committee for the remainder of the financial year.

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

As we emerge from the winter period we continue our focus on ambulance handovers, in particular reducing the number of patients waiting over 1 hour before handover. The first five months of the year have seen a notable increase in operational pressures across Wales and we saw the average ambulance handover time remain higher than in December 2023. Despite this, we continue to meet our commitment on reducing the number of lost hours.

The number of 1-hour ambulance handovers reduced in November (306) and December (172) from the number reported in October (516). In Q4 the number of 1-hour handovers was higher but when compared to Q4 22/23, total lost hours reduced from c3,600 to 2,200 and the number of 1-hour handover delays has reduced from 1,780 to 1,056. April 2024 saw a small reduction in lost hours compared to March 2024 and the same month last year, May saw a small increase in ambulance arrivals and lost hours.

Through Q3 considerable improvement was made on patients waiting 12-hours in the EU. We reported an increase in December and January but saw a modest reduction in February. March, April and May also saw small increases in 12 hour waits. Reducing the number of patients waiting 12 and 24-hours in the EU remains a priority and has been an area of specific focus for the EU and patient flow teams through some very challenging weeks.

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Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown some 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. Compliance with

the KPI for Admission to a Specialist Ward and Prompt Surgery remains well above the NHFD average. Using the annualized NHFD data, the UHB are at or above the national average for 7 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 with August and September and November's performance well above the national average.

April saw a drop 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 reduced to 43.5% but remains significantly above the all Wales average. Our percentage compliance and median time to ward and CT scan remains improved from our performance in 2022, we continue to work across Clinical Boards to progress the Stroke Service Improvement Plan. Our SSNAP grade improved to A for the period July-September 2023, this is a significant improvement from the previous quarters and a reflection of the work undertaken by the teams. Or most recent review saw a drop to Grade B but performance remains improved from last year. We continue to experience challenges in increasing the number of patients thrombolysed and this remains an area of continued focus, working with colleagues from the NHS Executive.

April saw our thrombolysis rate drop to 14.5% following consecutive months at over 20%. This remains above the Wales average. At a previous IQPD meeting with Welsh Government the Health Board presented our actions against the key recommendations from an HEIW review into the stroke pathway, including work on stroke/prevention awareness, the emergency pathway, implementation of AI software improving thrombolysis and thrombectomy rates and improvements to our rehabilitation provision. A plan for investing in the front end of our stroke pathway has received approval at Investment Group and will now progress for consideration at Senior Leadership Board and Board.

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.

We continue to treat our longest waiting patients as a priority and continue our pathway work to improve times to first outpatient appointment, diagnostic and diagnosis reporting, as well as definitive treatment. As a result, we have seen a reduction in the number of patients waiting over 62 and 104 days for their definitive treatment. Challenges within endoscopy are being addressed with improvements noted in the endoscopy backlog and the SCP compliance for upper and lower GI cancers. Capacity challenges are currently causing delays within our Pathology service, which has the potential to impact reporting of cancer specimens. The teams are working closely to minimise delays and the PTL is reviewed weekly to monitor the impact on waiting times for all tumour sites.

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	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Original submission	58.5%	55.1%	61.5%	62.2%	64.2%	61.7%	62.0%	65.6%	66.4%	56.6%	64.7%	58.0%	70.2%
Compliance following quaterly refresh	62.8%	57.5%	62.9%	63.5%	66.0%	64.5%	63.6%	67.5%	65.9%	57.8%	66.3%	62.4%	70.2%

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The numbers of patients waiting on an RTT waiting list has increased this month. We continue to focus on long-waiting cohorts and Cancer pathways with weekly scrutiny against the national standards and ministerial ambitions. We eliminated 3-year Outpatient waits in September and have maintained this since then. In December the Health Board delivered on our commitment to reduce the number of patients waiting 2 years for treatment to <3% of the waiting list.

At the end of March there were, 2681 patients waiting 2 years for treatment, which represents 1.8% of patients on a waiting list. While this has not delivered the Ministerial and UHB ambition to have fewer than 1% of patients waiting longer than 2 years, it is a considerable improvement from previous months. We have seen a significant reduction in the number of long waiting patients through the year, as well as halving the number of specialties with 2-year waits, for 14 in April 2023 to 7 in March 2024. This highlights our commitment to reducing the number of long waiting patients, while balancing urgent, emergency and cancer demands. We saw a small increase in the number of patients waiting over 2 years for treatment at the end of April 2024, while the number of patients waiting over 3 years reduced.

We did not deliver on 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. April 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 Q1. 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.

Through our planned care programme we are increasing the visibility of productivity and efficiency data. Outpatient, diagnostic and theatre productivity are central to reducing waiting times for patients and delivery of the Ministerial ambitions, we have included trended data in these areas as part of the attached IPR and will expand the number of measures in line with GIRFT recommendations once the datasets have been agreed. A particular area for improvement is outpatient DNA rates, this will be partially addressed through the reintroduction of the Patient Participation Booking system, but also through improved patient engagement at specialty level.

We have seen a reduction in the number of 100% delayed follow-up outpatient appointments in recent months. 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 will only be 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 54,153 patients who are past their target date for a follow-up appointment, of these 20 were over 2 years past their target date as shown below:

Overdue Follow-up Outpatients							
Clinical Board	Months past target date	22/04/2024	30/04/2024	07/05/2024	13/05/2024	20/05/2024	28/05/2024
Total	Total overdue	56473	55457	55429	55316	54641	54153
	Over 18 months	498	267	231	236	165	175
	Over 24 months	108	66	39	23	17	20
Surgery	Over 18 months	125	56	55	53	41	47
	Over 24 months	30	13	12	8	7	7
Children & Women	Over 18 months	88	87	53	62	13	23
	Over 24 months	23	20	5	5	4	4
Specialist	Over 18 months	187	71	69	54	46	44
	Over 24 months	47	27	17	5	2	5
Medicine	Over 18 months	86	40	41	54	51	47
	Over 24 months	4	2	1	1	0	0

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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.

The waiting list position for Diagnostics has deteriorated in recent months, with particular challenges in Radiology and Endoscopy. It is anticipated that the upcoming development of a Community Diagnostic Hub, and interim use of mobile facilities will address radiological backlogs. From December we have seen sustained improvements for MRI and CT, however, the number of patients waiting 8 weeks for a non-obstetric Ultrasound continues to grow.

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. While the number of 8-week waits has continued to increase through Q4 and into Q1, albeit at a slower rate than through the rest of the year.

We report monthly on the numbers of delayed pathways of care and our acute ward length of stay. These metrics have been included in the productivity and efficiency section of the IRP with trending of the delayed pathways of care and the monthly snapshot of patients in acute beds with a length of stay greater than 7 and 21 days. Through Q2 and Q3 we saw a reduction in the percentage of our acute beds occupied by patients with a >21-day length of stay, although the number of patients with long lengths of stay increased as we moved into the new year with a small increases noted through Q1.

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 in March and April 2024 and 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.

Demand for adult and children's Mental Health services remains significantly above pre-Covid levels, including an increased presentation of patients with complex mental health and behavioral needs. Part 1a compliance for adults fell to below 50% in April 2023 following an exceptionally high number of referrals in March 2023. However, the teams have managed to recover their waiting list position and June's reported compliance with the 28-day standard returned to 100%, and has remained at over the 80% standard each month until January. October 2023 saw the highest recorded number of referrals and Part 1a performance was expected to deteriorate from January 2024.

As forecasted, in January we reported 37.5% compliance with the 28-day standard and while this has 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. Performance is expected to remain low through this year. Part 2 compliance remains challenged, an improvement trajectory has been shared with NHS Executive colleagues, with Part 1 service developments supporting improvements to Part 2 compliance.

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 in March (92%) and April (91%). 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

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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.

As we move into the new financial year we currently have 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.

We have received updated guidance from Welsh Government on their expectations for performance improvement across NHS Wales this year, with key performance indicators aligned to the 5 priority areas: Urgent and Emergency Care, Cancer, Diagnostics, Elective care and Mental Health. We are currently developing trajectories to delivery on milestones described in the guidance. Further details will be shared at the next Board meeting, with performance tracking against the UHB's commitments and National milestones.

Recommendation:

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

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

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

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

Prevention		Long term	✔	Integration	✔	Collaboration		Involvement	

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

Risk: No

Safety: No

Financial: No

Workforce: No

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

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

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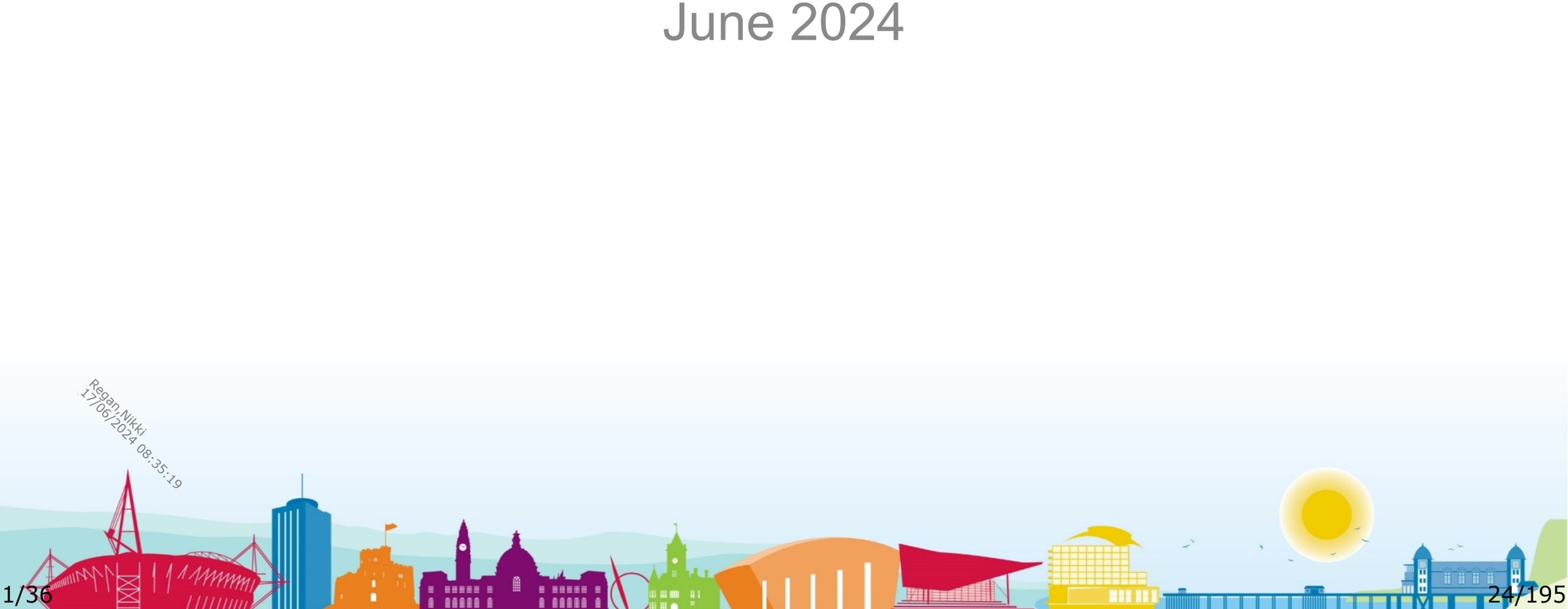
Cardiff and Vale
Integrated Performance Report

June 2024



Report Contents

Click on a hyperlink to navigate directly to the section required

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Section 1: Ministerial Priorities

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

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

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

Priority	Aim	C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment	Link in Performance Report
Delayed Transfers of Care	**Reduction in backlog of delayed transfers** Measure: number of delayed transfers of care. Reporting period: monthly	217	Yes	June 2023	179 May	Hyperlink to section
Primary Care Access to Services	**Improved access to GP and Community Services** Measure: >95% achievement of core access to in-hours GMS Services Reporting: monthly	95%	Yes	June 2023	98% December	Hyperlink to section
	Increased access to dental services Measure: 50% of expected new patient target Reporting: monthly	50%	Yes	June 2023	89% March	Hyperlink to section
	Improved use of community pharmacy Measure: >90% of all eligible community pharmacies providing CCPS (June 2023) Reporting: monthly	90%	Yes	June 2023	98% December	Hyperlink to section
	Improved use of optometry services Measure: Reduce number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services Reporting: monthly	877	Yes	Dec 2023	791 March	Hyperlink to section
Urgent and Emergency Care	**Implementation of a 24/7 urgent care service, accessible via NHS 111 Wales** Measure: Performance response time in NHS 111 Reporting: TBC	tbc	tbc	June 2023	tbc	Hyperlink to section
	Implementation of Same Day Emergency Care services Measure: Increase in SDEC attendances Reporting: monthly	1233	Yes	June 2023	1625 April	Hyperlink to section
	Honour commitments that have been made to reduce handover waits Measure: Eliminate 4 hour ambulance handover delays Reporting: monthly	0	Yes	June 2023	0 May	Hyperlink to section

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

Section 1: Ministerial Priorities

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

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Priority	Aim		C&V Commitment	Commitment to meet ministerial ambition?	By When	In Month Performance against C&V commitment	Link Performance Report
Planned Care, Recovery, Diagnostics and Pathways of Care	**Achieve RTT waiting time targets** Measure 1: 52 week new outpatient target by March 2024 Reporting: monthly		8999	No	Mar 2024	12695 April	Hyperlink to section
	Measure 2: 104 week treatment target by December 2023 Reporting: monthly		3788	Yes	Dec 2023	2816 April	Hyperlink to section
	Set foundations for achieving waiting list targets Measure: Reduce outpatient overdue follow by 25% against 2019/20 levels Reporting: monthly		37623	Yes	Mar 2024	28020 March	Hyperlink to section
	Implement regional diagnostic hubs Measure 1: progress reporting on regional diagnostic hub Reporting: quarterly		Go-Live	Yes	Dec 2023	Q1 24/25	Hyperlink to section
	Measure 2: Achieve 8-week diagnostic Reporting: monthly		0	No	June 2025	14835 April	Hyperlink to section
	Implement straight to test model Measure: progress reporting on straight to test Reporting: quarterly		Go-Live	Yes	Sept 2023	On track	Hyperlink to section
Cancer	**Achieve SCP target** Measure: 75% of patients starting their first definitive cancer treatment within 62 days Reporting: monthly		75%	Yes	June 2023	63.7% April	Hyperlink to section
	Implement the national cancer pathways within the national target Measure: progress reporting on national cancer pathways Reporting: quarterly		Go-Live	Yes	Sept 2023	Planning ongoing	Hyperlink to section
Mental Health and CAMHS	**Achieve waiting time performance for Local Primary Mental Health Support Services and Specialist CAMHS** Reporting (for all): monthly	Measure 1: Part 1a (adults)	80%	Yes	June 2023	16.1% Apr	Hyperlink to section
		Measure 2: Part 1b (adults)	80%	Yes	June 2023	100% Apr	
		Measure 3: Part 2 (adults)	80%	Yes	June 2023	61.2% Apr	
		Measure 4: Part 1a (children)	80%	Yes	June 2023	91% Apr	
		Measure 5: Part 1b (children)	80%	Yes	June 2023	24% Apr	
		Measure 6: Part 2 (children)	80%	Yes	June 2023	81.7% Apr	
	Implement 111 press 2 on a 24/7 Measure: progress on implementing NHS 111 press 2 Reporting: quarterly		Go-Live	Yes	Sept' 2023	Delivered	Hyperlink to section

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Section 2: Cardiff and Vale Performance Report

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

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

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

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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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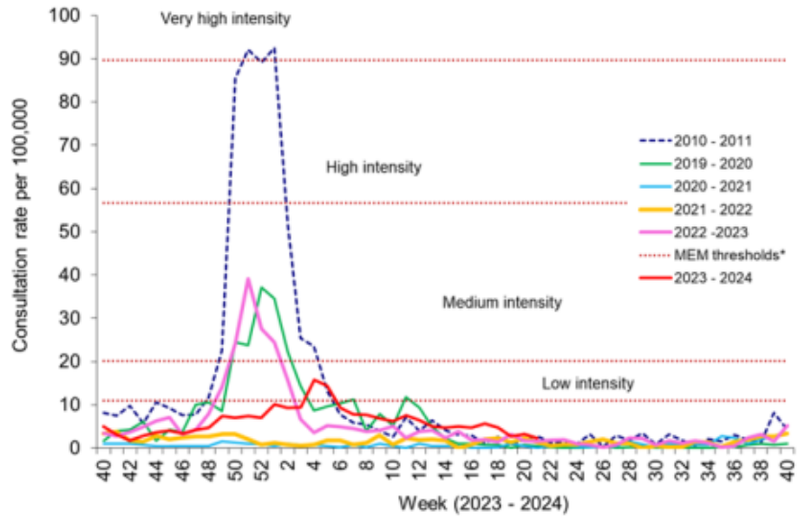
Priority	Performance Summary	Reported Period	On target?	Data
Health Protection	**Seasonal respiratory infections** **Immunisation** – COVID-19 and influenza • The Covid-19 vaccine spring booster campaign is now underway and it has delivered 28,657 vaccines since the 2nd of April when the campaign started. 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 51.70%. **Surveillance** • Influenza activity is low and continuing to decrease • Hospital admissions for Covid-19 increased from mid April, peaking in early May; since the second week of May the trend is unclear but remains elevated. PCR incidence and positivity peaked mid May and are both now declining • Omicron sub-variant JN.1 remains the most prevalent variant in Wales • There are currently **3** Covid-19 outbreaks and **zero** incidents in hospital; and **zero** influenza incidents or outbreaks. • Since the start of April 2024, **143** 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 April 2024 was due to influenza/COVID-19/respiratory conditions (data for May awaited). • 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 21	Below target	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

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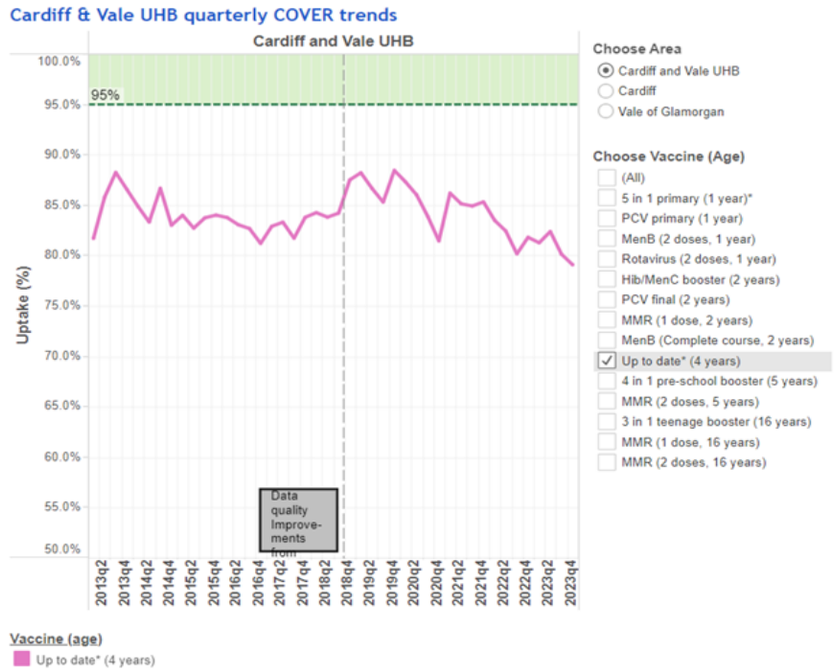
Priority	Performance Summary	Reported Period	On target?	Data
Health Protection	**Routine childhood immunisation** • 79.1% of children are up to date with vaccination at age 4, which is below the target of 95% and a Welsh average of 84.7%, uptake of all childhood vaccinations at age 5 is 85.7% which is still below the Welsh average of 88%.	Q2 2023/24 Oct 2023 – Dec 2023	Below target	 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 is under development.	Q4 2024/25	On target	*n/a*

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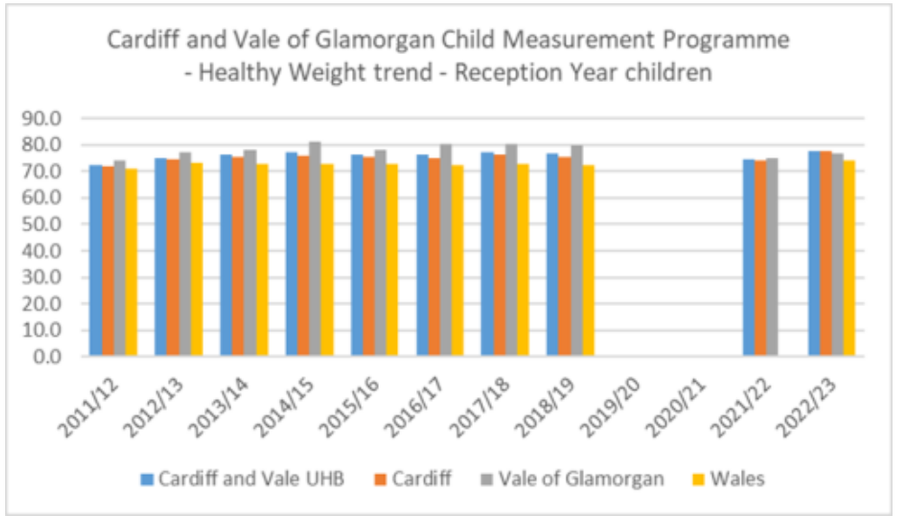
Priority	Performance Summary	Reported Period	On target?	Data
Health Improvement	**Healthy weight:** • 77.5% of reception aged children in Cardiff and Vale of Glamorgan are categorised as healthy weight (Child Measurement Programme, 2022/23). Cardiff and Vale have the highest proportion of healthy weight children compared to other Health Board areas based on the latest available data; and is equal to the English average for 2022/23 of 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: o Level 2 services: 1.6% (target: 1.5%) o Level 3 services: 0.2% (target: 0.5%)	Q4 2023/24	**Healthy weight:** On target **Weight management services:** Level 2 above target Level 3 below target	

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

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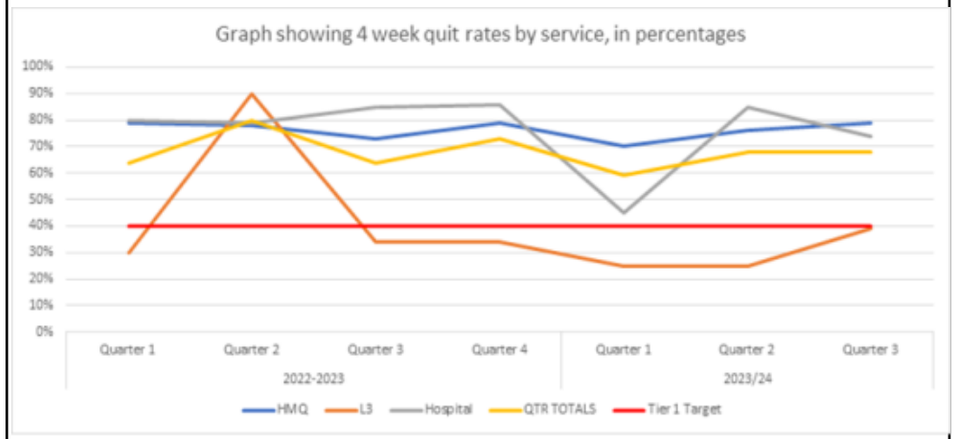
Priority	Performance Summary	Reported Period	On target?	Data

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 3 (the most up to date data received) 0.6 % of smokers set a firm quit date (this is below target). 68% of these quit smoking at 4 weeks (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 – 79% of Treated Smokers had quit smoking at 4 weeks.
	  • Level 3 Pharmacy –39% of Treated Smokers had quit smoking at 4 weeks.
	  • Hospital Service - 74% of Treated Smokers had quit smoking at 4 weeks.
		Quarter 3 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
				

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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 2023	0.8% (per quarter)	0.6% Below target	**Q1**	**Q2**	**Q3**	**Q4**
					0.6%	0.6%	0.6%	Awaited
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 2023	40%	68% Exceeding target	**Q1**	**Q2**	**Q3**	**Q4**
					59%	68%	68%	Awaited
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	tbc	100%	96.51% Below target	**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	tbc	100%	36% Below target	**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 October 2023 to 30 December 2023	95%	85.7% Below target	**Q1**	**Q2**	**Q3**	**Q4**
					83.7	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 target	**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 target	**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 September 2023 to 31 March 2024	75%	51.7% Below target	**25/04/24**	**04/06/24**		
					20.8%	51.7%		

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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	May 2024	1.5%	1.6% Above target				
n/a	% of people with BMI > 30 that can be treated through Level 3 Weight Management Services	May 2024	0.5%	0.2% Below target				

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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	Mar-24	90%	**31.1%**	Dec-23: 22.90%; Jan-24: 22.50%; Feb-24: 25.20%; Mar-24: 31.10%
9.	Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	Mar-24	90%	**96.4%**	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	Apr-24	95%	**96.2%**	Jan-24: 95.10%; Feb-24: 95.90%; Mar-24: 96.10%; Apr-24: 96.20%

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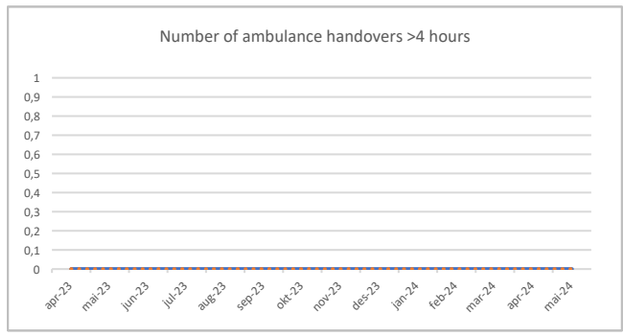
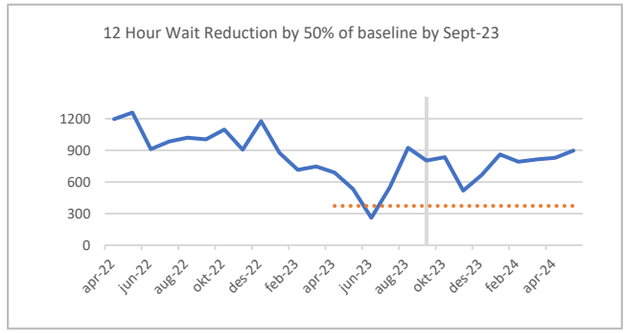
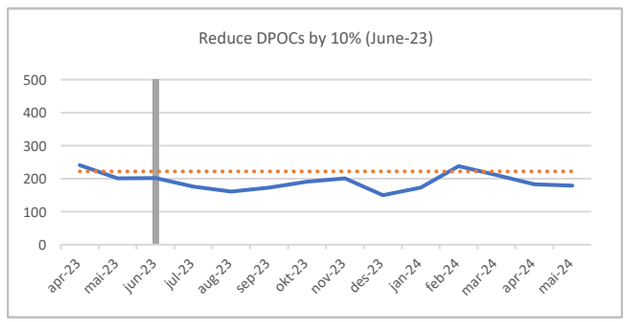
Priority	Performance Summary	Reporting Period	Data
Ambulance Handover Annual Plan Commitments: • Zero 4-hour ambulance delays (June 23) • Reduce average lost minutes to 30 (Sept 23)	• The number of ambulance handovers >4 hours has reduced from 230 in November 2022 to zero since April 2023. We are now giving the same focus to patients waiting 2-hours for an ambulance handover. In June there were two 2-hour holds, a reduction from 206 in March 2023. we reported 23 in May 2024, a reduction from the previous month. • Average lost minutes per arrival at UHW remains has remained at 21 minutes in May. Average lost minutes per arrival for the Health Board was 19. This performance remains better than our annual plan commitment.	May-24	
Emergency Department Annual Plan Commitments: • Zero 24-hour ED waits (June 23) • Reduce 12-hour ED waits by 50% (Sept 23)	• In May, 18 patients waited 24-hours in the EU footprint without a stop-clock, a small increase from the 17 patients in April. • 12-hour ED waits increased from 829 in April to 898 in May and remains above our IMTP ambition.	May-24	
Delayed Pathways of Care, LOS and Beds Annual Plan Commitments: • Reduce DPOCs by 10% (June-23) • Reduce >21 day LOS by 5% (June-23) • Re-establish dedicated AOS beds (Sept)	• Delayed pathways of care remain a national challenge, the May 2024 census reported 179 delayed pathways, a decrease from March and below our commitment of 217 • We are currently tracking the numbers of stranded (7-day LOS) and superstranded (>21-day LOS) patients in our Acute beds. This is a more operationally useful measure than LOS measures which include rehabilitation and integrated care beds. We will be monitoring these going forward against the standards of <40% stranded and < 20% superstranded. At the time of writing our analysis showed 32% and 57% respectively. • Work continues to evaluate the most appropriate and effective approach for the Acute Oncology Service (AOS).	May-24	

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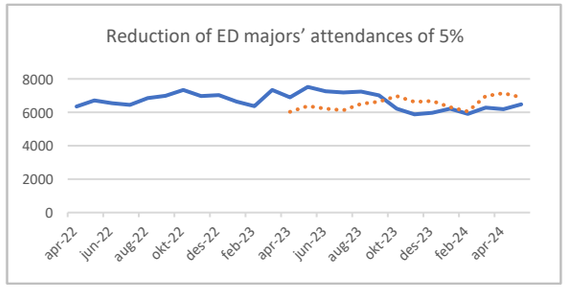
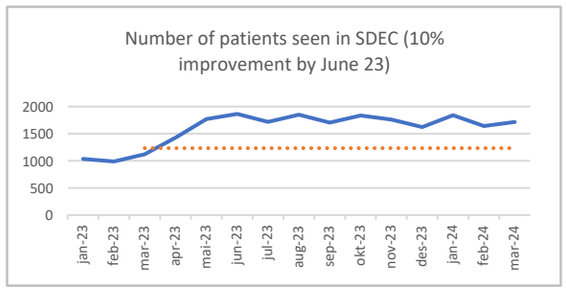
Priority	Performance Summary	Reporting Period	Data
ED Attendances Annual Plan Commitment • Reduction of ED majors' attendances of 5% compared to same period 2022/23 (every quarter)	• In May 2024 we reported 12,102 EU attendances, higher than the from the 11,484 reported in April • The number of EU Majors attendances in May 2024 was 6477 an increase from April and remaining below our ambition of 6895.	May-24	
Same Day Emergency Care Annual Plan Commitment • 10% increase in the total number of patients managed through SDEC (June 2023) • Reduced number of unplanned re-presentations within 7-days of SDEC attendance (September 2023) • Improve % of take managed in SDEC without requiring admission	• In April 2024 we saw 1,130 patients seen via surgical SDEC and 495 via the medical SDEC. In total 1,625 patients were seen, above our commitment of a 10% increase by the end of Q1 • A new process for national submissions has been undertaken and we hope to report on the other measures once complete. We are reviewing our SDEC reporting in line with next year's national performance framework.	Apr-24	

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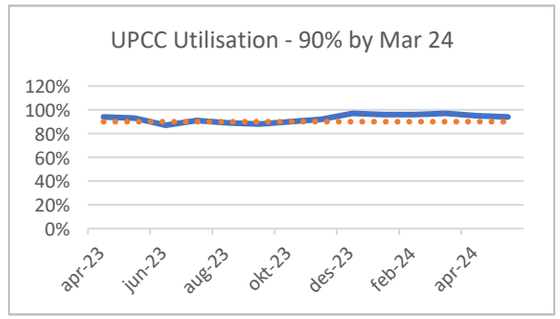
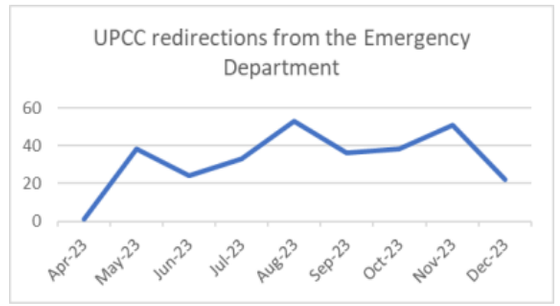
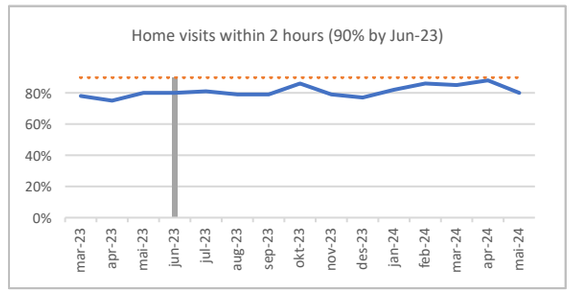
Priority	Performance Summary	Reporting Period	Data
Urgent Primary Care Annual Plan Commitments: • 80% appointment utilisation in UPCCs (June 2023), 85% (September 2023), 90% (March 2024) • All clusters to have adequate access to UPCC capacity (September 2023) • NHS 111 - >90% urgent calls logged and returned within 1 hr (December 2023) • Increased redirections from ED to UPCC (March 2024)	• Average utilisation of >90% achieved across Cardiff and Vale from September, increasing to 97% in December and remaining high at 96% in January and February, increasing to 97% for March 2024. 95% was reported in April decreasing to 94% in May • Delivery plan in place to develop Urgent Care Centers as part of the 6 Goals Programme, to achieve full and equitable access across Cardiff and Vale currently at 86% coverage of the C&V population • Calls to CAV247/OOH service - Q1 = 93%, Q2 = 87%, Q3 = 88%, Q4 = 87% • Work in progress – Pilot commenced to re-direct ED patients to UPCC slots. Work ongoing to expand this to 24/7 and to include Paediatrics. Total referrals for Q1 = 63, Q2 = 122 Q3 = 112 Q4 = 63	May-24 Q4-Mar 24	 
Community Services • Home Visit (P2) f2f in 2 hrs >90% (June 2023)	• The Health Board was 67% compliant in May 2024 against the standard of 100% for 'Emergency' GP OOH patients requiring a home visit within one hour, with 2 of 3 patients receiving their visit with one hour. • The Health Board was 50% compliant in May 2024 against the standard of 100% for 'Emergency' appointment at a primary care center within one hour, with 1 of 2 patients receiving a visit within one hour. • The Health Board was 80% compliant against the commitment of 90% for 'Urgent' GP OOH patients requiring a home visit within 2 hours, with 101 of 127 patients receiving their visit within 2 hours	May-24	

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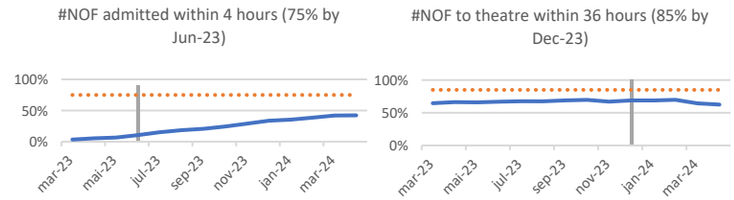
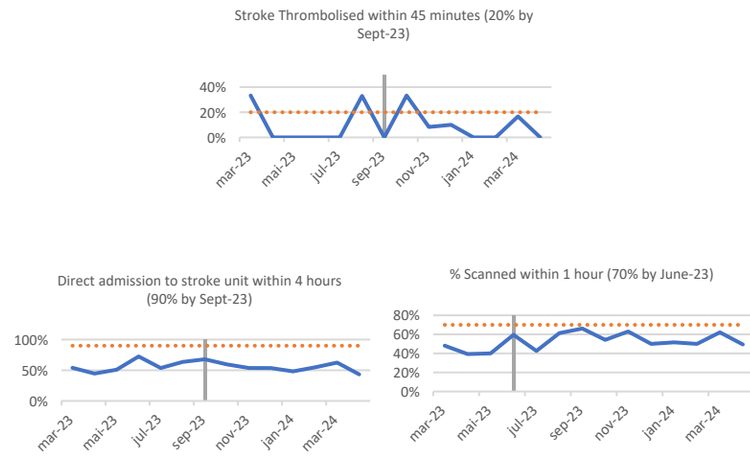
Priority	Performance Summary	Reporting Period	Data
Fracture Neck of Femur IMTP Commitments: • 75% admitted within 4 hours (June-23) • 85% to theatre within 36 hours (December-23)	Performance against the standards within the National Falls and Fragility Fracture Audit Programme (FFFAP) has shown some improvement. In April 2024 the annualised data shows 42.3% of patients were admitted to a specialist ward with a nerve block within 4 hours. In April, 62.5% of patients received surgery within 36 hours, this has been increasing since August 2022 and our performance is above the national average of 57.9% over the last 12 months.	Apr-24	
Stroke IMTP Commitments: • 70% scanned within 1 hour (June-23) • 90% admitted within 4 hours (Sept-23) • 20% thrombolysis rate (Sept-23)	While overall Stroke performance remains below the standards set out in the Acute Stroke Quality Improvement Measures and The Sentinel Stroke National Audit Programme (SSNAP), we have seen recent improvements in compliance from our historic trends. In April: • 0% of patients were thrombolysed within 45 minutes of arrival, the All-Wales average was 11.1% • The percentage of CT scans that were started within 1 hour in April was 49.4%, the All-Wales average was 58.1% • The percentage of patients who were admitted directly to a stroke unit within 4 hours was 43.5% in April, the All-Wales average was 31.0% The UHB has held a number of internal Stroke summits and improvements to the stroke pathway are now being implemented including increased Clinical Nurse Specialists during out of hours, additional middle grade medical cover for the Emergency Unit and ringfencing of additional stroke beds to deploy the pull model from EU effectively.	Apr-24	
Intensive Care Unit IMTP Commitments: • Patient at risk team 24/7 (Sept 23) • ITU - 1 additional staffed bed (Sept 23) • ITU - 2 additional staffed beds (March 24)	• The patient at risk team (PART) is now a 24/7 service. This expansion is important for supporting the wards and ITU with the save management and transfer of patients. • 3 additional ITU Level 3 beds will be resourced over the course of this financial year. The first of those beds was resourced from September 2023 following successful recruitment of staff	Dec-23	

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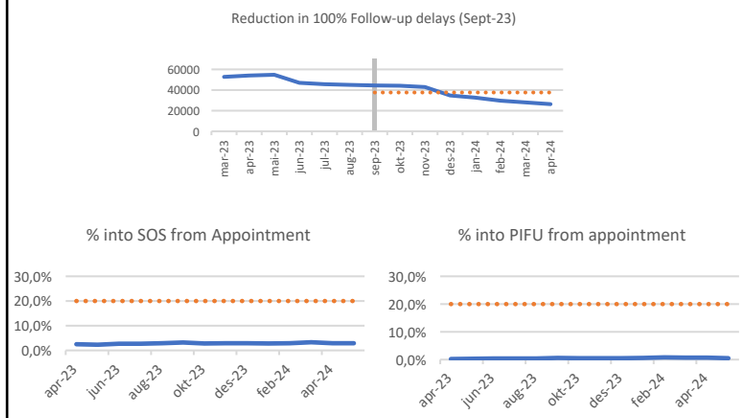
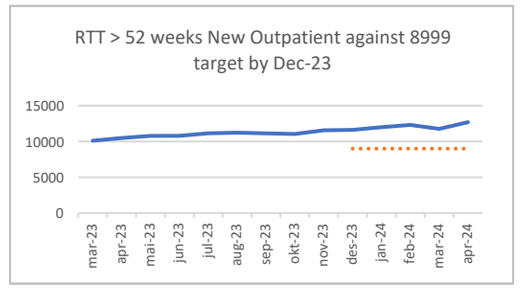
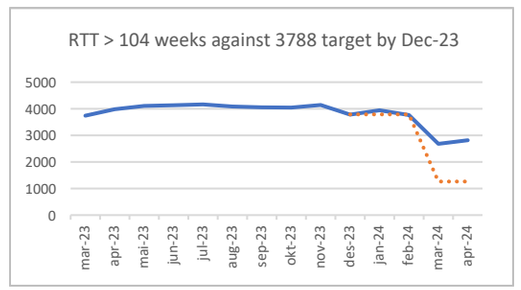
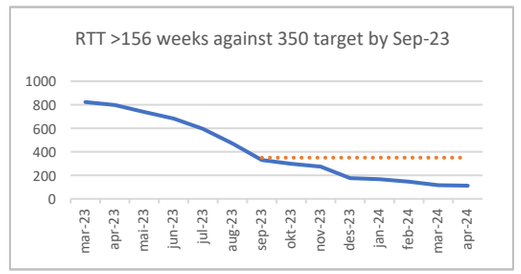
Priority	Performance Summary	Reporting Period	Data
Outpatient Follow-up Management Annual Plan Commitment • Follow up outpatients–reduce 100% delayed follow up by 25% on Jan'23 baseline of 50163 (September 2023) • SOS and PIFU –10% of appropriate outpatient appointments (September 2023); 20% (March 2024) • SOS and PIFU –20% of appropriate outpatient appointments	• In total there were 174,838 patients awaiting a follow-up outpatient appointment at the end of April • Of these, there were 26,338 patients who were 100% delayed for their follow-up outpatient appointment, a significant decrease noted from March • 2.9% of outpatient appointments saw patients moving into a See on Symptoms pathway • 0.5% of outpatient appointments saw patients moving into Patient Initiated Follow-up pathway	Apr-24 May-24	
52 Week New Outpatient Annual Plan Commitment • <8999 > 52 weeks (March 2024)	• We have developed a weekly monitoring and assurance process to update on progress against our key long waiting cohorts. Weekly updates and assurance is provided to the Chair and CEO for all long waiting patient groups. • In April, 12,310 patients had waited 52 weeks for their outpatient appointment, an increase from March and still above our ambition. We continue to work with our high volume specialties to reduce this as we move through Q1.	Apr-24	
104 Week Treatment Annual Plan Commitment • 3788 patients > 104 week waits for treatment (December 2023) • 1263 patients > 104 week waits for treatment (March 2024)	• In December the Health Board met its commitment to have no more than 3% of patients waiting more than 104 weeks for treatment. We closed April with 2816 patients waiting longer than 104 weeks which accounts for 1.87% of the total waiting list. This is above the ambition of 1% but represents a significant improvement from previous months. • Focussed work is ongoing to support key specialties reduce continue to reduce the number of patients with 2 year waits for treatment	Apr-24	
156 Week Waits Annual Plan Commitment • <350 patients >156 week wait for treatment (September 2023) • 0 patients >156 week wait for treatment (December 2023)	• At the end of September there were 330 patients waiting 156 weeks for treatment, lower than our commitment. We continue to see a reduction in the number of patients waiting over 3 years and reported 112 in April. Focussed work is ongoing to support key specialties reduce continue to reduce the number of patients with 3 year waits for treatment.	Apr-24	

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Priority	Performance Summary	Reporting Period	Data
Community Pharmacy Annual Plan Commitment: • >90% of all eligible community pharmacies providing CCPS (June 2023) • 10% increase in pharmacy independent provider access (December 2023)	100% of all eligible community pharmacies providing CCPS • 100 Community Pharmacies currently eligible to provide CCPS • 100/100 Community Pharmacies signed up to deliver CCPS. 4338 PIP consultations undertaken in Q4, increased from 3537, 3502 and 2395 in previous quarters. There has been an increase to 34% of pharmacies providing PIP services.	Mar-24	PIP consultations Dec-23: 1263 Jan-24: 1305 Feb-24: 1627 Mar-24: 1406
GMS Escalation Annual Plan Commitment: • >95% of practices reporting escalation levels (June 2023) • >95% achievement of core access to in-hours GMS Services (September 2023)	• Average of 97% of Practices reporting escalation levels, with 100% reported in March 24 – Significant increase in number of practices at level 3 or above (29 practices as at March 24 = 51%) • 98% achievement of core access standards to in hours GMS	Q4- Mar 2024	Escalation reporting Q2: 88.0% Q3: 92.0% Q4: 97.0% Access Standards Q2: 98.0% Q3: 98.0% Q4: 98.0%
Dental Annual Plan Commitment: • 50% of expected target for new patients, urgent and historic (June 2023); 90% (March 2024)	• % of Primary Care Dental Services Contract value (GDS) delivered for new patients seen – 178.2% • % of Primary Care Dental Services Contract value (GDS) delivered for new urgent patients seen - 91.5% • % of Primary Care Dental Services Contract value (GDS) delivered for historic patients seen – 81.6% In May 2021 the Centralised Dental Waiting List was established to indicate demand for access to NHS Dental Services and provide a pathway for patients to access general dental services. The number of patients requesting to be added has been increasing faster than allocation of patients to practices.	Q4- Mar 2024	Dec-23 / Jan-24 / Feb-24 / Mar-24 New: 139.27% / 151.72% / 164.46% / 178.19% New Urgent: 63.25% / 75.64% / 83.66% / 91.50% Historic: 64.69% / 70.99% / 76.57% / 81.55% Dec-23 / Jan-24 / Feb-24 / Mar-24 CDWL volume: 24,636 / 25,064 / 26,115 / 25,856
Optometry Annual Plan Commitment • >90% of eligible practices offering Clinical Community Optometry Services (CCOS) (June 2023); 95% (December 2023)	• Contract reform and implementation still in progress, currently 20 practices offer and Optometry Independent Prescribing service (33%)	Q4- Mar 2024	Data refreshed for 24/25 following contract reform implementation
Respiratory Annual Plan Commitment • 50% of backlog of suspected COPD patients receive spirometry (June 2023); 100% March 2024)	• Community Spirometry service available in both Cardiff and Vale regions. • Total of 2,759 appointments offered, of which 1,864 Patients appointed (67% utilisation), current waiting list of 254. • Phase 2 service implemented from November to include post bronchodilator spirometry and reversibility/FeNO testing for patients who are suspected of having asthma. Increased number of clinics in Community from January 2024.	Q4- Mar 2024	

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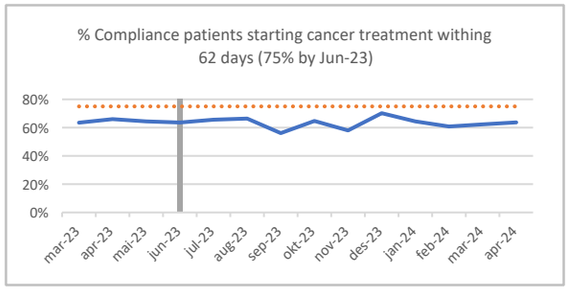
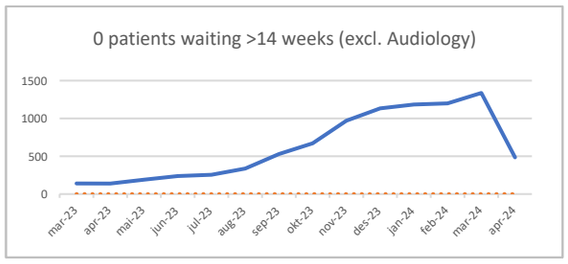
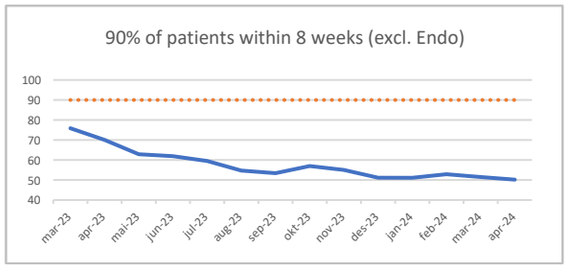
Priority	Performance Summary	Reporting Period	Data
Cancer Annual Plan Commitment • >75% compliance with the 62-day SCP standard (June 2023), 80% (December 2023) • Develop draft UHB strategy to deliver national cancer pathways (June 2023)	• Our compliance with the 62-day single cancer pathway standard improved in December to 70.2%, our highest performance since the introduction of the Single Cancer Pathway. As forecasted we saw a drop in compliance to 60.8% in February, which has raised slightly to 62.3% in March. We continue to address the backlog of long waiting patients. At the time of writing there are a total of 2187 suspected cancer patient on the SCP. 249 have waited over 62 days, of which 61 have waited over 104 days. There have been a number of actions taken to improve the oversight and operational grip of the process for overseeing patients. Three cancer summits have taken place with the tumour group leads and operational teams to understand the demand, the causes for delay in the 62-day pathway and what actions are required to reduce the delays experienced by our patients. • The UHB draft strategy has been developed including working with national cancer pathways	Apr-24 No date	
Therapies Annual Plan Commitment • 0 patients waiting over 14 weeks (excluding audiology) (June 2023)	• Excluding Audiology there were 485 patients waiting over 14-weeks for Therapy in at the end of April. • In total there were 498 patients waiting longer 14 weeks for Therapy, a decrease from previous months due to a reduction in Audiology / podiatry breaches and a significant reduction in Dietetics Adult breaches as we have now removed weight management patients from the reporting.	Apr-24	
Diagnostics Annual Plan Commitment • 90% of patients within 8-weeks (excl. endoscopy) (December 2023) • Endoscopy – urgent <6weeks; SCP<14days; 0 surveillance patients 100% past target date (December 2023) • Regional Diagnostic Centre go-live (December 2023)	• Excluding endoscopy there were 9,501 diagnostic patients waiting longer than 8 weeks for a Diagnostic at the end of April. In total there were 14,835 patients waiting longer than 8 weeks for a diagnostic test, an increase from March. • 50% of patients seen within 8 weeks in April (excluding Endoscopy), a small decrease from March. • Planning for the Community Diagnostic Hub is underway following agreement of central funding from WG. Expected go-live is estimated to be Q1 2024/25. Plans are in place to provide additional diagnostic capacity through mobile units in advance of this.	Apr-24 No date	

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Priority	Performance Summary	Reporting Period	Data
Whole System Evaluation Annual Plan Commitment: • Undertake high impact evaluations of three key specialities (June 2023) • Undertake high impact evaluations of three key specialities (Sept 2023)	Evaluations completed in Therapies and Cardiac Services. At the Theatres Summit in September. Endoscopy, Gynecology and dental services presented their evaluations. Work is ongoing to expand the evaluation process across key specialties and we are refining how we approach this across the UHB, working with colleagues from the NHS Executive.	Mar-24	
Supporting Patients Whilst Waiting Annual Plan Commitment: • Produce models of care (June 2023) • Develop pathways (Sept 2023) • Expand services (December 2023)	Models of care and pathways have so far been produced for 8 services including Prepare Well (Orthopaedics), ESCAPE Pain and Cancer Prehab2Rehab This workstream has been realigned with a national focus the 3 Ps programme and delivery of Single Point of Access from Q1 24/25: - Promoting healthy behaviours - Preventing deconditioning whilst waiting - Preparing for treatment and recovery	Mar-24	

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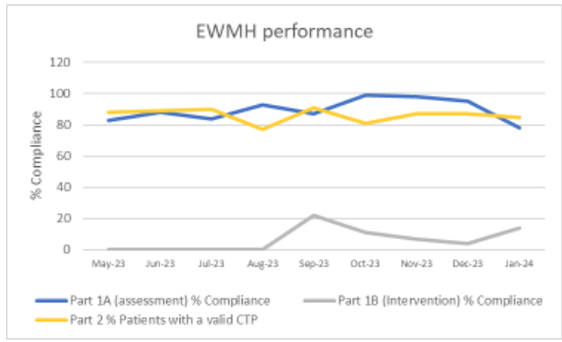
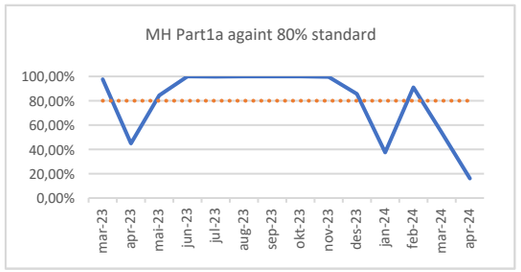
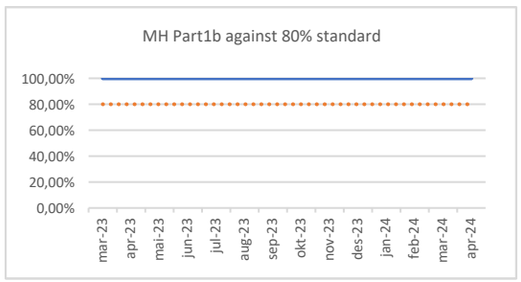
Priority	Performance Summary	Reporting Period	Data
Children's Mental Health Annual Plan Commitments: • >80% Part 1a performance – SCAMHS • Part 1b – 10% improvement (September 2023); further 10% (December 2023); achieve >80% compliance (March 2023) • Reduce SCAMHS Intervention longest wait to no longer than 6 weeks	Part 1a compliance was above the 80% standard at 91% in April 2024. Part 1b performance reduced to 16% and remains low due to additional assessments undertaken to meet Part 1a, high referral levels in June and July 23 and continued workforce challenges. The number waiting continues to increase but the longest wait reduced in February. The number waiting over 16 weeks remains low. There have been data quality issues and a thorough improvement in the capture of data which has further impacted reported performance. The implementation of a new PARIS module has improved data capture.	Apr-24	
Adult Mental Health Annual Plan Commitments: • >80% Part 1a performance • >80% Part 1b performance	Demand for adult and children's Mental Health services remains significantly above pre-Covid levels, with referrals for the Local Primary Mental Health Support Service (LPMHSS) at 1383 referrals in April 2024. As highlighted at the previous Board meetings, this demand increase includes an increased presentation of patients with complex mental health and behavioral needs. Significant work has been undertaken to improve access times to adult primary mental health: • Part 1a: as forecasted. in April the percentage of Mental Health assessments undertaken within 28 days dipped further to 16.1% • Part 1b compliance remains at 100%	Apr-24	 

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No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
10.	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	Mar-24	100%	**98%**	Q1: 98% · Q2: 98% · Q3: 98% · Q4: 98%
11.	Percentage of primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Mar-24	30% (Sept 23) 100% (Mar 24)	**New 178.2%** **New Urgent 91.5%** **Historic 81.6%**	Jan-24 / Feb-24 / Mar-24 New: 151.72% / 164.46% / 178.19% New Urgent: 75.64% / 83.66% / 91.50% Historic: 70.99% / 76.57% / 81.55%
12.	Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Mar-24	Reduction by Mar 24	**791**	Dec-23: 677 · Jan-24: 850 · Feb-24: 793 · Mar-24: 791
13.	Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Mar-24	Increase against 22/23	**1406**	Dec-23: 1263 · Jan-24: 1305 · Feb-24: 1627 · Mar-24: 1406
14.	Percentage of Local Primary Mental Health Support Service (LPMHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	Apr-24	80%	**91%**	Jan-24: 78% · Feb-24: 91% · Mar-24: 91% · Apr-24: 91%
15	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for people aged under 18 years	Apr-24	80%	**24%**	Jan-24: 14% · Feb-24: 19% · Mar-24: 23% · Apr-24: 24%
16	Percentage of Local Primary Mental Health Support Service (LMPHSS) assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	Apr-24	80%	**16.1%**	Jan-24: 37.5% · Feb-24: 91.0% · Mar-24: 53.9% · Apr-24: 16.1%
17	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by Local Primary Mental Health Support Service (LPMHSS) for adults aged 18 years and over	Apr-24	80%	**100%**	Jan-24: 100.0% · Feb-24: 100.0% · Mar-24: 100.0% · Apr-24: 100.0%

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No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
18.	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	May-24	65%	**52%**	Feb-24: 44% | Mar-24: 54% | Apr-24: 51% | May-24: 52%
19.	Median emergency response time to amber calls	Apr-24	12m improvement trend	**01:07:22**	Jan-24: 01:16:33 | Feb-24: 01:17:05 | Mar-24: 01:14:44 | Apr-24: 01:07:22
20.	Median time from arrival at an emergency department to triage by a clinician (minutes)	Mar-24	12m reduction trend	**20**	Dec-23: 19 | Jan-24: 20 | Feb-24: 21 | Mar-24: 20
21.	Median time from arrival at an emergency department to assessment by a senior clinical decision maker (minutes)	Mar-24	12m reduction trend	**68**	Dec-23: 59 | Jan-24: 57 | Feb-24: 67 | Mar-24: 68
22.	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	May-24	95%	**63.7%**	Feb-24: 64.4% | Mar-24: 64.5% | Apr-24: 64.7% | Apr-24: 63.7%
23.	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	May-24	0 (Mar 2024)	**898**	Feb-24: 792 | Mar-24: 814 | Apr-24: 829 | Apr-24: 898
24.	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Apr-24	80% (Mar 2026)	**63.7%**	Jan-24: 64.4% | Feb-24: 60.8% | Mar-24: 62.3% | Apr-24: 63.7%
25.	Number of patients waiting more than 8 weeks for a specified diagnostic	Apr-24	0 (Mar 2024)	**14835**	Jan-24: 14329 | Feb-24: 13908 | Mar-24: 14454 | Apr-24: 14835
26.	Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	Apr-24	Improvement trend	**81.45%**	Jan-24: 79.74% | Feb-24: 77.94% | Mar-24: 77.99% | Apr-24: 81.45%
27.	Number of patients (all ages) waiting more than 14 weeks for a specified therapy	Apr-24	0 (Mar 2024)	**498**	Jan-24: 1591 | Feb-24: 1405 | Mar-24: 1337 | Apr-24: 498

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No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
28.	Number of patients waiting more than 52 weeks for a new outpatient appointment	Apr-24	Improvement trajectory towards 0	**12695**	Jan-24: 11993; Feb-24: 12310; Mar-24: 11759; Apr-24: 12695
29.	Number of patients waiting more than 36 weeks for a new outpatient appointment	Apr-24	Improvement trajectory towards 0	**23382**	Jan-24: 21866; Feb-24: 22165; Mar-24: 22270; Apr-42: 23382
30.	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Apr-24	Improvement trajectory towards 0	**26338**	Jan-24: 32644; Feb-24: 29685; Mar-24: 28020; Apr-24: 26338
31	Number of patients waiting more than 104 weeks for referral to treatment	Apr-24	Improvement trajectory towards 0	**2816**	Jan-24: 3943; Feb-24: 3764; Mar-24: 2681; Apr-24: 2816
32.	Number of patients waiting more than 52 weeks for referral to treatment	Apr-24	Improvement trajectory towards 0	**32436**	Jan-24: 29854; Feb-24: 30757; Mar-24: 31124; Apr-24: 32436
33.	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS) – now EWMHS	Apr-24	80%	**91%**	Jan-24: 78%; Feb-24: 91%; Mar-24: 91%; Apr-24: 91%
34.	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Apr-24	80%	**20%**	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%**	Jan-24: 62%; Feb-24: 63%; Mar-24: 56%; Apr-24: 62%

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Measure		Internal standard	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	Trend
Outpatients	% DNAs - New appointments	5%	12.5%	11.2%	11.1%	9.9%	10.2%	11.2%	10.9%	10.6%	10.3%	10.3%	10.1%	11.4%	9.7%	
	% DNAs - Follow-up appointments	5%	13.0%	13.0%	12.7%	12.1%	12.2%	12.3%	12.1%	12.2%	13.2%	13.0%	12.4%	14.3%	12.3%	
Endoscopy	% room utilisation	90%	75%	87%	82%	95%	91%	95%	88%	87%	76%	70%	73%	83%	72%	
	% utilisation (activity points available)	95%	71%	75%	74%	93%	83%	90%	82%	79%	69%	84%	94%	83%	83%	
Theatres	Average turnaround time (minutes)	10	15.2	14.5	17.5	16.0	18.2	16.1	17.2	16.5	17.1	18.3	16.4	16.7	17.1	
	% of theatre session utilisation	95%	87%	90%	81%	81%	81%	83%	84%	88%	80%	75%	77%	73%	86%	
	% in session utilisation	85%	77%	78%	77%	79%	78%	78%	80%	77%	77%	77%	80%	78%	79%	
	<24 hour elective cancellations		238	314	344	293	292	255	308	338	322	267	289	209	296	
	% 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	126262	128670	131664	134603	135686	136185	140725	141684	141828	142758	145810	147620	149805	
Inpatient	Delayed pathways of Care - Mental Health	217		43	39	45	36	36	31	41	36	37	38	41	38	
	Delayed Pathways of Care - non-Mental Health			204	178	171	140	124	142	150	114	173	200	170	145	
	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%	
	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%	

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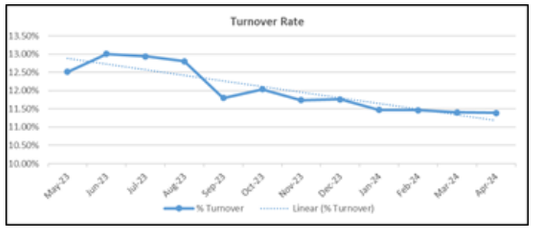
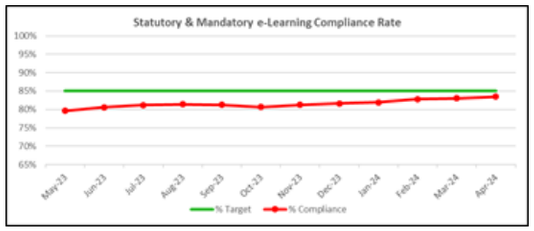
Priority	Performance Summary	Reported Period	Data
Turnover	The overall trend is downwards since May-23; the rates have fallen from 13.01% at Jun-23 to 11.39% in Apr-24 UHB wide. This is a net 1.62% decrease, which represents 230 WTE fewer leavers. The top 5 reasons recorded for leaving are; 'Voluntary Resignation - Other/Not Known', 'Voluntary Resignation – Relocation', 'Retirement Age', 'Voluntary Resignation - Work Life Balance' and 'Voluntary Resignation – Promotion'.	Apr-2024	
Sickness Absence	Rates remain high; although the rates appear to be the falling towards more 'normal' levels. The monthly sickness rate for Apr-24 was 5.36%. The 12-month cumulative rate has fallen steadily over the past 12 months to 6.23% (by comparison with Apr-23, which was 6.87%).	Apr-2024	
Statutory and Mandatory Training	The overall compliance rates rose for Apr-24 to 83.51%, 1.49% below the overall target. The compliance for Capital, Estates & Facilities, All-Wales Genomics Services, Clinical Diagnostics & Therapeutics, Children & Women's, Corporate Executives and PCIC are above the 85% target, and Specialist Services and Mental Health are above 80% compliance. The compliance with Fire training was 73.03% for Apr-23. All Wales Genomics Service have reached 85.37%, but the compliance for all of the other Clinical Boards is below the 85% compliance target.	Apr-2024	 
Values Based Appraisal	VBA compliance continues to rise, to 82.09% for Apr-24. All Wales Genomics Service, Children & Women's and Capital, Estates & Facilities have exceeded the 85% target. Surgical Services, PCIC, Medicine, Corporate and Mental Health are over 80%.	Apr-2024	

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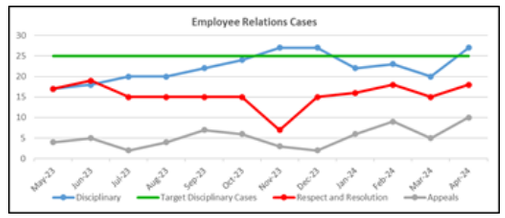
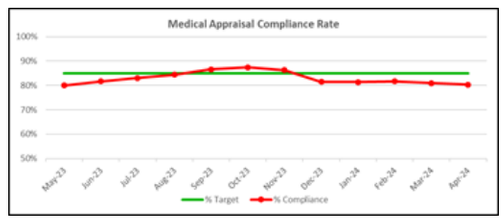
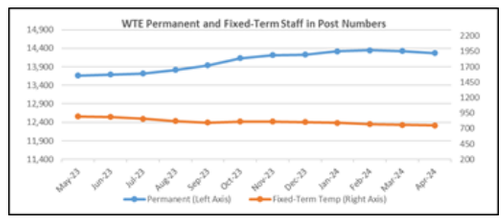
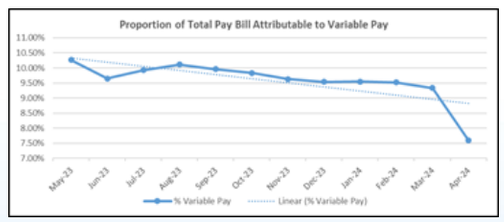
Priority	Performance Summary	Reported Period	Data
Employee Relations	As can be seen in the graph the number of employee relations cases the People Services team are supporting has risen in the past 12 months and have again exceeded the UHB Target. The People Services Team continue to analyse trends of employee relations cases to develop bespoke training packages or additional toolkits/support services where appropriate.	Apr-2024	
Job Plans	The vast majority of clinicians have now engaged with job planning and have a job plan in the system, however only 27.46% have an agreed job plan that has been signed off within the past 12 months. Focus now need to turn to ensuring that job plans are reviewed and signed off in a timely fashion.	Apr-2024	
Medical Appraisals	The rate of compliance with Medical Appraisal has fallen for the past 5 months. At Apr-24 the compliance was 80.32% and remains below the 85% target.	Apr-2024	
Staff in Post	The overall Health Board Staffing Numbers have increased in the last 12 months by 464 WTE, to 15,021.52 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.	Apr-2024	
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 May-23 the percentage was 10.278% of the total spend on pay, but in Apr-24 had fallen to 7.60%. It must however be borne in mind that the total pay bill is increasing.	Apr-2024	
Staff Influenza Vaccination Programme	The 2023-24 winter vaccination programme closed at the end of Mar-24.	Apr-2024	

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No.	Performance Measure	Reported Period	Performance Standard	In Month Performance	Trend
36.	Percentage of sickness absence rate of staff	Apr-24	6%	**5.36%**	Jan-24: 6.93%; Feb-24: 6.41%; Mar-24: 5.87%; Apr-24: 5.36%
37.	Staff turnover measure tbc starters and leavers and/or vacancies?	Apr-24	7%-9%	**11.39%**	Jan-24: 11.47%; Feb-24: 11.47%; Mar-24: 11.41%; Apr-24: 11.39%
38.	Agency spend as a percentage of the total pay bill	Apr-24	12 month reduction trend	**0.91%**	Jan-24: 1.16%; Feb-24: 1.39%; Mar-24: 0.60%; Apr-24: 0.91%
39.	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training)	Apr-24	85%	**81.98%**	Jan-24: 69.41%; Feb-24: 74.52%; Mar-24: 80.36%; Apr-24: 81.98%

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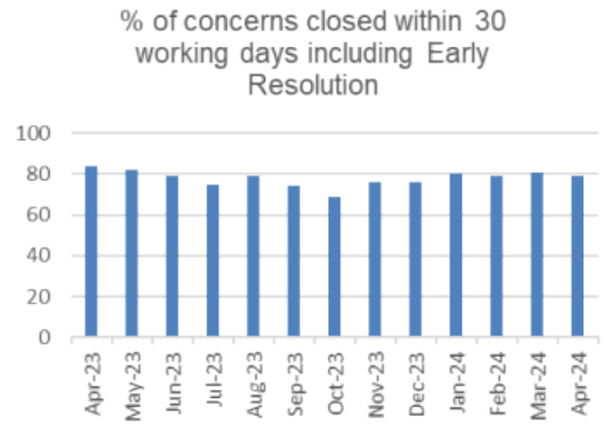
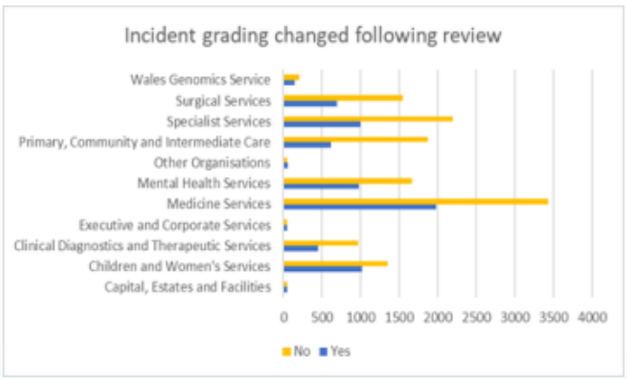
Priority	Performance Summary	Reported Period	Data
Concerns 30 day performance	**Welsh Government target for responding to concerns is 75% within 30 working days** **During March and April 24, the Health Board received :** 1. 704 Concerns 2. Closed 684 concerns 3. 81% closed within 30 working days (including Early Resolution) 4. 30 % closed under Early Resolution (within 2 days including day of receipt) 5. 201 Enquiries 6. 64 Compliments 7. We currently have 298 active concerns **Top 3 themes and trends** 1. Concerns around appointments (waiting times/cancellations) 2. Communication 3. Clinical Treatment and Assessment	March and April 2024	
Duty of Candour	• Since April 1st 2023, 29,273 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 139 occasions • We have internally audited the process and compliance	To March 2024	

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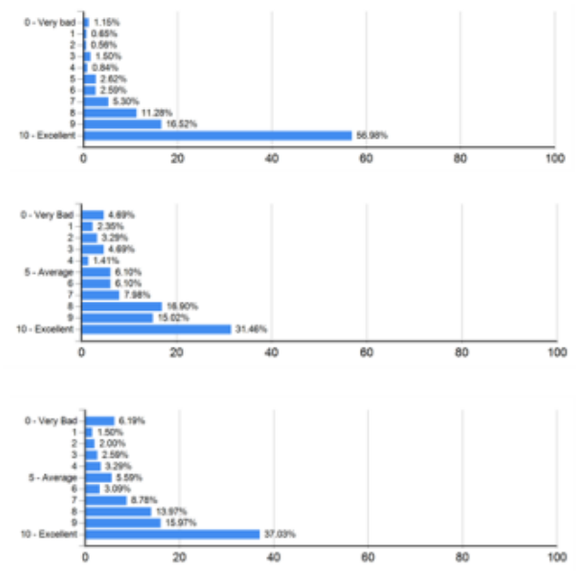
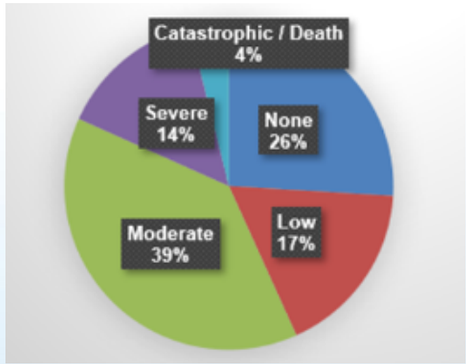
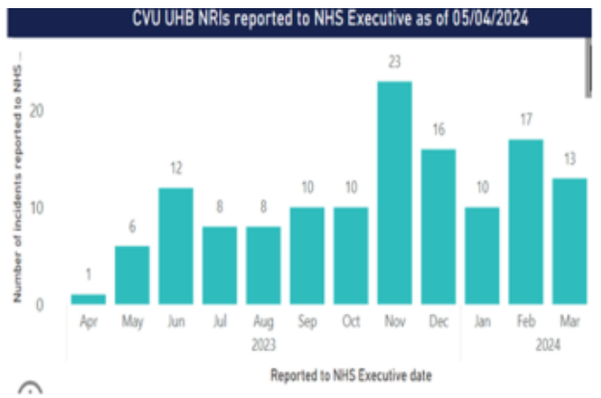
Priority	Performance Summary	Reported Period	Data
Patient Feedback – Civica	• We implemented the Civica feedback system in October 2022 randomly selecting 600 patients a day, we are now currently surveying up to 1000 patients daily via text, 600 chosen randomly from general hospital activity, 200 from EU activity and 200 from Mental Health activity. Over the past 12 months, we have sent 147,702 texts and are seeing a response of 17%. • In March, we sent 13,948 texts and had 2444 completions (18% response). • In April, we sent 13,947 texts and had 2236 completions (16% response). • Of those respondents who were discharged during March/April 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 10 NRIs to NHS Executive in April 2024; 2 relate to the new national requirement to NRI report MBRRACE cases, and 3 relate to hospital acquired pressure damage. A higher than average number of closure forms were submitted in April 2024 (16) leaving us with 92 open NRIs and 45 of these are overdue for closure. Overall, from 1st April 2023 to 30th March 2024, C&V UHB reported 134 NRIs. The top 5 NRI categories are illustrated in the second chart; clinical assessment/ diagnosis is the most prevalent reporting category, the improvement work aligned to this will be the theme for this 'World Patient Safety Day which is entitled *Improving diagnosis for Patient Safety. The increase in neonatal NRIs reflects the change in national reporting Criteria to include MBRRACE.* **Harm level** – 39% of the NRIs reported in this period were recorded with a post investigation harm level of moderate which triggers a DoC response. 43% had none or low harm attributed. 		

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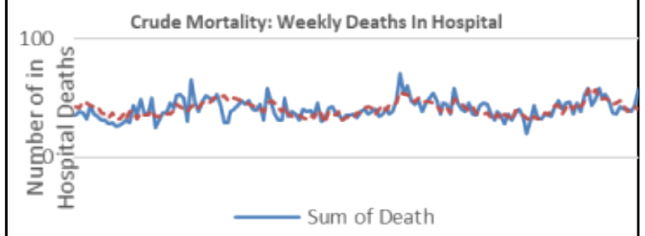
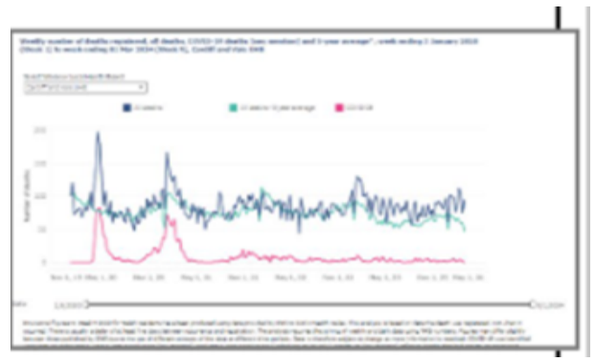
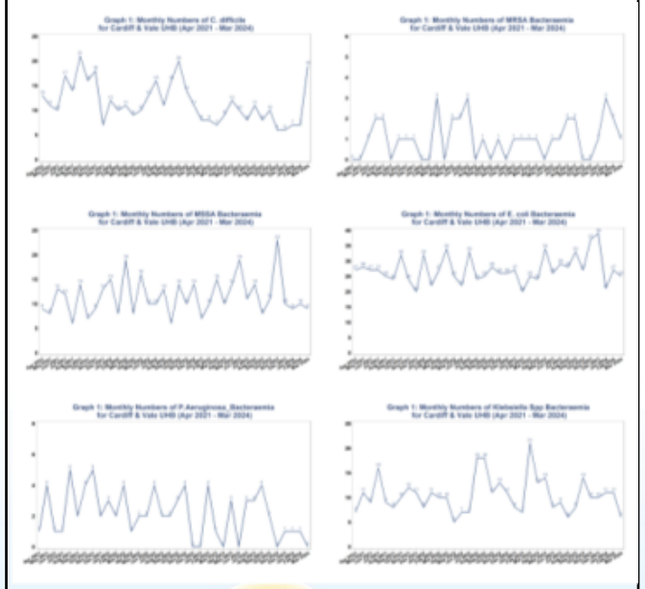
Priority	Performance Summary	Reported Period	Data
Tier 1 Mortality	Inpatient Mortality The Crude Inpatient Mortality chart demonstrates continued inpatient mortality in line with the five year average for the same reporting period. 100% of patients that die as an inpatient now receive independent scrutiny 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	March 20 – March 24	 
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.	x	

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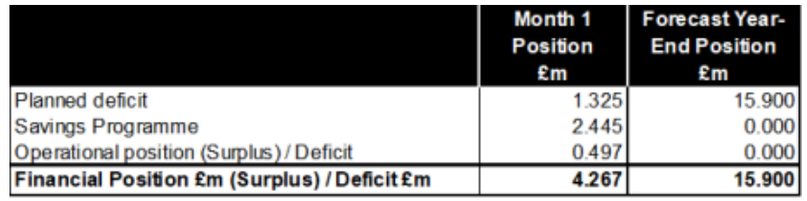
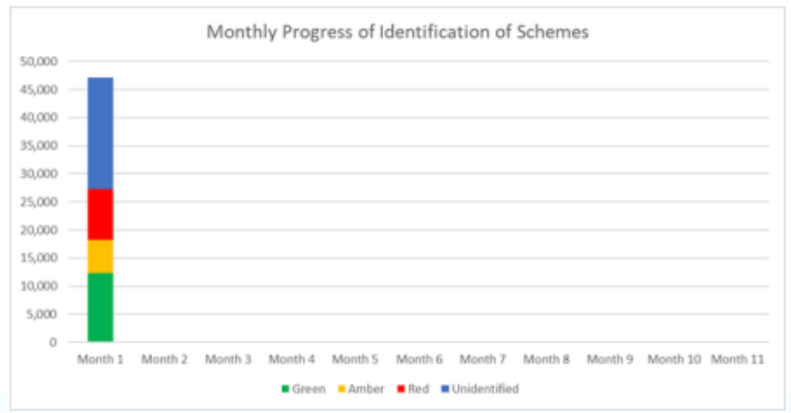
Priority	Performance Summary	Reported Period	Data
Deliver 2023/24 Draft Financial Plan	**Financial Plan Approved by Board and submitted to Welsh Government** • Brought forward underlying deficit of £60.9m • 2024/25 Demand and cost growth and unavoidable investments of £45.4m • Allocations and inflationary 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 1, the UHB is reporting an overspend of £4.267m. This is comprised of 0.497m operational overspend, a savings gap of £2.445m and the planned deficit of £1.325m (1 twelfth of the revised forecast year end deficit of £15.900m). The UHB expects to recover the month 1 operational & savings overspend to deliver the £15.900m planned deficit.	Apr-24	
Delivery of recurrent £32m savings target	At month 1, the UHB has identified £18.181m of green and amber savings against the £47.2m savings target. The progress in the identification of schemes during the year is shown in the graph on the right	Apr-24	Graph - Progress of Identification of Schemes 

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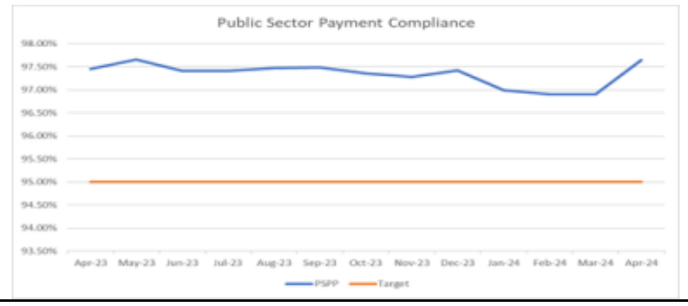
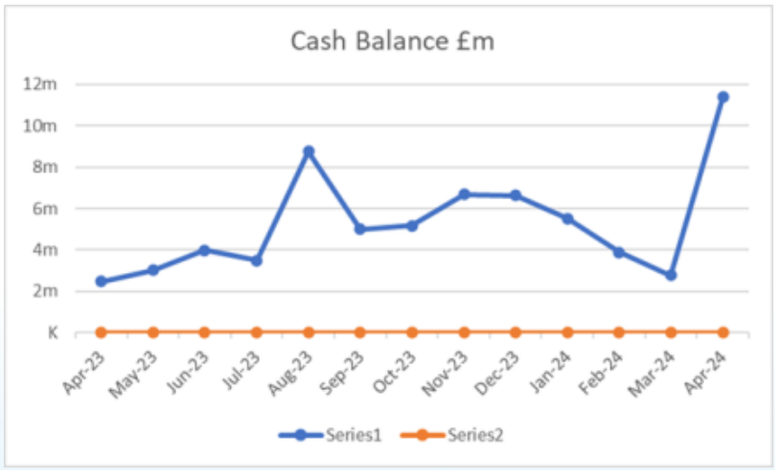
Priority	Performance Summary	Reported Period	Data
Remain within capital resource limits	The UHBs approved capital resource limit (CRL) is £33.932m in line with the CRL received from Welsh Government on the 18th April 2024. This comprises of £13.654m discretionary funding and £20.278m towards specific projects (including Efab, Interventional Neuroradiology Equipment, Mortuary, UHW Lift Refurb and upgrade). The UHB is reporting that it will remain within its Capital Resource limit in 2024/25.	Apr-24	
Creditor payments compliance 30 day Non-NHS	The UHB's public sector payment compliance performance is above the target of 95%. Performance for the month to the end of April was **97.6%** for the year to date as illustrated in the graph to the right.	Apr-24	
Remain within Cash Limit	The UHB forecasts to remain within its 2024/25 cash limit based on the assumption that Welsh Government will provide support for movements in working capital from the 2023-24 Balance Sheet and for the £15.900m 2024/25 planned deficit.	Apr-24	
Maintain Positive Cash Balance	The closing cash balance at the end of April 2024, was £11.379m. A detailed monthly cashflow forecast is included in the monthly monitoring return submission to Welsh Government.	Apr-24	

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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	Improvement trend	70%	Jan-23: 59%; Feb-23: 56%; Mar-23: 44%; Apr-23: 70%
41.	Percentage of all classifications' coding errors corrected by the next monthly reporting submission following		90%	Work in progress	
42.	Percentage of calls ended following WAST telephone assessment (Hear and Treat)		17% or more	Work in progress	
43.	Number of Pathways of Care delayed discharges		12 month reduction trend	Work in progress	
44.	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	Mar-24	90%	**83.6%**	Dec-23: 86.5%; Jan-24: 85.3%; Feb-24: 88.0%; Mar-24: 83.6%
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	Mar-24	90%	**55.2%**	Dec-23: 52.0%; Jan-24: 54.4%; Feb-24: 54.0%; Mar-24: 55.2%
46.	Number of patient experience surveys completed and recorded on CIVICA *(Total partial/full survey completions, including SMS, Bedside and bespoke)*	Feb/Mar-24	Month on month improvement	↑ **4489**	As noted IT issue is affecting returns-being addressed

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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* - 58 *P. aeruginosa* – 18	**14** **2**	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*; *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**	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**	On trajectory to achieve the reduction expectation rate
50.	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	May-23	Reduction against 22/23	Work in progress	Work in progress
51.	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Feb-24	95%	**56.23%**	Nov-23: 55.21%; Dec-23: 55.50%; Feb-24: 56.26%; Feb-24: 56.23%
52	Number of ambulance handovers over 1 hour	May-24	0 (Mar 24)	**1705**	Feb-24: 1648; Mar-24: 1797; Apr-24: 1704; May-24: 1705
53.	Number of patient safety incidents that remain open 90 days or more	Apr-24	12-month reduction trend	↓ **5,695**	First month reporting a reduction in this figure (March figure was 5,869).

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Report Title:	Progress against Decarbonisation Action Plan – Q4			Agenda Item no.	
Meeting:	Finance and Performance Committee	Public	X	Meeting Date:	19/06/2024
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive:	Marie Davies, Interim Executive Director for Strategic Planning				
Report Author (Title):	Calum Shaw, Environmental Sustainability Project/Planning Manager				

Main Report
Background and current situation:

The purpose of this paper is to update the Finance and Performance Committee on the closing out of the actions contained in the 2023/24 Decarbonisation Action Plan.

Context

In March 2023, the Board approved the 2023/24 Decarbonisation Action Plan and defined a series of actions, owned across the UHB. The plan built upon previous plans and the actions defined as mandatory by NHS Wales in their Decarbonisation Strategic Delivery Plan. Board also approved a 2024/25 action plan in March 2024.

The 2023/24 action plan contained 54 actions set out over 6 sectoral areas, Leadership, Estates, Transport, People and Communications, Clinical and Procurement. It was agreed actions will be reported back on a quarterly basis to the Decarbonisation Delivery Group and Finance and Performance Committee.

It is estimated that around 3% of our carbon footprint or 8,000 tonnes has been avoided in year.

The 2023/24 Decarbonisation action plan has created further momentum across the organisation; including:-

- The identification of how our operational priorities are avoiding carbon emissions
- Improved visibility and awareness of the need to reduce emissions
- The further ingraining of decarbonisation into the organisation

Detailed updates against all actions can be found at doc 1.

This report asks the Finance and Performance Committee to:

- **Note content of this report and the closure of the 2023/24 action plan**

Executive Director Opinion and Key Issues to bring to the attention of the group:

The table below shows the overall RAG status against actions contained in the DAP.

RAG	Q4 Actions
Blue/Complete	37
Green	10
Amber	4
Red	3
Total	54

Q4 Report

The majority of the actions (47) have been achieved this year, with 37 complete in year. Many actions have been carried forward into the 24/25 DAP to build on the successes and/or improve outcomes.

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Amber Actions

- Sustainable value working group – Work is underway to develop a green theatres and re-usable gowns project in collaboration with procurement. This action started later than envisaged and will continue to conclusion.
- Culture change – There has been work undertaken to change the culture to support decarbonisation, however, additional efforts are required to fully integrate it into the organisation. The action is being taken forward into the 2024/25 plan.

- Influence Course Materials – Work has been produced to feed into newsletters and corporate inductions. It has not been feasible to fully integrated into internal courses.

Red Actions

- SOFH Strategic Outline Case – The SOFH SOC has not been funded and therefore not written.
- Digital SOC - The Digital SOC has not been written with the year.
- Shaping our Future Clinical Services – The SOF Clinical services plan commenced but has not been written within this year, due to lack of SOFH funding.

Positive Q4 highlights include:

To date there has been significant progress against the Decarbonisation Action Plan. **It is estimated that around 3% of or 8,000 tonnes of our carbon footprint has been avoided in year.** The actions below provide a summary of the outputs under the programme:-

- Decarbonisation has been included in Shaping our Future Well-being Strategy, Acting for the Future theme.
- Around 5,000 tonnes of CO2e is estimated to have been avoided in 23/24 due to financial sustainability measures undertaken.
- 6 Goals and Planned Care programmes have been reviewed and estimated to have avoided 1,350 tonnes CO2e
- Decarbonisation is now included within the job description templates.
- Sustainability leaders in post for Clinical, Nursing and Therapies roles.
- Sustainability Fellow in post
- Climate Champion numbers have grown across the organisation including ED and ICU.
- Regular communications are being shared throughout the organisation which includes messaging from senior leaders.
- Decarbonisation is included in corporate inductions.
- Sustainability Pledge calendar has been developed to support staff to make lower carbon choices. With over 130 staff signed up.
- Regular Green Groups have taken place for staff to share knowledge on sustainable projects.
- Estates have completed 4 investment grade proposals to install low carbon heat solutions in community sites and several feasibility studies for renewable energy.
- Installed energy efficiency measures through REFIT are estimated to save c2,000 tonnes of CO2 per annum going forward.
- Level 2 Healthy Travel Charter has been approved by Board.
- Air Quality monitored at UHW and UHL and are compliant with WG targets.

Next steps

The new 2024-25 Decarbonisation Action Plan was approved by board on the 30 March 2024, which can be found at doc 2. Much more work is required across the organisation to embed low carbon behaviours in all that we do. The good news is that low carbon is compatible with efforts to improve patient experience, patient outcomes, quality, productive capacity and financial efficiency.

Quarterly reports will be provided to Finance and Performance committee with the 2024/25 Q1 report in October 2024.

Recommendation:

Finance and Performance Committee are asked to:

- **Note content of this report**

Link to Strategic Objectives of Shaping our Future Wellbeing:

Please tick as relevant

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
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	x	8. Work better together with partners to deliver care and support across care sectors,	

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		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	x

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

Impact Assessment: *Please state yes or no for each category. If yes please provide further details.*
Risk: ~~Yes~~/No
Safety: ~~Yes~~/No
No issues to safety
Financial: Yes/~~No~~
The delivery of carbon savings tend to have a positive impact upon cost savings. Several themes in the cost improvement plan can have associated carbon measures attached to them. Two examples are medicines management which is finding ways to reduce consumption and buildings through energy efficiency schemes.
Workforce: Yes/~~No~~
Our workforce adopting sustainable ways of delivering their day to day responsibilities is a long way off and our current action plan seeks to make inroads into that.
Legal: ~~Yes~~/No
Reputational: Yes/~~No~~
There is potential for reputational risk to the organisation if action are not completed on time.
Socio Economic: ~~Yes~~/No
Equality and Health: ~~Yes~~/No
Decarbonisation: Yes/~~No~~
The actions contained in the DAP directly impact on our emission reduction targets.

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Actions						Reporting update				
Sector	Action	Owner	Measure	By when	Quarter	Q1 - June	Q2 - Sept	Q3 - December	Q4- March	End of year RAG
Leadership	Decarbonisation to be an agenda item of all relevant executive meetings (with any ToRs amended).	Director of Corporate Governance	Audit of Exec and Department meetings. Carbon impact of work (KG/tCO2e)	2023	Q3	Finance & Performance Cttee has had its ToR amended to include, "provide assurance to the Board that all Health Board plans consider decarbonisation impact". F&P Committee reports to the Board. Papers for committees contains a risk assessment section that includes Decarbonisation. With the agreement of Corp Governance, updated guidance is being provided so that that section of the paper can be well considered by authors, providing simple guidance as to what decarbonisation is.	Reported on Q1 performance to F&P Committee on 19/7/23 and 20/9/23. Q2 to be reported on during December. Guidance for Board papers around what decarbonisation is to better inform people what could impact carbon was updated in Q1 and incorporated by Aaron and Nathan.	Paper went to Finance & Performance committee on progress in 12/23.	A direct link between this action and savings/avoidance of carbon cannot be proved at this time, however, a regular heartbeat of reporting to Finance and Performance Committee has been achieved.Internal audit commenced a review on 9/2/24, from which learning could be gleaned about whether our leadership could be improved. Enquiring with equality team whether decarb can be included in EHIAs. An all Wales template is being worked up and workforce have agreed to influence This action is being carried over into our 24/25 action plan through an action, "Setting CVUHB as leaders in low carbon delivery."	Red
Leadership	Develop an estimate of what 2025 16% reduction would take – effort and money.	Sustainability Manager	Estimate produced of cost and transformation to achieve a 16% saving.	Autumn 2023	Q2	A problem statement has been drafted on the route to 16% and has been socialised with colleagues. Finance are looking into the likely future movements in spend that will drive emissions. Clinicians have engaged to consider the wider service changes that may be needed to deliver a significant emissions shift. Further workshops to be held in July.	Complete as an illustration of what needs to be done using a combination of real data and assumptions. The message is that spending less money (Financial Sustainability), improving productivity through existing programmes such as 6 Goals and Planned Care and reducing supply of services through reducing demand provide a means of reducing carbon significantly. These activities show how 16 and 34% could potentially be achieved. The costs of decarbonising are at this stage not real in the model. If it is assumed that existing programmes (6 Goals, etc) are already funded. Additional or re-prioritised existing funding would be required to fund demand reduction activity with an ROI that varies between 5:1 and 14:1 according to studies. The findings have and are being socialised around colleagues to determine their onward use. Feedback from colleagues has been positive and interest shown from PHW and Value In Health. The approach has been shared pan-Wales. Furthermore, the impact that	The previous work thas been used to inform the next action plan which is being developed during Q3 and Q4. Actions that focus upon prevention and operational efficiency are candidates to be included. Finding the operational programmes that are avoiding carbon is stimulating ways in which carbon benefits can be tagged onto these work items.	Complete	Amber
Leadership	Decarbonisation to form a part of the SOFW strategy refresh.	Executive Director of Strategy and Planning	Included in refreshed strategy having completed public engagement.	aug-23	Q2	Decarbonisation has been included. SOFW strategy refresh is currently out for public engagement. It is a theme under Acting for the Future: "Be the exemplar organisation in NHS Wales for delivering our carbon emissions targets and fully supporting active and sustainable travel for staff and visitors to patients"	Complete. Clinical Boards have presented their plans and begin a process of prioritisation. Plans will be checked back against the strategy (Acting for the future in the case of decarbonisation). The decarb team will be involved in the initial fact finding about what the clinical board plans will aim to achieve and whether there will be carbon saving potential. Clinical Board plans were presented to SLB in mid November. Activities that have potential carbon impact have been identified.	Work in Q3 entailed following through clinical board plans to ensure they have decarb built in. Seeing the candidate initiatives for the IMTP early is allowing the decarb team to identify what will deliver carbon savings on top of any operational/financial/patient benefits. The 100k day bed opportunity is a large carbon avoidance opportunity for example. Discussions have been held with Operations about aligning their intentions for 24/25 with carbon impact. These discussions are positive and a contact has been provided to liaise with the carbon team - the Value Programme Manager. The 24/25 decarb action plan is being developed with alignment to SOFW's 2027 ambitions.	Opportunities are being used to communicate that the SOFW strategy has low carbon throughout the four themes even though only one theme mentions it directly, i.e. it is by hitting the strategic ambitions that our carbon footprint will be better managed.	Green
Leadership	Executive colleagues to continue to take annual objective to impact carbon emissions.	Executives	Impact as a result of taking an objective.	Ongoing	Q4	Due to be implemented.		Chair's objectives passed down from Minister, allowing executive objectives to be set. They will include carbon.	TBC	Blue
Leadership	Decarbonisation Identified as a risk on the corporate risk register	Sustainability manager	Board assess the risks of mitigation and adaptation to the Health Board	2023- Ongoing	Q3	A draft strategic risk has been produced for the UHB. Once the draft has been agreed it will go through the corporate approval process.	Following corporate governance comments a revised version of the document has been drafted for apporval. Risk will need to sit with Strategic planning prior to being escalated to corporate risk team.	Additional advice has been sought from Director of Corporate Governance. It will require a significant revision to the draft risk. A final risk will be in place within Q4.	Risk raised on Strategy risk register. Working with Corp Governance on a climate risk being part of the new approach to the Board Assurance Framework. This action has been carried over into the 24/25 action plan given the work taking place to the Board assurance framework. Marking as amber for the end of the year given carbon is not in the BAF but will be once the way of aligning the BAF to the SOFW strategy has been thought through by Corp Governance.	
Leadership	Decarbonisation to be a central pillar of decision making across all leadership functions from Board through to at least department/clinical board.	Executives	Evidence of decisions made taking decarbonisation into account	2023	Q3	Investment Group consider carbon impact as part of its evaluation criteria. Finance & Performance Cttee provides assurance to the Board that all health board plans consider decarbonisation". Further work is required to understand effectiveness.	Will review upcoming cases for IG so that decarb questions can be raised to the case owners. Ashleigh will include Ed in the planning for 24/25 cases this autumn so that opportunities are having decarb built in. After Ash sent the list of business cases, all seem on the face of it to have carbon impact that could be articulated. Ed has contacted some of the owners. As of 29/8 no replies yet apart from Public Health. Sustainability team have been asked to review the regional diagnostic	It cannot be said that decision making is yet taking carbon into account, though progress is being made with Value and Ed has agreed with Adam to embed into the Ops programme of work the carbon by-product benefits coming from their projects and programmes.	Business cases for Stroke, EPMA and WICIS have been reviewed with queries being fielded back to the business case owners. Carbon benefits/disbenefits have been tagged to these business cases and its interesting that the technology business cases all add to our carbon footprint. This action is being carried over into 24/25 plan. Decision making is not happening naturally and is relying on the carbon team getting involved in business case reviews so there is still work to do, but marking as complete.	

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Sector	Action	Owner	Measure	By when	By when	Q1	Q2	Q3	Q4	End of year RAG
Leadership	Investigate how to measure emissions at a departmental level with the aim of monitoring savings and actions for decarbonisation	Sustainability manager	A means to track changes in financial and/or carbon using Health Board data.	March 2024 - ongoing	Q4	A plan is being drafted to set out how this project will move forward. Emissions against Waste, energy and procurement are the predominant focus, however this can be expanded to cover transport commuting emissions. Initial engagement has taken place with procurement to understand the emissions profile for individual departments. Data has been provided for a trial department and an assessment of emissions is in progress. We are also looking at opportunities for assessing energy usage per department across sites.	Data has been provided for a number of areas including departmental glove usage and to Therapies for a pilot. Gloves is progressing through a centrally supported programme. Therapies data has been used to identify the top 5 items each of the 5 therapies use/buy in order to run improvement projects to find better alternatives. Actions are going to be developed alongside sustainability champions. Financial sustainability actions have been assessed against the decarbonisation potential/ carbon avoidance. For data cut at the end of September, a possible estimated 4,000t of carbon avoidance benefit is up for grabs.	The Gloves off projects will commence in ICU in Q4in pilot form. Reductions in usage will be reviewed against current baseline. This is in advance of a wider campaign supported by I&I. ICU team have a view of their energy use and the products used to treat a patient with multiple organ failure over 24 hours. ICU team are systematically reviewing high usage items to assess potential reductions. Efficiencies have been made. The Energy team through the Enica programme are planning to install more localised metering which will provide departments with a more accurate picture of reductions in energy usage.	ICU have created a measure of their carbon footprint through the manual compilation of many data points. This has required a team of willing volunteers. so the collation is not 'turn key'. At the moment, replicating this is not sensible, though if another department wish to measure their footprint, a template exists.	
Leadership	Sponsorship of Climate Champions across the organisation with either dedicated time allocated to research and recommend change or to drive change that is known to have worked elsewhere.	Executives	Each champion to keep a record of delivery against their champion assignment specification. - Carbon impact of work (KG/tCO2e)	2023 – Ongoing	Q3	Therapies have their own decarbonisation action plan. This includes the creation of champion roles within each services with dedicated time. The plan goes further also, considering products used, promoting virtual consultations, incorporating in service redesign to name a few. In nursing, a nursing decarbonisation forum will be set up by the lead decarbonisation nurse (Rebecca Aylward). This forum will consider and qualify quality improvement initiatives that have a carbon benefit, starting with non-sterile glove use reduction and continence pads. How champions work will be considered on a per project basis, but in the short term there is part time a role identified (for approval) to co-ordinate the projects qualified by the nursing forum. In the clinical community, championing further carbon improvements could be done through projects approved by the Value programme.	Rebecca Hanmer is the lead for Therapies and each off the 5 therapies have a nominated champion to work on improvement projects. Rebecca A has established 3 priority programmes (gloves, continence pads and nurses uniforms) and set up groups to support delivery. Clinical Champion in post 8th Sept - update Q3 Roles have been established within ED and critical care which will support sustainability within those specialities. Need to find out from Sophia the plan for Value projects are being taken through for approval.	Therapies actions: -Ensure recruitment of champions for each area within therapies. -From baseline Maturity Matrix data collected in Q2 by each of the champions, match areas that have achieved against the plan to those where improvements need to support learning. -Action Plan Spreadsheet set up for each of the champions to collect the detail against the plan of current progress. -SharePoint page set up to share information on progress and house current maturity matrixes for each area and Action Plan Spreadsheet. Clinical -Working with 3 clinicians - CD (surgical clinical board), CA (Palliative/supportive care) & CD (peri-op & diabetes) to retrospectively & prospectively measure the carbon savings & carbon avoidance of their value work. Numbers will be available for Q4. -We have supported Revolution-ZERO with a Welsh SBRI circular economy bid focused on how we could establish Revolution-ZERO reusable sterile surgical textiles into Wales, starting with 6/52 trial across 3 HBS. (CAV, ABUHB & Swansea Bay)	•Identified funding for role 'Let's Not Waste (Sustainability) Champion'. To be advertised internally within Dental shortly. Initially for 12 months. •Work streams and progress: SALUD electronic upgrade and going paperless - Directorate plans to go paperless with student clinics upgraded by September 2024 (expected timeline) and rest of Dental afterwards. Intermediate Oral Surgery Services (ImOSS, CAVUHB) providing Oral Surgery care closer to home. 3D innovation - our IMTP. Workstreams on developing 3D inhouse capability including metal printing. Don't Forget Your Toothbrush (please see attached). Started in Dental 2023. We are joining forces with the Dental School in sustainability efforts. I have attached the Dental School publication on sustainability workstreams. Collaborating with School on this will open many doors. Decommissioning N2O manifolds and convert to cylinders. Staff survey completed and full support for this switch. Working with Pharmacy and Clinical Engineering to implement. Therapies actions Currently in the Quality Planning stage position to date: •35 champions across areas •1:1 time offered to champion leads in areas to support actions required	
Leadership	Propose Board level training on Decarbonisation to increase awareness and be able to be seen as evangelists to the rest of the organisation.	Sustainability manager	TBC	2023	Q3	The options for a board level training courses are being researched with an options paper being drafted. A proposal paper will be set to the Decarbonisation SRO, Abi Harris, prior to submission to the Chair for consideration.	Document has been highlighted but there is no availability of funding to support delivery. Provisionally scheduled for Feb Board development and seeking alternative funding opportunities	A session has been booked in for April to present during Board Development. The session will run for 90 minutes and will raise awareness of Climate change and actions to decarbonise. A draft structure and storyboard to be developed shortly. Completion by end of Q4.	Delivered in April 2024 having been moved from February 2024.	
Leadership	Sponsor a decarbonisation behaviour change programme with an associated communications campaign to encourage self participation and increase skills.	Senior Leadership Board	Audit and assessment of delivery Carbon impact of work (KG/tCO2e)	2023-2025	2023-2025	There is agreement that the emerging Quality programme can include carbon reduction. A programme will be set up this summer and this will be the vehicle to promote quality of which carbon reduction is an element. The 6 Goals also contain principles that would see reduced carbon. It has been agreed with Operations that Admissions, Healthy Days At Home, LoS and Ambulance conveyances are relevant metrics that they are capturing and from which shifts can have carbon values attached. Candidate measures are also being considered with the planned care programme - through the running of this improvement programme, carbon savings should fall out. Ways to assist are being sought.	Mike Bond wants to run a campaign. Zoe Hilton has a campaign template to consider. Will likely be aimed at cost/waste reduction with knock on of carbon savings. Meeting to be held w/c 31/7. 31/7 - Workshop on 2/8 organised by Jo Brandon on the back of cost saving. The cost improvement programme will save carbon and is where the UHB's priority is. Comms will be supporting the people leading workstreams tasked with making savings. Messages can be complimentary to decarb. EH has contacted Mike Bond about how to activate.	Regular heartbeat of communications, including Welsh Climate Week in December. A sustainability pledge calendar for 2024 has been created for rolling out in 2024.	Sustainability pledge calendar has been created for staff to undertake actions across the year which support carbon reduction, as well as, improved improving staffs personal health and the financial sustainability of the organisation. A session was held with the CEO to discuss the deacrbonisation and the action which we will require all staff to undertake. At an "ask Suzanne" session the updated deacrbonisation action plan was also presented to raise awareness and undertanding of the programme. ICU have been working up a campaign to encourage staff to use non-sterile gloves in only certain circumstances to reduce usage (only when necessary). Its been soft launched in February and will be launched in April. There will be learning coming from this to inform other campaign initiatives. As of Feb, there are no results to report yet.	
Leadership	Leaders are prominent in sharing, promoting, valuing and reinforcing decarbonisation actions to all staff	Executives	TBC	March 2024 - ongoing	Q4	comms to develop the engagement strategy. A plan is being developed to support leaders share information with their stakeholders and be kept abreast of emerging decarbonisation news. The need to save money, push on quality and deliver against agendas such as the 6 Goals will see carbon savings.	sustainability work indicate a potential carbon avoidance for 23/24 of approx 4,000 tonnes. Further work is going to be going into disinvestment and productivity improvements for the rest of this year and next. Safer @ Home estimates 1,200 - 1,800 bed days per month being saved. This equates to 542-819 tonnes of carbon potentially to be saved per annum (even as high as 1,404t based on Chris' latest figures	MSDEC = 5766 patients seen minus 644 patients admitted. 5122 patients net x 37.9kg = 194t SDEC = 9959 patients seen minus 2529 admitted. 7430 patients net x 37.9kg = 282t Virtual ward. Ops report estimated bed days saved as 1989. Therefore 1989 x 37.9kg = 75t A total of 551 tonnes of carbon avoided since 1/4/23. Length of stays for patients over 21 days have been	the carbon team. Digital team have introduced an electronic way of requesting inpatient radiology. It has been estimated that 700kg of carbon has been saved through not using paper. The push on 6 Goals, planned care and the financial sustainability programme are yielding operational as well as carbon benefits. Highlight	
Leadership	Decarbonisation is included in all clinical service redesign	Executives	Audit and assessment of delivery	March 2024 - ongoing	Q4	Work is underway to embed decarbonisation in clinical services redesign. To be integrated into IMTP planning, therefore working alongside Marie Davies and Ashleigh O'Callaghan. The Tertiary Services Strategic team are using carbon impact as part of their consideration, for example in their future of HPV work and how	Met with Ashleigh on 26/7. Guidance on what decarb is sent for consideration by Ash. Agreed to trial carbon as a factor in service redesign for the emerging regional cataracts service. Engagement this autumn and business case around December 2023. Ashleigh thinks we need design principles that fall out of the Strategy Refresh. Carbon to be in these design principles, but to be further worked upon.		Opportunities will be exploited as and when they arise.	

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Estates	Decisions on estate and new buildings made with decarbonisation as a central pillar	Executives	Implementation of projects with measures included.	Ongoing	Q4	A process in in place to support the delivery of new low carbon buildings. Updates will be provided as new projects come online	Nothing to report	Nothing to report	Nothing to report	
Estates	Assess the future of UHW and UHL through a Strategic Outline Case for Shaping Our Future Hospitals to inform long term decarbonisation investment bids.	Programme Director Shaping our future hospitals	Complete pending approval	TBC	TBC	The SOC for SOFH is not yet being funded by WG. Options work is not forecast to take place until 2024. This action is unlikely to be delivered by 3/24.		Presented to IIB on 13/11 and a proposal to develop a maste	A 30/5 IIB has been arranged to seek permission to procure a masterplanner for SOFH.	
Estates	Commit to undertaking a programme of feasibility studies to decarbonise our estate to understand the potential projects, the costs and carbon benefits.	Director of Estates	Feasibility studies delivered	March 2024	Q4	As the UHB has implemented energy conservation and decarbonisation measures via the Refit program. Studies to identify opportunities at specific sites have been undertaken and presented in an Investment Grade Proposal.	As Q1	There is limited funding available through the WGES Grant - Aiming to apply for additional funding which needs to be submitted by the end of January. If approved work will likely commence in March. On site works not until June. £6.9m investment completed during 2025. The project will include Solar PV roof UHW, PV on multi-story UHW, solar car ports outside UHL, UHL replacing 171 single glazed windows, pipe lagging(insulation) and LED lighting. Solar PV and LED at community sites - sites identified, ALAC, Fieldway and Riverside. Low carbon heat at community sites has stalled. UHL is being reviewed for heat pumps. £3.2 million low carbon heat project assessed for Barry Hospital and was not seen as feasible. Bid for Re:Fit phase 3 being prepared.	Refit 2 - The programme has now been closed. Solar panels have been fitted but there are some technical aspects will be finalised early next year. The benefits of REFIT 2 will be 2,026 tonnes of co2 saving (300tco2e solar TBC). As the programme was completed at the end of the year benefits will not be realised until 2024-25 emissions report. Re:fit 3 - Bid has been submitted - estlimated savings of 476 tonnes of carbon and £603k. The programme will have a 10 year payback. The scheme did not get approval for Heat pumps at Barry. Payback did not meet the WGES scheme criteria. UHL hotwell project underway, where the steam system will be updated - likely to generate savings £ and carbon.	
Estates	Consider external opportunities such as district heating to reduce estate emissions. An early stage proposal has been developed for Barry.	Director of Estates	Assessment of viability of proposed Barry scheme	TBC	Q4	Discussions are in progress to assess the feasibility of Barry and Cardiff District heating networks. NOTE THE INITIATIVES BY CARDIFF AND VALE OF GLAM FOR LOCAL AREA ENERGY PLANNING.	Whilst the study had positive potential opportunities, it was to be undertaken as a collaborative district heating partnership program. Unfortunately the district heating program has not been implemented.	Project has stalled due to other organisations pulling out and there is no further update. CVUHB are ready to co-operate with feasible proposals around such schemes.	Nothing further to report	
Estates	Implementation of RE:FIT/ EFAB and other energy conservation and decarbonisation scheme planned for 2023/24 and 24/25.	Director of Estates	Delivery of milestones over 2023/24.	March 2025	March 2025	Projects are in place for REFIT and EFAB and will be complete in August/ September - REFIT 2023/24 scheme is in the feasibility phase which is likely to conclude in August.	Current Refit project will be concluded in November 2023. The next Phase is in the feasibility IGP stage to be concluded in October/November 2023.	Re:Fit phase 2 has almost complete - 95% complete. Aiming to apply for additional funding which needs to be completed by the end of January. Should be approved with Vital, likely to commence in March. On site works not until June. £6.9m investment completed during 2025. Solar PV	Implented through the programmes see above	
Estates	Investigate options to increase sequestration as much as possible across the estate	Sustainability Manager	Proposal developed	01.12.2025	Q3	A plan is being drafted to understand the opportunities for sequestration across the UHB estate. Initial discussion have been held with the estates team on current land use across sites.	Information is being gathered on projects which have been undertaken and the additional opportunities across the site. Initial findings are there are limited opportunities to significantly improve sequestration	Funding across the UHB is limited. There has been no additional support through the Health Charity during this period and there are no projects underway. Although there is capacity to extend planting, it is unlikely it will be done this year.	Nothing further to report on sequestration. A biodiversity report is being drafted and could require increases to tree planting to support habitat creation.	
Estates	Commission a specialist Biodiversity audit across our estates	Director of Estates	Complete and action plan adopted	30.09.2023	Q2	A bid for a biodiversity audit is being produced by the estates team.	held with execs to discuss and an action agreed to find out how other health boards manage their obligations under Section 6. AB have been contacted and so has Swansea Bay. It is becoming clear that other Health Boards will need to be asked as a clear answer has not yet emerged. The cost of running the biodiversity audit as mentioned in the action plan needs to be reconsidered given the current financial issues. Tom Porter has questioned whether volunteers/NRW could help. To be progressed when ownership is resolved and models of governance	Public Health investigating how a baseline assessment could be commissioned.	Reports have been completed and provided to Public Health. Results being interpreted at the time of writing.	
Estates	Allocation of champions and staff training and support to reduce waste and energy usage.	Director of Estates	Record of champions and actions taken - Carbon impact of work (KG/tCO2e)	6 monthly	6 monthly		This action has not been progressed by the estates team to date. Geoff has been talking with Adam Wright. Adam off until 1st week Sept.	Although, work will be required to improve waste management over the coming year, to bring us in line with Waste legislation. Support has been provided by Estates and Waste to departments to improve carbon efficiency, however, this is on request. Waste have supported EU in	compliance, plus there have been more bins installed around the estate. It cannot be estimated what carbon may have been saved by better seggregation until the 23/24 carbon emissions report is compiled in Q2 24/25. Digital's DESC project is seeking to reduce energy usage by turning off PC's	
Estates	Search for savings opportunities as a result of a developing electricity metering programme	Energy Manager	Closing off of identified opportunities - Carbon impact of work (KG/tCO2e)	Quarterly	Quarterly	Awaiting update from Energy manager	UHB Energy/Estates teams implement metering where it is highlighted additional monitoring may yield benefits. This includes electricity, gas, heat and steam metering. Metering of certain theatre areas is being proposed in addition to gas and steam metering of specific areas/plant and equipment.	Woodland closed over Xmas. Saved £35k. Work underway on the switching off of idle PC's overnight, being led by D&HI. 60 x PC pilot group identified Further meters installed across estate to provide more granular data.	Results from metering review being analysed. Results of the 60 PC pilot group for the DESC initiative showing promise. This will save energy by turning off PCs left on at night. Enica metering programme is underway - Metering in Children hosiptal is being reviewed but benefits will not be realised until next FY.	
Estates	Water conservation – Across large estate, work with Welsh Water to identify/avoid/address any instances of leakage.	Energy Manager	Rectifying any identified leaks.	March 2024	Q4	Water management is being assessed across the UHB and is reviewed for major leaks frequently. An assessment of water usage for 2022/23 will be produced by Q3.	Water study currently being undertaken at UHL to assess consumptions and opportunities. External resource engaged to complete the study and provide analysis of water usage and identification of potential conservation opportunities.		Work has commenced to identify leaks or issues with the water infrastructure which is being monitored by metering. More works to take place in the coming year.	
Sector	**Action**	**Owner**	**Measure**	**By when**	**By when**	**Q1**	**Q2**	**Q3**	**Q4**	**End of year RAG**

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Transport	Recommend with a costed plan that our SLB formally sign Level 2 Healthy Travel Charter, with agreed capacity to implement.	Executive Team	Approved y/n - Carbon impact of work (KG/tCO2e)	30.06.2023	Q1	Staff capacity to co-ordinate being agreed with Geoff Walsh, to be provided by Capital Estates and Facilities. Paper being prepared for consideration which will recommend how a budget request will be built up. To present to SLB in August.	The UHB agreed to sign up to the Level 2 Healthy Travel Charter in October.	Next HTC meeting will take place on the 8th February.	CVUHB have signed up to the charter. Updates on progress will be reported to the QSE Committee. The committments in the charter that will incur cost will be scoped in detail and taken through the relevant body (e.g. IG, CMG, etc). The current capacity to deliver is also limited and this was pointed out to SLB. A paper will go back to SLB in due course on which elements of the charter will be taken on.	
Transport	Promotion campaign for new cycleway linking city centre to UHW when opens in 2023	Consultant in Public Health – Lead HTC	Promotion campaign - Number of interactions	30.06.2023	Q1	ACTION COMPLETE Initial 'soft launch' during Bike Week (w/c 5 Jun) with story on intranet; to follow up with further comms during June (discussing with Council if want to do jointly) and offer to cycle route with others to increase familiarity	As additional work, GoPro footage of cycleway recorded, CEO Connects session in early September to highlight cycle facilities at UHW site and proximity of new cycleway	No additional work on this in Q3. Cardiff Council still considering event though none confirmed yet.	Nothing further to report	
Transport	Review trend in air quality on UHW and UHL sites	Consultant in Public Health – Lead HTC	Measurement of trend	Quarterly	Quarterly	Data being received monthly, two months' worth of data currently received (6 Jun 2023). To provide interpretation and quarterly updates once 6 months' worth of data available (data is annual mean so cannot be reliably interpreted with few data points)	Monitors have been in place and data gathered since February 2023. A full report will be published after 12 months, however, NO2 levels are not currently breaching Welsh Government guidance. A summary of the initial findings for a 6 month period will be provided to SLB.	Through the installation of monitors airquality is being reviewed across the site. **Welsh Government targets for Air Quality are - 40 µg/m3 - annual mean - 200 µg/m3 1 hour mean.** The first 6 month period is as follows: •UHW: 17.6 mcg/m3 (range 12.2 to 23.2 across different locations at UHW) •UHL: 10 mcg/m3 mean NO2 (range 6.9 to 15.1 across different locations at UHL) While these data is annualised and bias adjusted (corrected to enable like-for-like comparison between different equipment and locations), they remain incomplete and should therefore be interpreted with caution. Currently levels above are well witin the target levels set by Welsh Government.	Interim findings are reassuring in that there is no evidence to date that NO2 levels at any of the locations sampled at UHW or UHL sites exceed the annual legal limit values currently in force in Wales.	
Transport	Fleet transitioning to EV as a preference and where practical.	Transport Manager	All new cars and light goods fleet vehicles procured across NHS` Wales after - April 2022 will be battery-electric wherever practically possible - Carbon impact of work	March 2024	Q4	There has been engagement with transport groups who manage their fleet across the Health Board. Options are appraised as they become available to ensure compliance. To date we have 5 BEV and 1 LCEV. across the UHB. An all Wales approach to procuring EVs (pooling demand in the face of scarce supply) is being	There is national programme to support the delivery of the transition to EVs. Additional guidance has been provided for EV charging infrastructure in Wales.	Vehicles are being reviewed as they come up for renewal. A fund was made available to public sector organisation ito support the uplift costs for EVs and charging infrastructure through WGES. Delivery is expected by the end of the finanical year making realisation extreamly challenging.	Vehicles are being assessed by depts as they come up for renewal. A fund which was available for Public Sector organisations was not utilised due to timescales. Currently six BEV, one FHEV & one MHEV in UHB fleet	
Sector	**Action**	**Owner**	**Measure**	**By when**	**By when**	**Q1**	**Q2**	**Q3**	**Q4**	**End of year RAG**
Procurement	Review top suppliers and seek ways to reduce emissions from products/services / packaging in CVUHB to assess high value gains.	Head of Procurement	Number of suppliers reviewed and issues/opportunities fed back	March 2024	Q4	Grounds and Gardens Maintenance 1. Decarbonisation travel efficiency (100% local workforce) - use of battery operated equipment - promote biodiversity - create and enhance wildfire, fruit and veg production & onsite recycling of leaves & creating compost area Non-Hazardous Waste Collection for CVUHB 1. Decarbonisation: BIFFA will use Welsh disposal and processing for this contract - less vehicle mileage contributes to lower carbon emissions and keeps waste within the Welsh borders. General Waste will be sent to landfill diversion Trident EFW, Recycling will be processed at their Cardiff MRF, and Food will be anaerobically digested at Bryn Composting. Provision of Renal Dialysis Services in East and West Swansea and In Centre Equipment and Consumables Brief: Provision of community based dialysis units to ensure closer to home treatment which	Animal Bedding - cardboard collection Carbon reduction Use of local workforce including supporting those with disabilities/challenging circumstances Cardiac Patient Transport Contract awarded to St John's Ambulance Cymru, a charity primarily staffed by volunteers to transport patients from any Welsh hospital site into University Hospital of Wales to be treated within the same day and then transferred back to their base site. PROMS Framework Continuing on from current work within the C&V UHB Digital and Health Intelligence team, Procurement Services are in the process of awarding an All Wales PROMS framework. This will allow all Health Boards in Wales to fully convert from paper or part paper collection and recording of PROM/PREM to a digital solution. The digital solution will enable NHS Wales to support the broader model of collecting outcomes across multidisciplinary clinical pathways – outpatient transformation, long term conditions management integrated across inpatient, outpatients, community, primary care and provide a seamless patient experience for equality of healthcare treatment and service from standard PROMS/PREMS across the whole of Wales. "	Planning for a local consultancy framework for construction: putting in a place a local consultancy framework to cover architects, PM, CM, Healthcare planners, NEC supervisors..etc (100% based locally) - reduce travel time - Encourage commute through local transportation means to the UHB premises. - Appoint locally based consultants and support the foundational economy agenda. Planning Building Consumables Contract: - setup a contract for various building, Electrical, and Mechanical consumables with local suppliers. - local supply chain to reduce carbon emission and time on the road and support FE with an estimate annual saving of £30k. Rookwood Preliminary Ecological Survey: - Survey compromise a habitat survey of the site footprint to collect botanical data and assess the site for its sustainability to support protected and/or Notable species. Aroma re-usable cups:	For Q4 outcome TBC: "Project initiated to reduce excessive packaging: the project will include a working group lead by procurement and the waste team, with the support of the Stores team and sustainability team. The premise is to engage with the supplier frequently used and agree better means to deliver the HB orders without having to double pack in carboards and pallets which the HB dispose off at a cost. the main benefits that could be achieved: -reduce the amount of carboard that goes to waste (carbon & monetary savings) - reduce the frequency of deliveries which impact the carbon emission - reduce the weight of transported cargo which has a significant effect on fuel consumption. a change in fuel consumption will lead to a change in the amount harmful substances and exhaust gas emissions. Bio-food Processor: discussion with Biffa regarding the potential implementation of a bio processor for the disposal of food waste. . The bio processor boasts an impressive capability to reduce organic waste by more than 80%, subsequently minimizing the need for frequent collections. Additionally, it captures carbon from organic waste, preventing the generation of greenhouse gases. Following a discussion with Aneurin Bevan UHB, it was suggested that we verify this with National Resources Wales. They	
Procurement	Clear process for clinical staff and procurement to engage with each other on the purchase and use of more sustainable products	Head of Procurement	Operating process and pipeline of opportunities - Number of interactions	30.09.2024	Q2	Planning papers for procurements over £25K to be signed off by the Director of Operations and Finance Lead prior to Procurement sign off. The papers will include sustainable procurement considerations, including the Wellbeing of Future Generations Wales Act goals, ethical employment and community benefits. New Product Panels scheduled to be introduced across clinical boards for quarter 2. Clinical staff requesting to utilities new products will be	"Papers now being approved by the director of operations and finance lead, ensuring sustainability considerations are considered by all areas prior to commencing a procurement process. New product panels on pause due to current financial position."	New process in place no further update at this point	Reporting at the end of the year, there is not a good enough means to ensure low carbon poducts are procured. This action is being carried over into 24/25.	

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Procurement	Embed circular economy principles in our procurement.	Head of Procurement	£ Value	March 2024	Q4	Procurement embed the principles and encourage suppliers to adopt and improve the circular economy in Wales through the specification of requirements. Example: In-House 3D Metal Printing, Dental Hospital UHW. Economic Benefit – currently we spend £70k per year outsourcing the 3D metal printing service, producing in-house will eliminate this cost. There is potential for an All Wales opportunity to print metal for other Welsh Health Boards, creating further savings on an All Wales basis.	~~Continue to embed the principles and encourage suppliers to adopt~~ and improve the circular economy in Wales through the specification of requirements. Animal Bedding - Cardboard collection Supplier collects cardboard from 3 separate C&V locations - University Hospital of Wales (UHW) are often five times a week, and collections at Cardiff Royal Infirmary (CRI) and Woodland House (WH) are 2-3 times a week. 48 tonnes of cardboard is collecting resulting in 19.36 tonnes of carbon emissions saved per annum. The cardboard is correctly sorted and reviewed to ensure it is free of impurities such as staples, toxins and other objects. The cardboard is then shredded by machines into animal bedding and packed ready for purchase Aroma Rice Husk Re-Usable Coffee Cups There are a lot of single use products being used by Catering within Cardiff & Vale UHB. CEF stakeholders and Procurement completed a	The procurement team are continuing to embed the priniciples of circular economy and encouraging suppliers to adopt and improve the circular economy in Wales through the specification of requirements. Catering contract has been awarded buring Q3 for Aroma Rice Husk Re-Usable Coffee Cups	~~IS THERE A £ VALUE WE CAN ATTRIBUTE TO CIRCULAR ECONOMY?~~ Coffee cups being handed out. "Coffee beans, Coffee Machines and Cups: Amalgamating the coffee contract and cups contract into one to streamline the process. - testing the market locally with an open tender - better prices and lead time - ability to incorporate coffee ground recycling into the contract - ability to have a recycling system for the cups to support circular economy and close the loop. Setting up an online reuse Platform for CVUHB (Warp-it): a new equipment/furniture/resource reuse and management system (think trading-post only bigger & better with freebies) -making it very easy for staff in CVT to get or give surplus items to other	
Procurement	Embed foundation economy principles in our procurement	Head of Procurement	£ Value	March 2024	Q4	£25m spent with Welsh suppliers in Q1. Examples: Grounds and Gardens Maintenance FE 100% contract value retained in Wales as the contract will be awarded to a Welsh based supplier with locally based workforce. Non-Hazardous Waste Collection for CVUHB FE: Hiring local – 95% of Biffa employees in Wales are living within 20 Miles of the place of employment. Resourcing local supply chains for sustainable produce, eg re-use networks for end-of-life furniture and using local SME for ancillary services such as printers for literature.	"£54,147,469.38 expenditure with Welsh providers in the first month of quarter two Animal Bedding Elite Paper Solutions is a supplier based in South Wales empowering local communities by providing employment opportunities and prospects to individuals with disabilities and those facing disadvantages. Working on case-by-case bases, they offer training and equip individuals with new work, life and social skills. The supplier provides a community for the long time unemployed and has created diverse and inclusive workforces. Construction Related Labour Framework The framework increases the opportunities for local, domestic	"Local Frameworks part of the qualification for getting onto the framework is specifically related to the location of the bidder's branch from the main hospitals and how long they have operated from their local branch. This will support the local SMEs and give them better changes to score high on the quality aspect. Maintenance/Engineering Contracts For all engineering and Maintenance contracts, the suppliers arerequired to have Engineers based locally and available at short notice for emergency call outs in the UHB Premises Foundation economy spend Between April- December 2023 CAVUHB spent £215m	TBC	
Procurement	Instant fail on procurement assessment for any organisations who do not have a carbon reduction plan. For tenders > £5m.	Head of Procurement	Implementation y/n and evidence of operation - Carbon impact of work (KG/tCO2e)	March 2024	Q4	For contracts >5m we have included a mandatory pass/fail question to exclude any provider that does not have a carbon reduction plan. In quarter 1, no organisation was failed for not meeting this requirement. For any contracts <5m the standard process on Tenders is for bidders to provide confirmation of whether or not they have, or are working towards, a carbon reduction plan - this is currently an information only required response.	For the first two months of quarter 2, no organisation had failed due to this requirement.	For quarter 3, no organisation was failed for not meeting this requirement. - There are 15% of marks availble in tenders based upon social value. This is a small part of the overall scoring, but its introduction has seen the difference between suppliers being awarded contracts and not. Procurement have, 'recently undertaken insourcing and outsourcing projects for the Children and Women Clinical Board and two providers scored full marks for the technical score (45%) and there was a percentage difference of less than 2% for the commercial score. The remaining percentage for social value therefore played a part in influencing the outcome of the award.'	TBC	
Sector	**Action**	**Owner**	**Measure**	**By when**	**By when**	**Q1**	**Q2**	**Q3**	**Q4**	**End of year RAG**
Clinical	Decarbonisation embedded into Value Based Healthcare	Clinical Sustainability Lead	Embedded and carbon saved - Carbon impact of work (KG/tCO2e)	31.03.2024	Q4	Two leadership positions for VBH is being appointed to report into the AMD for Quality (for acute and primary care settings). Value work being led by Claire Dunstan is showing promising results which could result in carbon savings once the projects are formally reviewed in Q3.	Ed met with Sophia Jones (Prog Manager) for value. Carbon is in the proposal and highlight report template. Ed provided some critiera for people to think about when filling out a Value proposal. Also shared carbon values for clinical activity from CSH and criteria for consideration when redesigning services from the SE Clinical Senate. Agreed to embed in a pilot project - Heart Failure. Expected to start in early October. 2 x clinical leads appointed who will face into acute and primary care respectively.	Claire Dunstan has been running small Value based projects and tracking the various benefits including carbon which are expected to report in Q4. Paeds project to have carbon benefits built in, along with heart failure. Investigating patient stories being created to help communications.	The Value in Health programme now has a number of projects underway in various stages of delivery. Projects include diabetes, cellulitis, supportive care and frailty among others. It has been shown that the value projects focussed on cellulitis and supportive care are saving bed days. Bed days have a carbon footprint of 37kg/day (for a low intensity inpatient bed). Cellulitis is reporting 1,050 bed days saved and supportive care 1,211 = 2,261 bed days saved = 84 tonnes of carbon potentially avoided. While that is a small number in the grand scheme, it can be shown that by applying the principles of VBHC, you get better outcomes for the patient, for the health	
Clinical	We will bid for our 4th HEIW Leadership Fellow in Sustainability	Clinical Sustainability Lead	In place y/n	30.09.2023	Q2	A bid was successfully completed, with a new Sustainability fellow starting in July 2023	Our 4th Sustainability fellow is now in post. There is an additional Sustainability Fellow within EU (2 sessions a week).	There are a number of initatives under development:- - A bid is being devloped through SBRI as a cluster approach to work with Revolution Zero - Working with Elis to trail reusable drapes in UHL - Working with procurement and Vanguard to set up a collection for devices which can be remaufactured and resold for a discounted price to the UHB.	N/A	
Clinical	Develop a Sustainable value working group to highlight high carbon areas and product switches (procurement/clinical interface)	Clinical Sustainability Lead	Implemented y/n - Carbon impact of work (KG/tCO2e)	30.09.2023	Q2	A clinical sustainability lead is being appointed. The position will report into the AMD for Quality. Procurement in NWSSP are separately considering the same problem and links are being sought to move any opportunity forward.	Clinical leader who will embed sustainability into Q&S was appointed on 5/9/23. This action will roll into Q3. Therapies leader and action plan reports into Quality & Safety.	Commenced. Looking at a small handful of products, ligatures, hamonics and reusable drapes. Clinical and theatre management and procurement involvement. At the moment, it seems there is a need to walk through one product at a time. With the J&J Harmonic product, using reprocessed versions by Vanguard could save £££ and carbon. Clinical Fellow working with procurement on the opportunity. If 50% of the devices used by C&V could be remanufactured, a 90t and £63k saving opportunity is possible.	Work is underway to develop a green theatres and re-usable gowns project in collaboration with procurement. This action started later than envisaged and will continue to conclusion.	
Clinical	Decarbonisation embed into quality and safety (investigate/propose)	Clinical Sustainability Lead	Embedded y/n	30.06.2023	Q1	A clinical sustainability lead is being appointed. The position will report into the AMD for Quality. Therapies have committed to this. Therapies	As above for clinical. Therapies action plan reports into Quality & Safety.	Awaiting SOF Quality Excellence programme	Awaiting SOF Quality Excellence programme	

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Clinical	Allocate time to staff to research and/or implement environmental improvement. This is a limited proposal for specific benefit and not universal to all staff.	Nursing, Clinical, Therapies, Clinical Boards	Body of work demonstrating education, adoption, direct improvement. - Carbon impact of work (KG/tCO2e)	31.03.2024	Q4	Therapies are going to create champion roles. In nursing, a nursing decarbonisation forum will be set up by the lead decarbonisation nurse (Rebecca Aylward). This forum will consider and qualify quality improvement initiatives that have a carbon benefit, starting with non-sterile glove use reduction and continence pads. How champions work will be considered on a per project basis, but in the short term there is part time a role identified (for approval) to co-ordinate the projects qualified by the nursing forum. It is likely that time will be allocated from the clinical community for approved Value based projects.	Is this where the benefits from 6 Goals etc get reported? We have virtual wards, SoS and PIFU, etc. Projects have comenced within Nursing for both Gloves Off, burses unifroms and Incontinence pads - I&I are supporting Gloves off as a "spread and scale" opportunity. Therapies have integrated decarb into their governance and allocated a number of climate champions. They are starting to take forward their decarbonisation action plan. Crital care - are systimatically working through a list of high usage item to assess whether a reduction/ alternative products can be used. DOSH case studies - Rachel Drayton has provided a comms update on her reusable sceculums project. Medclair units - They have been returned due to cost - There is a project underway with SBRI to support the development of this tech	ICU hold a monthly green group. ICU and the water safety team have agreed to stop using medical grade sterile water and use tap water instead (from a specified tap). Saving an estimated £11k and an estimated 6 tonnes of carbon p/a. The initiative will be rolled out from 2/1/24. Therapies have allocated champions (see below). EU are following a Royal College green accreditation scheme and presented their findings to the C&V Green group.	Without dedicated time allocated, colleagues have reduced Entonox usage by 40% which will avoid an estimated 2,250 tonnes of CO2e p/a and £18k-24k p/a. EU have developed a green group and small team to support the delivery of the GreenED accreditation. Therapies have 35 Sustainabiloity champions working towards the objectives set out in their deacrbonisation plan. Dentistry have a sustainbility lead (with Cardiff Uni) who is supporting work to improve action within the department. ICU don't allocate time per se but they clearly have champions and a dedicated green group. They have created a sustainability pledge which colleagues have signed. The response to which has been significant. Yousuf's work? Or report that under the fellow? Where else?	
Clinical	Embed sustainable principles into "Shaping our future Clinical services" programme.	Shaping our future Clinical Services lead	Clinical Services Plan complete y/n	31.12.2023	Q3	Embedding decarbonisation has been agreed and a workshop is being set up to gather assumptions that can be made to contribute to the early clinical services plan. Value will also be built into the CSP.	Chapter written for CSP, authored by Flona Brennan, Tom Porter and Ed Hunt.	The CSP will not be complete in f/y 23/24 given the SOFH funding issues. A CSP is anticipated to be produced in autumn 2024. Sustainability is a pillar of the plan at this point however (Nov 23).	Work started in Dec 23. Will conclude at the end of 2024.	
Clinical	Investigate becoming a Beacon site and implementing SusQI into Quality Improvement	Head of Improvement implementation	Implemented y/n	31.12.2023	Q3	CAVUHB have signed up to become an aspiring SuSQI beacon site. Staff in I&I are being trained as trainer to support the implementation of the programme. Information has been put on the news pages and shared via the comms team to further promote.	Mark said, 'In a word, slowly. Nick had started his courses over the summer but Kate is only starting now so I have asked them to work together to develop our approach to incorporate susQI into our work programme. Nick has already started to include elements into our training. We also have Magda, our Value in Health post, who is contributing and helping us. I'll be meeting with them in the next couple of weeks to see where we are and I can let you know our intended timeline.'	Shaping change team have been liasing with the Centre for Sustainable Healthcare to review QI training content for implementation in the UHB. The UHB has aspiring Beacon site status and are working towards Beacon Site accreditation. The aim is to achieve full status early in the new year	Shaping change team are supporting staff develop case studies to acheive Beacon site status. Work is underway but completion likely in Q1 of 2024.	
Clinical	Create a Digital Strategic Outline Case for the modernisation of the Digital capability in C&V on the condition of WG funding in 23/24.	Director of Digital Transformation	Complete and approved y/n	31.03.2024	Q4	WG have not funded this piece of work. A letter has been sent to WG asking for an urgent meeting to receive clarity on when it will be funded. This same meeting will seek clarity on the SOFH SOC as well. Delivery of a SOC by 3/24 is unlikely to be possible, however a Strategic Advisor is being sought to write the business case in anticipation of receiving the funds.	Angela Parratt is producing an invest case for internal purposes for digital transformation.	Pushing through the UHW2 IIB meetings with WG	Discussions held with WG CIO. Searching for funding for Digital Foundations and an all Wales approach to electronic patient records. This approach is being worked up. An update to be given to IIB on 30/5/24.	
Clinical	Commit to providing time to leaders in Nursing, Therapies and Clinical specialities at least on the scale of that committed to in 22/23.	Executive Medical Director/ Executive Nursing Director / Executive Director of Therapies & Health Science	Leaders appointed - Carbon impact of work (KG/tCO2e)	30.06.2023	Q1	A leader in Nursing is in place. A Clinical leader will be appointed reporting into the AMD for Quality. 2 sessions per week. Also two leaders for Value to be recruited. Therapies have agreed a leader position and the creation of champion roles.	Therapies action plan created signed off. Rebecca Hanmer is the leader. Champions being put in place. Nursing are running 3 improvement projects. Rebecca Aylward is the leader. ICU and EU have green groups that are working through local sustainability initiatives actively. ICU have their own candidate list of initiatives, whilst EU are working through recommendations from their Royal College. Dental likewise have a small set of projects they're working through. Primary Care are setting up an initiative. Sarah Williams (a GP) has been given time to promote the greener primary care framework within C&V. Nursing update 1. Gloves & Aprons off Campaign – Shaping change team supporting to deliver using spread & scale methodology. Clinical areas of focus Critical care and surgery Project is in early scoping phase, with plan for spread in new year. 2. Linked in with All Wales lead Sustainability Nurse. – participated in Sustainability feedback surveys 3. Reduction use of continence products – Shaping change team supporting to deliver using spread & scale methodology. Identified high users Lakeside wing and St Davids Hospital.	board), Clea Atkinson (Palliative/supportive care) & Cath Doyle (peri-op & diabetes) to retrospectively & prospectively measure the carbon savings & carbon avoidance of their value work. We have supported Revolution-ZERO with a Welsh SBRI circular economy bid focused on how we could establish Revolution-ZERO reusable sterile surgical textiles into Wales, starting with 6/52 trial across 3 HBS. (CAV, ABUHB & Swansea Bay) Therapies Actions: • Champions forum run 6 weekly to support delivery of the action plan • Members at the forum include National Therapies Sustainability lead and Therapies Shaping Change Improvement manager. • Sharing of Sustainability Improvement Projects within the forum • Sustainability Improvement Projects are communicated and celebrated across Therapies at service meetings and learning is accessible to all on the Therapies SharePoint	See action regarding champions above.	
Clinical	Establish good linkages/ Robust relationship with PHW on with the impacts of Decarbonisation on public health	Sustainability Manager	Number of interactions	30.06.2023	Q1	Discussion are underway with the PHW team to review the approach to assessing the impact of decarbonisation on Public Health. This will be with the aim of demonstrating how the UHB can support delivery of positive outcomes. The decarb team will work with the local PH team on the next Dir Public Health report centred upon biodiversity. There will also be a forthcoming opportunity to attend a PH team meeting to discuss how/whether value can be added into the PH team's portfolios.	Presented to and sought feedback from Tom Porter and Claire Beynon on the 16% work which intersectcs with their Value work. Interest has been shown and possibility to present to Board Development in Oct 2023. Tom Porter assisting with Travel reporting matters.	Carbon team have been working with a lead consultatnt in Public Health on a carbon risk being articulated for the UHB, transport, biodiversity and embedding into programmes. EH provided Claire Beynon/Sophia Jones with decarb content for a December SLB presentation about diabetes.	Excellent relationships with public health. A PH consultant has been integral to the Board Development session delivered in April 24. Other areas of co-work have included adaptation, biodiversity, risk, prevention, transport. ongoing relationship BAU.	
Clinical	Pharmacy - Commence a pilot medicines waste avoidance project, where pharmacy manage and rotate ward stock.	Pharmacy Sustainability Lead	Measure of waste avoided - Carbon impact of work (KG/tCO2e)	31.03.2024	Q4	The project is across 6 wards and plan to be developed by October to take across other wards within the UHB. This is part of the Bevan Exemplar project which will conclude July 2024.	We have extended this to all medical wards at UHW and we are reviewing moving this forward in Q3 – this has meant a saving in nursing time and reduction in medicine waste.	We are formulating a plan for 2024/25 across all wards at UHW will Q4 into surgery as the next step	TBC	

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Clinical	Introduce Kidz Med Cymru – moving from liquid to tablet based products which are more sustainable. Testing in respiratory.	Pharmacy Sustainability Lead	Reduction in use of liquid based drugs across paediatric services - Carbon impact of work (KG/tCO2e)	31.03.2024	Q4	[illegible] of teaching 400 children to swallow tablets or capsules within 1 year and reduce liquid medicines by 20%. The pharmacy team has run an audit to review near misses and errors when prescription. The programme has been launched in paediatric, cystic fibrosis, nephrology and oncology.	This has been implemented in cystic fibrosis, gastro and nephrology with a plan for oncology is in conjunction with Latch. Identify other areas and put a plan in place. Currently gathering data also patient story has recently been published.	We are monitoring this and extending to Oncology and applied for additional funding. Currently working with comms on relevant patient stories	An estimated £10k saved with 500kg of carbon associated saved. More due to be delivered.	
Sector	**Action**	**Owner**	**Measure**	**By when**	**By when**	**Q1**	**Q2**	**Q3**	**Q4**	**End of year RAG**
People and Comms	Incorporate Decarbonisation into a Culture Change Programme, considering an ERG (Employee Resource Group), proposing a programme if going beyond set aside budget.	Ass Director OD, well-being and culture	Survey results showing movement in level of awareness and ability to act - Number of responses	31.03.2024	Q4	As noted above, sustainability will be incorporated into the emerging Quality programme. How this programme will be delivered will be determined over the summer of 2023. Meanwhile a communications heartbeat is being undertaken and leadership within our three main front-line functions are being put in place.	Awaiting quality programme. HB will be working with Ruth on its inception. 16/8 - Awaiting feedback from Jo B on the outcome of Ask Suzanne and progressing ideas and comms around cost reduction. With I&I. Comms will be supporting the workstream leads running the cost savings initiatives. EH meeting Mike Bond on 1/9 to discuss getting comms going. 11/9 - Claire Whiles has included 3 questions authored by Tom and Ed for the culture survey which is being piloted with Theatres on 11/9. 22/11 - CLaire Whiles has asked Ed to be on a Health & Wellbeing Steering Group to represent the decarb agenda. 22/11 - Ed meeting Mike Bons on 24/11 about roadshows linking into Financial Sustainability. What can be planned in.	ICU have been rolling out a simple pledge aimed at making four simple changes. All people need to do is sign the pledge. It has proven successful with the majority of the 350 nurses having signed. Around the same time, the carbon team have developed a 12 month calendar of pledges that can be acted upon at home and in work. This has been rolled out across the health board though its original intent was for distribution to the Strategy team. Currently x have pledged.	The sustainability pledge is bringing up opportunties to align with other initiatives. One with Estates for April is emerging. Carried forward to 24/25. The effort to go into a campaign is considerable and with the knowledge that other initiatives that are 'must do' impact carbon an opportunity arises to kill several birds with one stone.	
People and Comms	Include decarbonisation in the induction material for all staff.	Sustainability manager/Clinical Leaders	Complete y/n - Number of interactions	30.06.2023	Q1	Discussion have commenced with the workforce team and a provisional agreement is in place to incorporate decarbonisation into induction material. From September, there is a possibility that an induction event will be held monthly to welcome new joiners. Decarb can have a seat at that table. Also, consideration is being given for a brochure/leaflet to give to new joiners at that event. Work will continue over the coming weeks.	Sessions in the diary to attend induction events starting in October. Content being produced.	Complete. First session run successfuly to 20 peopleon 26/10/23. Second session held in November. Further sessions in the diary once a month moving forward.	During Q4 there was only one induction session held (7/3/24). A decarbonisation presentation was included within this session.	
People and Comms	Feasibility for inclusion of decarbonisation into staff annual appraisals (for VBA community).	Ass Director OD, well-being and culture	Complete in appraisal document y/n - Number of interactions	30.06.2023	Q1	This has been discussed with Workforce and consideration/feasibility is underway. The VBA process has seen low levels of compliance because of its length, so adding to it is a matter for careful consideration. Furthermore the document is about personal development. Final agreement of any changes would require approval of SLB.	Won't go into VBAs. Offered section in guidance notes that managers could pose to their people. A opportunity to follow up on travel planning for colleagues to seek active travel or public transport ways into work is appropriate. This will roll into Q3.	NA	How decarb can be incorporated into the VBA process is an action put into the 2024/25 plan.	
People and Comms	Decarbonisation to be included in job descriptions	Sustainability manager	Integration in template	30.06.2023	Q1	Discussion have been held with the workforce team and a provisional agreement is in place to incorporate decarbonisation into job descriptions. Draft text has been provided for inclusion into the template JD.	COMPLETE - The Job description template has now been updated (english and welsh) to include the statement on decarbonisation.	COMPLETE	COMPLETE	
People and Comms	Encourage staff to undertake Decarbonisation training. This may include Welsh e training and other delivery methods including a Masterclass	Sustainability manager	Number of training courses accessed	Quarterly	Quarterly	Information has been distributed to staff , through existing sustainability networks, including the green group. There has been a number of decarbonisation and sustainability training courses run by various suppliers, including HEIW. There is work underway to gather and track information on staff attendance. Staff time has been noted as a concern, as courses are often within working hours. During this period 2 staff member undertook Env Sustainability in QI training	Courses have been promoted through Decarbonisation Networks. Cardiff and Vale UHB attends meeting to influence Climate training which includes HEIW and PHW. Output of this work are to be confirmed but its aims are to improve the level of training and national promotion of courses. Climate Smart Champions – 21 people have been trained with an additional 27 people signed up. ESR sustainbaility courses sign up (July-Sept) Environmental Sustainability in Quality Improvement – number of sign ups - 3 NHS Wales - Climate Change and Sustainability - number of sign ups - 4 Building a Net Zero NHS - number of sign ups - 2 NHS Wales - Achieving Net Zero in Wales - number of sign ups - 1	ESR Course - Between 1st October and 31st December - 3 people undertook SusQI training. Training will be promited through additional communications and the sustainability pledge calendar.	A Sustainability Pledges programme has been developed for staff to engage in the decarbonisation agenda. 12 actions over the year have been set out with the first action asks staff to complete Decarbonisation training on ESR and understand their carbon footprint. Within Q4 91 people signed up to the pledge and 21 completing the online training. Other actions with Q4 were Febraurys action to switch off lighting and equipment and Marchs action to increase recycling aligned with the newly incoming waste legislation. The decarbonisation team presented at one induction session to increase awareness of training options.	
People and Comms	Leadership and Management - Review opportunities to influence internal course materials	Ass Director OD, well-being and culture	State where included	31.03.2024	Q4	Meeting have been held with workforce and OD colleagues to include decarbonisation in course materials. Initial plans are to develop a package of documentation, at various levels, which can be included into multiple course/ programmes. There have been 20 people in CAVUHB who have successfully complete the Climate Smart Champions with a further 29 enrolled and 39 expressing an interest. Further conversation are required to map out where information can be included.	There is still some work to do around this. There are different opportunities to integrate into courses. SusQi will be a key opportunity to involve clinical staff within the climate agenda. Promotion of courses and materials are done frequently to increase awareness.	Claire Whiles has agreed that Decarbonisation can form part of the Leadership and Culture strategies.	Work has been produced to feed into newsletters and corporate inductions. Decarbonisation is not has not been feasible to t fully integrated into internal courses. No update	
People and Comms	Communicate case studies, successes, energy saving opportunities, events, etc to UHB colleagues.	Sustainability manager	Number stories - Number of interactions	Monthly	Monthly	A comms plan is in place and a bi weekly meeting with comms held to ensure momentum is maintained - information has been scheduled for distribution. To date the Decarbonisation Action Plan has been published, SusQI Beacon site article published online, DOSH case study is scheduled for publication. The publication of the decarbonisation action plan received 4 likes, 14 retweets and 2,919 views on twitter. It had 48 views on CAV SharePoint.	Can get update from Mark. Need to know number of reads, i.e. metrics. Mark said he would summarise.	Across Wales Climate Week we published 6 different WCW-related stories on SharePoint, creating a total of 281 page views. 6 Green Group posts, include the HB video from Abi, Jan and Fiona - 3 representatives from Cardiff and Vale UHB presented during the week including Fiona and Kathryn Speedy on GHW and Rob Skellett on the walking aids programme . We also promoted Frank Atherton's sessions AN X thread, which showcased some of the ways the health board is trying to reduce its carbon footprint, had 1,700 views, 8 likes and 4 retweets. Animal bedding - from waste cardboard The innovative way the Health Board is helping to improve circularity of cardboard for animal bedding - Facebook - 67 likes, 11 reposts , 8 comments (positive and engaging), 2,000 views	During Q4 there were 12 articles (avg one per week) which reference deacrbonisation which combined had c3,200 views. The greatest engagemnet came from a workplace recycling article (623 views). The sustianability pledge social media post reached around 4,600 people. An Ask Suzanne video was filed in Feb 24 and released during April 2024.	

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People and Comms	Spread the word using existing leadership networks such as the alumni programme	Sustainability manager	Number presentations	30/6/23 & 31/3/24	30/6/23 & 31/3/24	Leadership networks are being identified. Calum - has contacted workforce for support. Calum is also working with the CAV Leadership and Management mapping group to further integrate decarbonisation to processes.	There was a review of leadership course which the Decarbonisation Team have actively participated in. The programme has stalled in the interim but this work will continue once the group is re-established. Also we've had offer of providing content on leadership courses.	Calum has provided text for the Learning and development newsletter to Rebecca Corbin. This covered information on how staff can participate in decarbonisation training such as, on ESR and HEIW climate smart champions. It also included links to the Green Group network to encourage staff to become more involved.	No further update	
People and Comms	Continue sustainability award at annual staff awards	Head of learning	Judged candidates and award made	31.03.2024	Q4	People & Culture team considering a recognition event for end of Sept 23. Categories being reworked and Claire Whiles has taken a proposal from EH on waste reduction which plays into many initiatives important to the UHB such as quality, 6 goals, decarb, cost improvement.	28/09 - Update from Claire W - Staff Awards in general are currently under review in light of the financial situation. The categories will be part of the discussion but I currently do not have any timeframes around this I'm afraid.	To be held in f/y 2024 with a decarbonisation award.	To be held in f/y 2024 with a decarbonisation award.	
People and Comms	Incorporate air quality and climate change impacts into sustainable travel messaging	Consultant in Public Health	At least four updates - Number of interactions	30/6/23 & 3/31/2024	30/6/23 & 3/31/2024	The comms plan contains information in relation to sustainable travel - Information is scheduled for distribution in line with Clean Air Day on the 15th June. Plans are also in place for Cycle to work day in August. Messaging was put out as part of the cycleway communications on the 5th June. The SharePoint article received 536 views, 6 likes an 3 comments.	Messaging shared during cycle week incorporated clean air messaging. There are ongoing discussion with comms to ensure its included in future comms. Awaiting update from Tom on AQ data.	Through the installation of monitors, air quality is being reviewed across the UHW site. Welsh Government targets for Air Quality are - 40 µg/m3 - annual mean - 200 µg/m3 1 hour mean. The first 6 month period is as follows: •UHW: 17.6 mcg/m3 (range 12.2 to 23.2 across different locations at UHW) •UHL: 10 mcg/m3 mean NO2 (range 6.9 to 15.1 across different locations at UHL) While these data is annualised and bias adjusted (corrected to enable like-for-like comparison between different equipment and locations), they remain incomplete and should therefore be interpreted with caution. Currently levels above are well witin the target levels set by Welsh Government.	The air quality across our sites has been monitored for a 12 months and the data is as follows:- •UHW - Annual adjusted mean across all diffusion tubes = 21.0 µg/m3 •UHL - Annual adjusted mean across all diffusion tubes = 10.7 µg/m3 Welsh Government targets to limit air quality are set at 40 µg/m3. UHW and UHL are both well below this limit and are compliant.	
People and Comms	Regular cross-channel promotion of public transport discounts and options for reaching main sites, working with bus and train operators	Ass Director OD, well-being and culture	At least 4 quarterly updates - Number of interactions	31.03.2024	Q4	Messaging was scheduled into the comms plan and information was distributed in line with other messaging such as Cycle week and Clean Air Day to reinforce take up of actions.	During Cycle week and clean air day there were X messaged put out. Promotion of salary sacrifice schemes for EVs across UHB through September (3 events).	There has been work undertaken with the Carshare providers which includes share point articles, engagemnet with the teams channel and session during the green group. Since then we have seen a 50% increase in the amount of members signed up to the platform from CAVUHB.	Messaging was distributed by comms on active and sustainable travel options available to staff. The article had 381 views.	

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Report Title:	Stroke Business Case			Agenda Item no.	3.1
Meeting:	F&P	Public	X	Meeting Date:	19th June 2024
		Private			
Status *(please tick one only):*	Assurance		Approval	X	Information
Lead Executive Title:	Paul Bostock, Chief Operating Officer				
Report Author (Title):	Adam Wright, Director of Operational Planning and Performance				

Main Report
Background and current situation:

Stroke is a life changing event; the fourth highest cause of death in Wales and the leading cause of disability. In the severest of cases, if survived, stroke carries a high level of disability and dependency with ongoing both physical and mental health needs.There is a need for CAVUHB to review its service provision, quality and outcomes for people with stroke across the whole clinical pathway – from hyperacute care to specialist recovery and rehabilitation including into integrated community stroke services and long-term life after stroke support. This will require a longitudinal phased improvement programme imbedding the principles of value-based health care provision, aligned to developments of the National Stroke Programme and the regional South Central Wales Stroke Delivery Network. The totality of this work is outside of the scope of this business case; rather this case is the first step in addressing the identified gaps in the stroke service by starting at the emergency stroke and TIA part of the patient pathway. To this end, Stroke was prioritsed of one of the few investment priorities through the annual planning process.

This business case, to the value of £1,385,852 p/a sets out the resource requirements to right size the stroke service in order to deliver the optimal clinical model for acute stroke and Transient Ischaemic Attack (TIA) at the University Hospital of Wales (UHW).

Over the last 18 months, the stroke service has applied a sustained and focused improvement programme, which has included trialling elements of different working models and interventions for improving patient flow and the clinical pathway. The intended improvements have been somewhat realised with progressive change in performance indicators for stroke; the service was recently awarded a 'A' grade on the Sentinel Stroke National Audit Programme (SSNAP).

Despite these improvements, consistent delivery of the optimal stroke pathway remains vulnerable due to workforce constraints and large variability in the service across the week, and our outcomes from stroke are relatively poor. 30-day mortality from stroke at CAVUHB was 13.3% for the 12-month period to November 2023 (NHS Executive data). More than one third of patients with stroke at CAVUHB leave hospital with a dependency level requiring long term health and social care, many of these after a long period of recovery and rehabilitation in hospital. TIA patients currently wait an average of up to 12 weeks to be seen when the clinical standard for assessment is within 24 hours of referral.

The proposal in this business case is to reconfigure the clinical model for acute stroke and TIA care, enabling a sustainable upward performing trajectory, reducing variation in our service across the week, and delivering a sustainable and effective workforce model. The optimal pathway for stroke prioritises improving access for eligible patients to thrombolysis and thrombectomy treatments, with the aims of improving outcomes for patients, reducing the level of dependency and the length of hospital stay for this population.

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This case presents the current gap in resources and ongoing requirements to enable the implementation of a new clinical model, supporting UHW to operate as the South Wales Thrombectomy Service (business case

agreed by WHSSC January 2024 for service commencement Summer / Autumn 2024) and to be considered as the Comprehensive Regional Stroke Centre for the South Central Wales Regional Stroke Delivery Network.

The proposed improved patient pathway and clinical model has been developed with the Executive Management Team and colleagues from other Clinical Boards across the Health Board through regular Stroke Summit meetings during 2023.

Benefits expected in this case include:

- Implementation of the Health Board's Stroke Improvement Action Plan
- Improvement against all measured stroke clinical standards and performance indicators
- Reduction in adverse events and patient safety concerns
- Reduction in investigations and diagnostics resources
- Supporting the management of the acute and emergency medicine caseload and improving flow of this patient group within the emergency department
- Avoidance of admission for a proportion of patients with TIA, stroke or suspected stroke
- Anticipated reduced length of stay for patients requiring admission
- Through reduction in admissions, investigations and diagnostics, reduced length of stay and reduced health and care dependency and treatment need, carbon emissions can be reduced.
- Improved patient and carer experience
- Improved staff experience and wellbeing through sustainable workforce delivery; better career pathways in stroke as a speciality and opportunity to build UHW as a centre of excellence

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

- Stroke is one of the organisations priority areas for 24/25
- Our outcomes and performance in stroke are highly variable and susceptible to deterioration especially out of hours
- This paper is focused on the front end of stroke pathway. Further work is ongoing locally and regionally to develop all parts of the service
- Investment Group and SLB have supported the investment on the proviso that costs are only incurred from Q4 in 2024/25

Recommendation:

The Committee is requested to:

a) Approve the business case for the expansion of the Cardiff and Vale Health Inclusion Case

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	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
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	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X

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5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	X

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		Integration		Collaboration		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
Please include the detail of any Risk Assessments undertaken when preparing and considering the content of this report and, where appropriate, the nature of any risks identified. (If this has been addressed in the main body of the report, please confirm)
Safety: Yes/No
Are there any Staff or Patient safety implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Financial: Yes/No
Are there any Financial implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Workforce: Yes/No
Are there any Workforce implications associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Legal: Yes/No
Are there any legal implications that arise from the content and proposals contained within this report? If so, has advice been sought and what was the outcome? (If this has been addressed in the main body of the report, please confirm)
Reputational: Yes/No
Are there any reputational risks associated with the content and proposals contained within this report? If so, have these been fully considered and have plans been put in place to mitigate these? (If this has been addressed in the main body of the report, please confirm)
Socio Economic: Yes/No
The Socio-Economic Duty is to designed to encourage better decision making, ensuring more equal outcomes. Do the proposals within this report contain strategic decisions, such as setting objectives and the development of services. If so has consideration been given to how the proposals can improve inequality of outcome for people who suffer socio-economic disadvantage? Please include detail. *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES* *(If this has been addressed in the main body of the report, please confirm)*
Equality and Health: Yes/No
Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so. *Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)* *(If this has been addressed in the main body of the report, please confirm)*
Decarbonisation: Yes/No
There are a number of ways by which carbon emissions can be avoided through the operations of CVUHB. These include: • *A focus upon preventing ill health in our population* • *Saving energy or increasing throughput.*

- *Value based healthcare. Being prudent by not over-treating/intervening. Avoid delivering low-value interventions.*
- *Patients empowered to manage their conditions, utilising See on Symptoms and Patient Initiated Follow Ups to reduce unnecessary outpatient appointments.*
- *Service delivery in the most appropriate setting, e.g. in a community setting rather than an acute setting.*
- *Reducing waste – for example use non-sterile gloves only when needed, manage use-by dates to avoid throwing out good products, recycle and reuse.*

Does the subject matter of your paper risk any of the above not being achieved. Any queries, please contact edward.hunt@wales.nhs.uk or calum.shaw@wales.nhs.uk.

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	**Implementation of a new Acute Stroke Clinical Model at UHW**
Clinical /Service Board or Department	Medicine Clinical Board

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

Approval and scrutiny route	
Has this case been signed off by the Clinical Board / Corporate Departments senior team?	16.2.24 Alun Tomkinson, Clinical Board Director Jane Murphy, Director of Nursing Mike Bond / Hannah Mastafa, Director of Operations
Has this case been signed off by the Clinical Board / Corporate Departments finance and workforce business partners?	16.2.24 Gareth Jenkins, Finance representative Donna Davies, Workforce and OD
Clinical Boards: Has the COOs office signed off this document? **Corporate Departments:** Has the relevant Executive sponsor signed off this document?	Please add name and signature of either COO Executive sponsor

Contents

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1. Executive Summary

This business case, to the value of £1,385,852 sets out the resource requirements to right size the stroke service in order to deliver the optimal clinical model for acute stroke and Transient Ischaemic Attack (TIA) at the University Hospital of Wales (UHW).

Over the last 18 months, the stroke service has applied a sustained and focused improvement programme, which has included trialling elements of different working models and interventions for improving patient flow and the clinical pathway. The intended improvements have been somewhat realised with progressive change in performance indicators for stroke; the service was recently awarded a 'A' grade on the Sentinel Stroke National Audit Programme (SSNAP).

Despite these improvements, consistent delivery of the optimal stroke pathway remains vulnerable due to workforce constraints and large variability in the service across the week, and our outcomes from stroke are relatively poor. 30-day mortality from stroke at CAVUHB was 13.3% for the 12-month period to November 2023 (NHS Executive data). More than one third of patients with stroke at CAVUHB leave hospital with a dependency level requiring long term health and social care, many of these after a long period of recovery and rehabilitation in hospital. TIA patients currently wait an average of up to 12 weeks to be seen when the clinical standard for assessment is within 24 hours of referral.

The proposal in this business case is to reconfigure the clinical model for acute stroke and TIA care, enabling a sustainable upward performing trajectory, reducing variation in our service across the week, and delivering a sustainable and effective workforce model. The optimal pathway for stroke prioritises improving access for eligible patients to thrombolysis and thrombectomy treatments, with the aims of improving outcomes for patients, reducing the level of dependency and the length of hospital stay for this population.

This case presents the current gap in resources and ongoing requirements to enable the implementation of a new clinical model, supporting UHW to operate as the South Wales Thrombectomy Service (business case agreed by WHSSC January 2024 for service commencement Summer / Autumn 2024) and to be considered as the Comprehensive Regional Stroke Centre for the South Central Wales Regional Stroke Delivery Network.

The proposed improved patient pathway and clinical model has been developed with the Executive Management Team and colleagues from other Clinical Boards across the Health Board through regular Stroke Summit meetings during 2023. Three options for delivery are presented int his paper; the preferred option is Option 3.

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Benefits expected in this case include:

- Implementation of the Health Board's Stroke Improvement Action Plan
- Improvement against all measured stroke clinical standards and performance indicators

- Reduction in adverse events and patient safety concerns
- Reduction in investigations and diagnostics resources
- Supporting the management of the acute and emergency medicine caseload and improving flow of this patient group within the emergency department
- Avoidance of admission for a proportion of patients with TIA, stroke or suspected stroke
- Anticipated reduced length of stay for patients requiring admission
- Through reduction in admissions, investigations and diagnostics, reduced length of stay and reduced health and care dependency and treatment need, carbon emissions can be reduced.
- Improved patient and carer experience
- Improved staff experience and wellbeing through sustainable workforce delivery; better career pathways in stroke as a speciality and opportunity to build UHW as a centre of excellence

Risks include:

- Inability to recruit into new posts or delays to recruitment
- Demand on the service will exceed that anticipated in this case
- Fragility of neighbouring stroke services in other health boards, and developments in the regional stroke programme
- Progression of the Business Case to WHSSC for UHW to be commissioned as the South Wales Thrombectomy Centre.

Annual Revenue Requirement	**Current Year 2024-25 (£)**	**Recurrent (£)**
	654,237*	1,385,852
Capital Requirement (£)	0	

*updated for May 2024 IG

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2. Introduction and Background

Stroke is a life changing event; the fourth highest cause of death in Wales and the leading cause of disability. In the severest of cases, if survived, stroke carries a high level of disability and dependency with ongoing both physical and mental health needs. There is a need for CAVUHB to review its service provision, quality and outcomes for people with stroke across the whole clinical pathway – from hyperacute care to specialist recovery and rehabilitation including into integrated community stroke services and long-term life after stroke support. This will require a longitudinal phased improvement programme imbedding the principles of value-based health care provision, aligned to developments of the National Stroke Programme and the regional South Central Wales Stroke Delivery Network. The totality of this work is outside of the scope of this business case; rather this case is the first step in addressing the identified gaps in the stroke service by starting at the emergency stroke and TIA part of the patient pathway.

CAVUHB's stroke service assesses around 2,000 patients per year who present to hospital with suspected stroke. Around 1,000 of these are admitted to the acute stroke unit and 700-750 of these have a final diagnosis of stroke. In addition, approximately 1,200 patients are referred to stroke outpatients after a suspected TIA each year.

Following an acute stroke unit stay at UHW (median length of stay 3.5 days), just under half of stroke patients require further inpatient recovery and rehabilitation care at the Stroke Rehabilitation Centre (SRC) UHL. The median length of stay at SRC is 42 days and around a third of stroke patients leave hospital with a dependency level requiring long term care. Stroke is estimated to cost NHS Wales £220 million annually, and for all sectors of the Welsh economy, a combined £1.63 billion. The high costs are related to the large number of patients who survive their stroke but are left with a disability, often requiring a care package, or long-term institutional care. This cost is forecast to rise to £2.8bn by 2035 if no action is taken.

Developments in stroke care over the last 10 to 15 years have placed increased demand on clinicians to deliver a better hyperacute model for stroke and TIA. There is a need to provide an emergency 'front door' service working closely with emergency medicine and radiology to deliver an early diagnostic and treatment pathway for stroke and TIA, similar to that for emergency cardiology and major trauma.

Treatments for stroke are advancing.

- Patients treated with the time-dependent thrombolysis (clot-busting treatment) are less likely to be dependent afterwards, and the quicker the treatment is given the more likely it is to be effective.
- Mechanical Thrombectomy (clot removal by an Interventional Neuroradiologist) is associated with an increased chance of survival and a reduced risk of surviving with a significant disability
- The number needed to treat with thrombectomy for one patient to experience a good outcome, leaving hospital with little or no disability, is 2.8 - making it the most effective intervention in modern medicine.
- Thrombectomy, for eligible patients represents a saving of £47,000 per patient treated over a 5-year period. A 10% thrombectomy rate in Cardiff and Vale

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University Health Board would save £3.29million over 5 years (70 patients saving £47,000 each).

Patients are more likely to access these emergency stroke interventions when a stroke specialist team including a senior decision maker are involved at an early stage.

The optimal pathway for stroke prioritises improving access for eligible patients to thrombolysis and thrombectomy, with the aims of improving outcomes for patients, reducing the level of dependency and the length of hospital stay for this population. The optimal pathway for TIA sees TIA patients being managed within the emergency stroke service, in a 'hot clinic' or same day emergency care model. Changes are now required to CAVUHB's clinical service for acute Stroke and TIA in order to place a dedicated stroke specialist team within the emergency pathway.

The current model involves emergency stroke cases being seen on an urgent bleep call basis by junior medical doctors on call in ED, with support from a clinical nurse specialist in stroke by day, and with a consultant available 24/7 for advice and decision-making support by telephone.

Reflecting the advances in stroke medicine internationally, the National Clinical Guideline for Stroke for the UK and Ireland was extensively updated in 2023, providing authoritative and evidence-based guidance to improve the quality of care delivered to every adult with stroke in the United Kingdom and Ireland (see p.21 for link). Implementing the guideline's ambitious recommendations poses a challenge however, especially given the current financial climate. The guideline sets high standards for stroke care, emphasising the importance of organisational structure, staffing levels, high quality rehabilitation and timely access to care. While the difficulty in meeting these targets is acknowledged, the potential long-term benefits for stroke survivors, their families, and our healthcare system far outweigh the initial challenges. There is a moral, clinical and fiscal responsibility on services to organise themselves around providing the recognised optimal clinical pathway in order to promote best possible outcomes for all affected by stroke.

Stroke as a speciality sits organisationally at CAVUHB in Integrated Medicine within Medicine Clinical Board. Clinically it is closely aligned with Neurology and Acute and Emergency Medicine, representing its complex service interactions and interdependencies. To this end, the development of stroke services in CAVUHB may determine the viability of a number of other services because of the relatively new and mutual dependency of stroke and Interventional Neuroradiology. Currently, in the majority of units in the UK, thrombectomy is done only by Interventional Neuroradiologists (INRs). This may change in the future but this means that thrombectomy is done only in Neurosciences centres where there are enough INRs to maintain 24/7 rotas, and they in turn need to be supported by a clinical stroke service that can reliably triage patients to ensure only those with large vessel occlusions are then referred to the INRs for an intervention.

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Currently in Cardiff we have two INRs, both of whom are able to perform thrombectomy for stroke patients. However, the bulk of their work comes from Neurosurgery (e.g. coiling of aneurysms in patients who have had a subarachnoid haemorrhage, diagnostic and check angiography, treatment of complex vascular abnormalities). If

CAVUHB does not have a comprehensive acute stroke service it will not be possible to reliably select patients for thrombectomy, the INRs may then be unable to maintain their thrombectomy skills, and they may then seek posts in units where clinical and radiological services in stroke are more developed. Tertiary services would be difficult - and in the long term impossible - to maintain in Cardiff without INRs.

This business case is intended to uplift CAVUHB's acute stroke service, securing it as a platform on which to further build and establish UHW as a future Comprehensive Regional Stroke Centre and as the South Wales Thrombectomy Centre. The intended timeframe of implementing a new clinical model for acute stroke and TIA will be largely driven by recruitment to additional sessions and new posts. It is intended that this will be completed as soon as possible, with the aim of going live in a new clinical model from late Spring 2024, incrementally extending the hours of provision and building the clinical model as recruitment occurs and more sessions come online.

Strategic Context – Alignment to UHB strategic direction

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	This case is about improvement opportunities for treatment and improving outcomes for the whole population. Creating a sustainable workforce is one of the key benefits in this case – people will feel valued, supported and able to develop in their roles. Expansion of the stroke workforce has transferrable benefits across the emergency medical provision. There will be more scope for training and development in stroke as a specialism, with increased attractiveness of the service to new staff.
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 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	Improving the quality of this service is the key driver for this business case. This model intends to improve the outcomes after stroke across the CAVUHB population. Reducing stroke occurrence, delivering higher quality TIA and stroke prevention clinics. There is potential for admission avoidance in this model with a senior decision maker at the forefront of the service. This model offers opportunity to use resources allocated to stroke in the most prudent and effective way.

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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 TIA service moving into a Same Day Emergency Care model will provide a more appropriate setting for emergency assessments than an outpatient setting. Patients will have improved access to senior clinical decision makers, reducing delays and potentially reducing length of hospital stay.
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	This model supports the sustainable development of the thrombectomy pathway, improving access for all patients with anticipated associated improved outcomes. Increasing numbers of patients accessing thrombolysis and thrombectomy treatments for stroke offers potential savings for NHS Wales of up to £350 million over a 10-year period, with associated wider savings for the Welsh economy as a whole. Through reduction in admissions, investigations and diagnostics, reduced length of stay and reduced health and care dependency and treatment need, carbon emissions can be reduced.

Rightsizing the workforce for the acute stroke and TIA service is included as a priority ambition in the Health Board's Integrated Medium Term Plan for 2024-25. This business case provides the context and background to the required service reconfiguration.

This case truly aligns with both the Health Board's *Shaping Our Future Wellbeing* strategy and *Shaping our Future Clinical Services* plan, by ensuring that patients with stroke have equitable access to care, focused on achieving the best possible outcomes with the highest opportunity for independence, surviving, thriving and living well after stroke. There will be better emphasis on stroke prevention though a reorganisation of TIA services, supporting the population to live healthier lives.

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Ensuring our stroke services are of the highest standard, comparing with the best in the world and developing UHW as a stroke centre of excellence will have far reaching impact, leading the way for NHS Wales and delivering the next generation of stroke care for the population of Cardiff and the Vale.

This case aligns with CAVUHB's desire to lower its carbon footprint. Through capturing TIAs and preventing them having a subsequent stroke, emitting carbon through the use of products and drugs can be avoided. Whilst there is a fixed cost of energy bills, improved efficiency of the system will mean that less waste occurs in day to day service operation. The use of diagnostic equipment comes with a carbon footprint, by reducing the number of diagnostic tests required, there will be a proportionate emission reduction. Finally, patient dependency consumes medical products and services, thus avoiding and/or lowering dependency means a lower carbon footprint. Reducing dependency also has positive socioeconomic benefits especially for those of working age.

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3. Summary of current service provision, proposed changes and the case for change

4.1 Patient Stories

Case 1	NRI ID 38447, Arrival Monday 7th August 2023, 8:12pm.
Synopsis	A 56-year-old gentleman, Mr P, was brought to the Emergency Department (ED) by his family on a Monday evening having been found collapsed with right sided weakness and unable to speak; he had last been seen well at 3pm. On arrival to ED, he was triaged as suspected stroke, sent for scanning immediately and moved into the Resuscitation area. The Code Stroke 2 alert was used because the time of symptom onset was not clearly within the last 4.5 hours. Scans confirmed that he was suffering a stroke, with a clot in one of the main arteries of the brain. There was no Stroke Clinical Nurse Specialist (CNS) on shift and the medical team's junior doctors were busy with a large caseload in ED and their handover to the night team. There was a delay of almost 2 hours before this patient was assessed under the Code Stroke 2 pathway. Mr P was deemed appropriate to have been referred to the Stroke Thrombectomy service at Southmead Hospital, Bristol but by the time this was identified, it was too late to make the referral and he had already suffered a severe stroke. The stroke service reported this case as an NRI and a Patient Safety Learning Review (PSLR) was undertaken. Mr P was admitted to the acute stroke unit and transferred a few days later to the Stroke Rehabilitation Centre at UHL where his health unfortunately deteriorated and he died from the complications of severe stroke 11 weeks after the event.
PSLR findings and recommendations	The key findings of the PSLR were that the delay to assessment of Mr P by the medical doctor in ED led to the missed opportunity to refer him for thrombectomy. The possible outcome of this if it had gone ahead is unknown but the patient missed an opportunity for potential improvement. Recommendations to be included in the stroke improvement action plan included seeking investment into the dedicated stroke workforce, specifically the CNS team and junior doctor workforce, improving the stroke pathway and communication in ED, and delivering an education programme with a focus on identifying patients eligible for thrombectomy. Mr P's family were engaged and involved in this review process; they fully endorse our action plan and this business case to support the development of a new clinical model for stroke which is focused on delivering the optimal patient pathway in any similar future cases.

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Case 2	Arrival Tuesday 14th June 2022, 10:14am
Synopsis	Ms W, 50, collapsed at work at 9.15am whilst teaching a class of primary school children. After being told an ambulance would take several hours, colleagues brought her by car to ED. She had facial weakness, right arm weakness and language difficulty, was immediately identified as a suspected stroke and sent for scanning. The Code Stroke 1 alert was attended to by the Stroke CNS and the medical registrar covering ED. Scans demonstrated that she was suffering a stroke, with an identified clot in one of the main arteries of the brain. The stroke consultant was contacted; Ms W was given thrombolysis and referred to the Interventional Neuroradiologist for thrombectomy treatment. Ms W underwent a thrombectomy procedure within 3 ½ hours of her stroke symptoms with a good outcome. She stayed on the acute stroke unit for 13 days, receiving daily Occupational Therapy and Speech and Language Therapy. Her rehabilitation continued at home with the stroke Early Supported Discharge team. Whilst Ms W is unable to return to her job as a primary school teacher after her stroke, she is able to live independently. She is active and well, and volunteers as a patient representative with the Stroke Association. She has since returned to UHW to visit the Interventional Neuroradiology department where her thrombectomy took place, and she has recorded a patient digital story with the Patient Experience team (See extract from this in Appendix 1).
Learning points and recommendations	This lady presented to hospital on a Tuesday morning. A Stroke CNS was involved in her care and coordinated her pathway in ED. Thrombectomy was available at UHW and able to be accessed quickly. This case demonstrates how the optimal stroke pathway can be implemented when resources and timings align, as well as possible outcomes for patients if the service is modelled around promoting thrombolysis and thrombectomy treatment.

Case 3	Arrival Sunday 11th February 2024, 9:46am
Synopsis	Mr T, 51, presented to ED after waking up with symptoms of slurred speech, arm weakness and numbness. This stroke event had possibly occurred during sleep, with an unknown onset time. He was seen on arrival to hospital by the Stroke CNS who identified that the patient may be a candidate for thrombolysis and/or thrombectomy, and called the stroke consultant who was on C4 doing the Sunday morning ward round. The consultant attended in person to ED to assess Mr T and requested the advanced stroke imaging pathway which included a CT Perfusion scan. Scans showed that whilst the time of onset could not be determined, there was a large area of vulnerable yet potentially salvageable brain tissue and Mr T was deemed appropriate for

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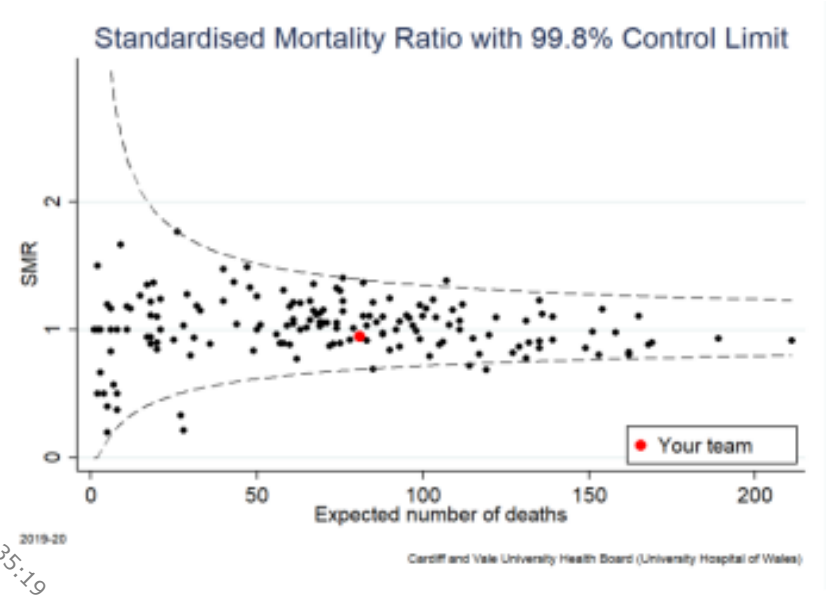
	thrombolysis and thrombectomy. This diagnosis and treatment plan were supported by AI through Brainomix e-stroke software. Mr T was given thrombolysis treatment whilst being referred for thrombectomy in Bristol, and he was taken to Bristol as an emergency transfer. On arrival there he was reassessed; the stroke symptoms had improved and thrombectomy was no longer clinically indicated. He was brought back to UHW and admitted to C4 acute stroke unit at 4.15pm. Mr T had a full recovery from the stroke event with no lasting neurological deficits. He was discharged home on the evening of Monday 12th February, with a total length of stay of less than 36 hours.
Learning points and recommendations	This patient attended to hospital at the weekend, but at a time of day when both the stroke CNS and stroke consultant were present and could deliver the optimal pathway for this patient quickly. This case demonstrates the need to resource a clinical model which supports every patient eligible to access thrombolysis and thrombectomy. It also shows the value of the investment into AI stroke imaging interpretation software and its place in supporting the clinical team with decision making.

4.2 Patient Outcomes

Mortality

The 30-day mortality rate for stroke at CAVUHB for the 12-month period to November 2023 was 13.3%. The mortality rate for the whole of Wales for this period was 13.9% (NHS Executive Performance and Assurance team data). UHW is not an outlier for mortality after stroke within Wales.

UHW's standardised mortality ratio after stroke for April 2019 to March 2020 was 0.95, and crude mortality 12% (SSNAP 2020). UHW is not an outlier for mortality after stroke in the UK.



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Length of Stay and Discharge Destination

Data from SSNAP and internal patient admission records show that the median length of stay at CAVUHB after stroke is:

C4 acute stroke unit, UHW 3.5 days
Stroke Rehabilitation Centre (SRC) 42 days

Discharge destinations for patients with confirmed stroke under our care during the SSNAP measured period of July to September 2023 are shown in Table 1 below. UHW received a SSNAP grade A within this audit period.

- 48.2% of stroke patients from this cohort went home directly from the acute stroke unit at UHW
- 44.4% were transferred to SRC for ongoing rehabilitation input.
- 73.1% of patients discharged from SRC during this period went home to their own home - most of these patients had ongoing rehabilitation and therapy needs; some had ongoing care needs.
- To note, very few patients were discharged to new care home placements (0% of C4 and 5.4% of SRC discharges)

Whilst it is seen as a good outcome to achieve discharge home for so many patients after stroke, this is with a relatively high level of dependency.

Table 1. Discharge Destinations from CAVUHB Stroke Service

Discharge Destinations SSNAP Quarter Jul-Sep 2023	C4 Acute Stroke Unit, UHW	Stroke Rehab Centre, UHL
Home without any ongoing rehab need	27.5%	19.6%
Home with stroke Early Supported Discharge team	18.5%	33.9%
Home with Community Resource Team	2.2%	19.6%
Transfer to further inpatient rehab	44.4%	10.8%
Transferred to another clinical service	0.6%	1.8%
Discharged to a new care home placement	0.0%	5.4%
Died	6.7%	8.9%

Level of dependency

Dependency level after stroke is measured using the modified Rankin score (mRs):

0 Independent, with no ongoing deficits after stroke
1-2 Able to mobilise independently, but requiring some support with performing activities of daily living
3-4 Assistance to mobilise and with all activities of daily living
5 Fully dependent for all care and reliant on manual handling equipment for transfers
6 Died

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The mRs on discharge for the cohort of patients with confirmed stroke under our care during the SSNAP measured period of July to September 2023 is shown in Table 2 below.

Table 2. Modified Rankin score on discharge from CAVUHB Stroke Service

Modified Rankin score on discharge SSNAP Quarter Jul-Sep 2023	C4 Acute Stroke Unit, UHW	Stroke Rehab Centre, UHL
0	18.7%	0.0%
1	39.3%	3.6%
2	14.0%	16.1%
3	11.2%	46.4%
4	4.7%	7.1%
5	0.9%	12.5%
6	11.2%	8.9%

- 18.7% of patients discharged from the service had an mRs of 0 after stroke
- No patients were discharged from SRC fully independent.
- An mRs of 2 or less is seen as a 'good outcome' towards independence after stroke, a measure used in stroke research and to indicate good outcomes after thrombolysis and thrombectomy treatment.
- 16.8% of patients discharged from C4, UHW and 66% of those discharged from SRC had an mRS of 3 or more.

In the current service model, approximately one third of all stroke patients are discharged from hospital with a dependency level requiring long term care and support. Many more have longstanding milder disabilities meaning they face long periods of recovery and rehabilitation after stroke. Many stroke survivors of working age do not return to meaningful occupation and employment. It is anticipated that by increasing the number of patients receiving thrombolysis and thrombectomy treatments, there will be a positive change in outcome for this patient group. By reaching the target rates of 20% thrombolysis rate and 10% thrombectomy, it is expected that more patients will be able to leave hospital directly from the acute stroke unit, and that a proportion of patients will have an accelerated pathway through rehabilitation, shortening the average length of stay and reducing the overall levels of dependency on discharge seen in this patient group.

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4.3 Current Performance against key indicators

Stroke performance is measured by the SSNAP audit against standards of care as set out in national clinical guidelines, with quarterly reports offering a performance score rating based on 10 key domains. UHW's SSNAP grade score over the last 3 years is as follows:

Table 3. UHW SSNAP grades 2021-23

	Q1 Jan – Mar	Q2 Apr – Jun	Q3 Jul- Sep	Q4 Oct- Dec
2021	C	B	C	C
2022	C	D	C	C
2023	C	B	A	B

In Wales, stroke performance for each Health Board is additionally monitored by the NHS Executive Performance and Assurance team (Formerly the NHS Wales Delivery Unit) against a group of Quality Improvement Measures.

The NHS Wales stroke performance dashboard is available here Dashboard and Observations (sharepoint.com)

UHW's performance against key measures for the quarter Jul-Sep 2023 is shown in Table 4 below, along with the all Wales performance and that of the London Integrated Stroke Delivery Network for the same time period for comparison with a more developed service.

In the last year, UHW's stroke performance has improved significantly, most notably in the admission to the stroke unit within 4 hours measure. Achieving an A grade on SSNAP deserves to be celebrated, however we meet just the minimum standard for this. It should be acknowledged that this has been achieved through intensive and focused improvement work and interim resource redirection (temporary CNS rota changes to cover weekends and moving sessions of stroke consultant time to the front door where possible). Achieving a sustainable A grade will require reconfiguration of the service to change the clinical model for stroke and TIA, as is proposed in this business case.

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Table 4. Comparison of Stroke Performance Key Measures and Outcome Indicators

Stroke Performance Measure	Target for SSNAP grade A	All Wales Jul-Sep 2023	UHW Jul-Sep 2023	London stroke network Jul-Sep 2023
Percentage of Patients given thrombectomy	Not currently measured on SSNAP	2.0% *NHS Wales data	2.7% *NHS Wales data	Data unavailable, but patients in this network have 24/7 thrombectomy access
Percentage of patients given thrombolysis	>16%	13.2%	8.0%	13.0%
Median door to needle Thrombolysis treatment time	<45 mins	1 hr 16 min	1 hr 5 min	44 min
Percentage of patients scanned within 1 hour of arrival	>50%	58.0%	56.9%	72.6%
Median time to scan	<45 mins	49 min	53 min	29 min
Percentage of patients admitted to the stroke unit within 4 hours of arrival	>80%	30.7%	60.8%	53.4%
Percentage of patients having a swallow screen assessment within 4 hours of arrival	>80%	73.3%	77.1%	84.1%
Percentage of patients seen by a stroke specialist consultant within 24 hours of arrival	>80%	80.1%	88.3%	100%
Median time to stroke consultant	<6 hours	12 hr 0 min	11 hr 42 min	4 hr 50 min
Median time to stroke specialist nurse	<30 mins	2 hr 22 min	1 hr 46 min	0 min

Outcome indicators		All Wales	UHW	London network
Crude Mortality April 2019-March 2020	SSNAP data	Range 10-18%	12%	Range 8-15%
Median mRs on discharge from acute site April 22-Mar 23		3	2	2

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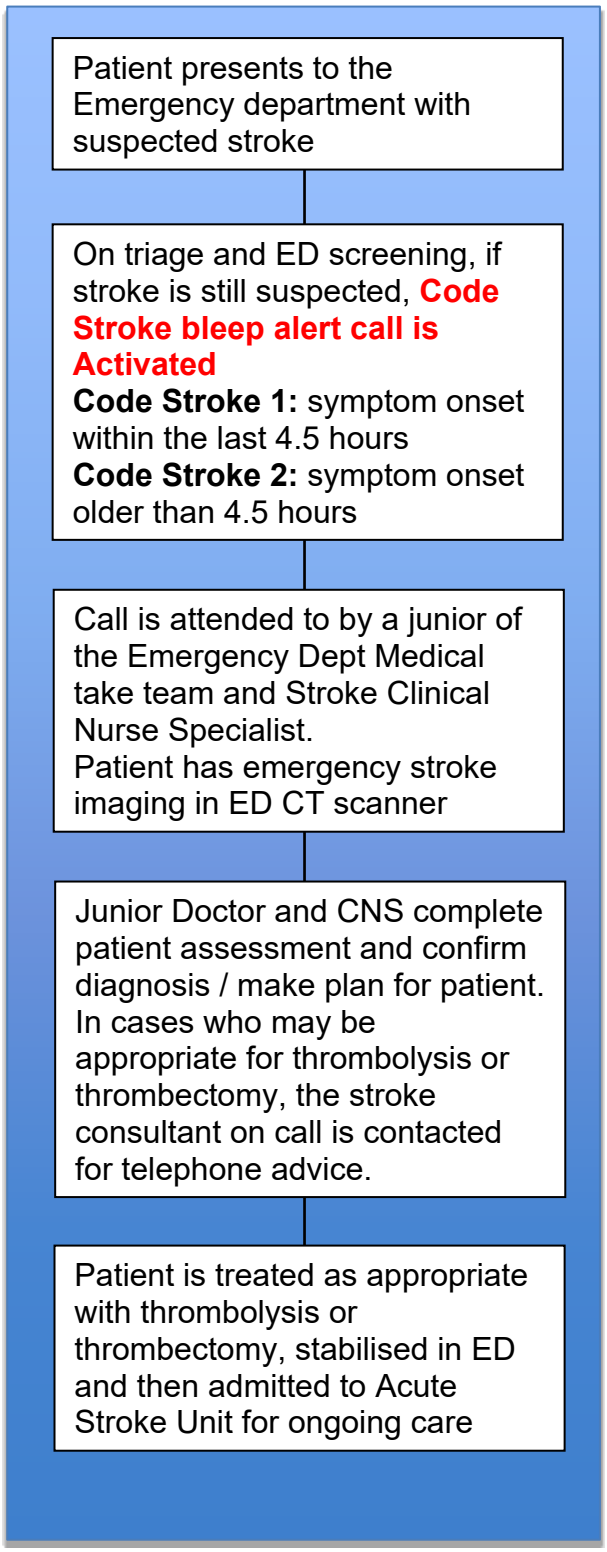
4.4 Current and Proposed Patient Pathways for Stroke and TIA

Figure 1. Current Emergency Stroke Assessment Pathway



Narrative Issues / Points of Delay

Multiple methods: Ambulance conveyance, GP referral, self-presenting

Stratifying urgency of stroke assessment by time of onset is no longer clinically appropriate.
Risk that patients will miss treatment opportunities such as thrombolysis and thrombectomy

CNS hours currently 0700 to 1930 7 days / week (unfunded interim rota) **No CNS cover after 1930.**

Junior doctor holding bleep is not specifically stroke trained, often with limited stroke experience. Risk of delay to assessment and treatment as this doctor is not exclusively holding the stroke bleep and has other clinical duties which presents a large caseload with competing priorities.

Thrombectomy referral (particularly out of hours to Bristol) requires sending images online, completion of online referral and booking transport via WAST trauma desk – time consuming, takes junior doctor away from other duties and more difficult when CNS is not present.

Senior clinical decision maker is not present with the team unless workload supports (telephone code stroke cover is doubled up with other clinical duties in current workforce model)

Risk that patients will miss treatment opportunities such as thrombolysis and thrombectomy

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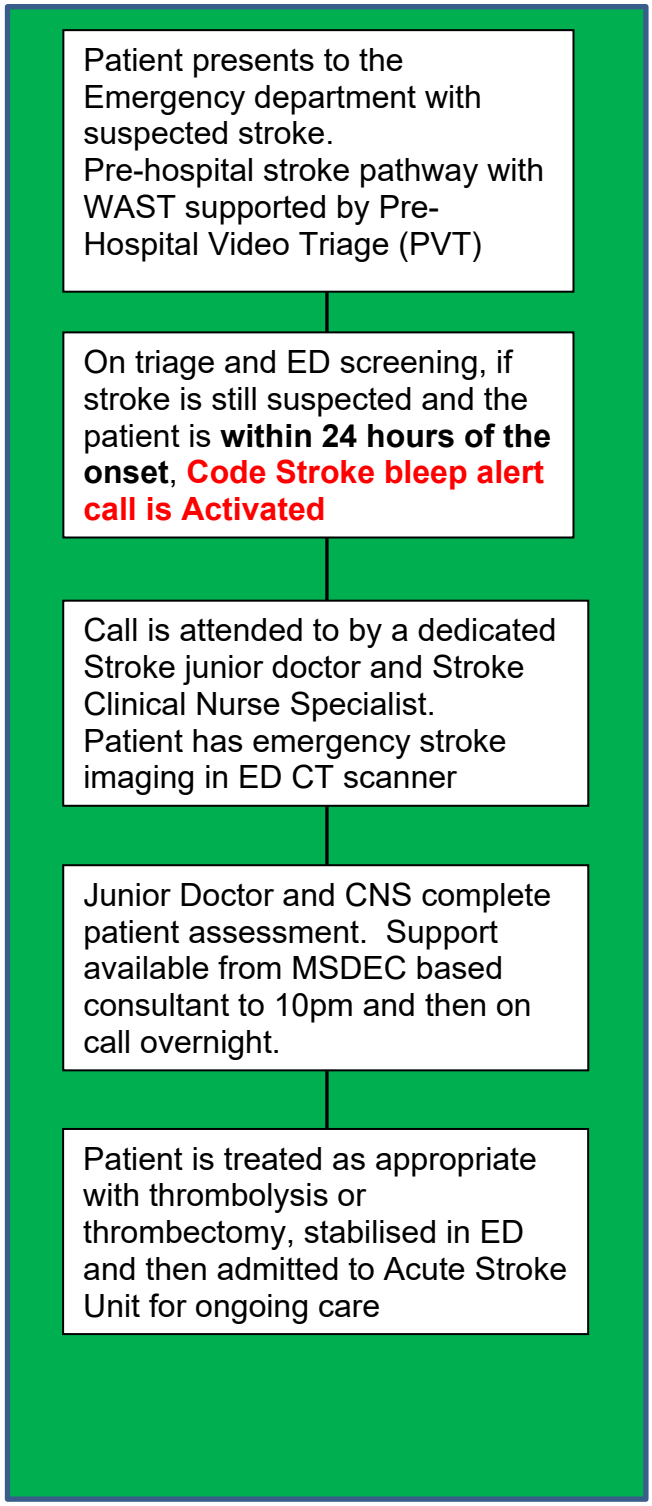
Figure 2. Proposed Emergency Single Stroke Pathway



Issue	Resolution
	PVT will enable the stroke consultant to advise if stroke is unlikely, and alert the stroke team ready to receive a new patient when it is. Stroke junior doctor and CNS will also be connected to PVT to support pathway planning.
	Code stroke to be used for all patients within 24 hours of symptom onset, **removing Code 1 and 2,** promoting thrombolysis and thrombectomy treatment opportunity for all eligible patients Patients with onset >24 hours may be redirected to MSDEC to be assessed by the stroke consultant as appropriate, reducing the suspected stroke cases going through the ED pathway. This is supported by PVT.
	CNS cover extended and dedicated stroke junior doctor cover both phasing up to 24/7. PVT will support the team being ready to receive patients, reducing delays at the start of the pathway **Dedicated stroke resource** - standardising the pathway, reducing delay to assessment & maximising treatment opportunities. **Senior clinical decision maker** can attend to support assessment and treatment as indicated (PVT will also support this as the consultant will have seen the patient before arrival)
	Maximising opportunities for all eligible patients to be considered, referred and treated with thrombolysis and thrombectomy.

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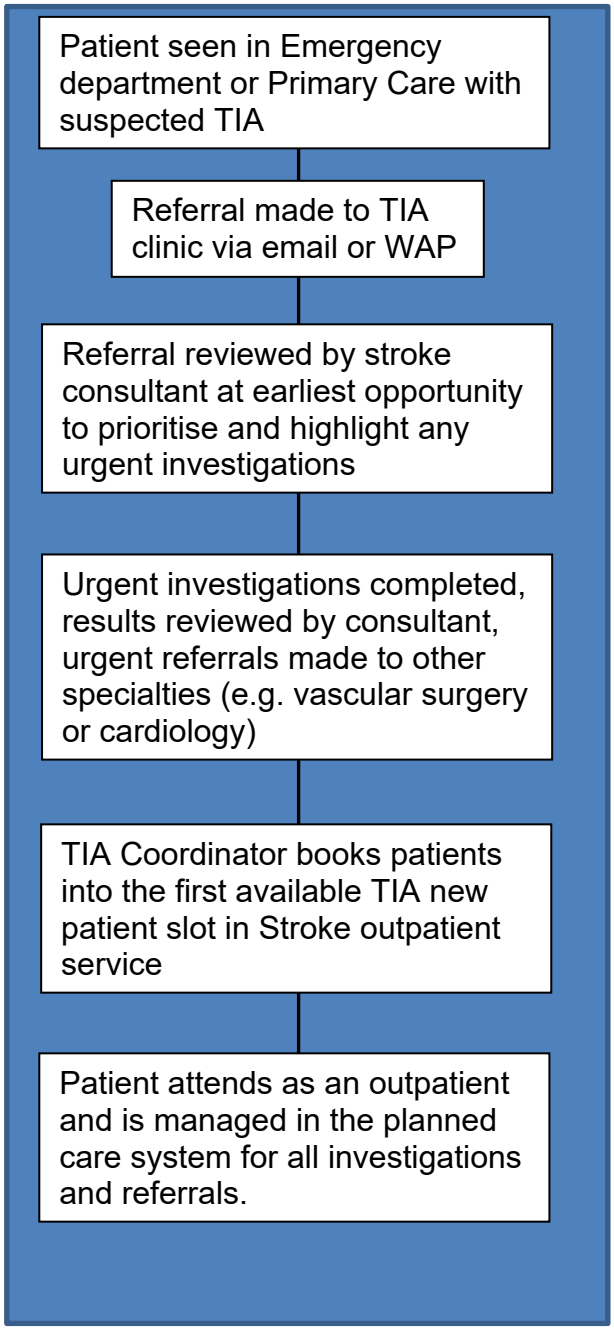
Figure 3. Current TIA Pathway in the Stroke Outpatient Service



Narrative Issues / Points of Delay

Referrals received and grouped for review by consultants – no dedicated time for this, ad hoc task amongst other duties.
TIA service is not on consultant connect as no ability to cover a consultant connect line
Limited ability to decline or redirect referrals unlikely to need TIA service.

Patients with significant findings on urgent investigations are often referred to other services without having seen a Stroke Consultant, reducing opportunity for joint care decision making to optimise patient outcomes.

16 new patient slots per week, current wait time approx. 8-12 weeks

Clinical Standard: Patients should be assessed and investigated for TIA as soon as possible after the event and within 24 hours of the referral.

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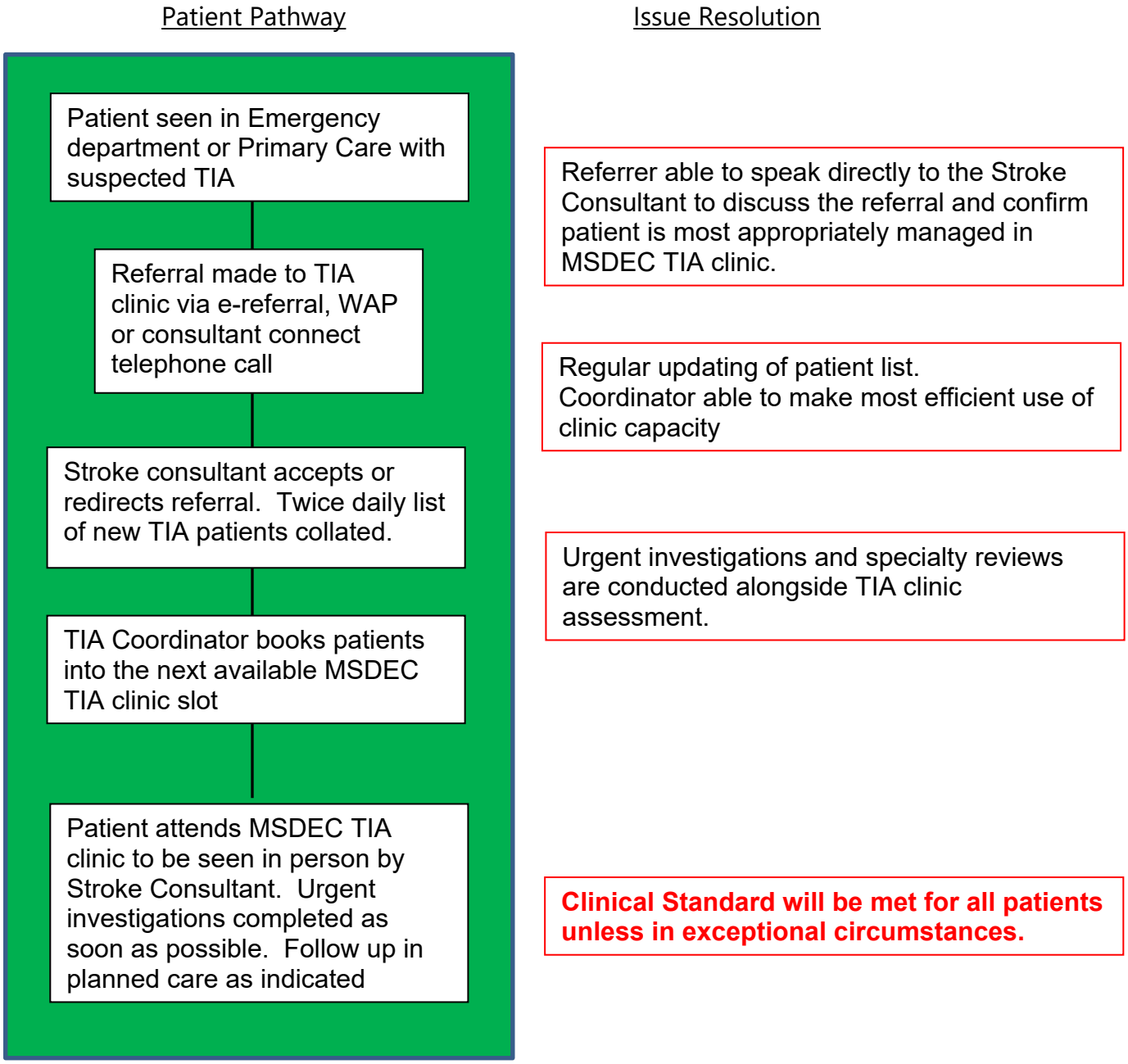
Figure 4. Proposed new TIA Pathway in the Medical Same Day Emergency Care unit



These proposed clinical pathways have been designed around achieving the recognised clinical standards for stroke and TIA, meeting key performance indicators and SSNAP measures.

They have been developed in collaboration with colleagues from Acute and Emergency Medicine, complement the proposed Neurology Consultant of the Week model and have been endorsed by the Executive Management team through the stroke summits.

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Stroke Mimic Cases

All stroke services need to manage the cohort of patients who present with symptoms and signs suggestive of stroke but in whom the diagnosis is shown to be something other than a stroke. These patients are known as 'Stroke mimics' and make up just over half of the stroke department's demand. In stark contrast to the simple and revealing ECG in patients with acute cardiac disease, the basic test in suspected stroke (a plain CT scan) can often be relatively normal for the first 2-3 hours after a blood vessel has become occluded, leaving the clinician with the story told and the findings on clinical examination as the main clues to the diagnosis.

The list of stroke mimicking conditions is long. It includes very common conditions e.g. fainting, seizures, sepsis and drug side effects, as well as rarer and more complex diseases the diagnosis of which requires repeat brain imaging or more complex investigations (e.g. lumbar puncture, Electroencephalogram, PET scanning).

There are multiple benefits of placing a senior decision maker as early as possible in the pathway, improving the management of patients with stroke mimicking conditions. The sooner a patient with a stroke mimicking condition can be seen and assessed by a stroke expert team, the sooner they can be placed onto the optimal pathway for their individual needs. It is expected that for this patient group there will be a reduction in the requesting of some investigations and imaging tests, a reduction in unnecessary treatment and the associated risk of harm from this, and a reduction in unnecessary admissions for observation or to wait to be seen by the right professional. More efficient management of stroke mimicking cases is expected to release capacity within the system, allowing the allocated resources (bed capacity, diagnostics and specialist staff) for stroke and TIA services to be optimised within the stroke pathway.

Recent pathway developments and digital innovations

Optimal Stroke Imaging Pathway: In response to updates to the National Clinical Guidelines for Stroke for the UK and Ireland (2023), the optimal stroke imaging pathway has been developed with radiology to include advanced imaging modalities supporting thrombolysis and thrombectomy treatment decisions.

Brainomix e-stroke: AI image interpretation software which provides a rapid graphical report of CT, CT Angiogram and CT Perfusion scan images to support emergency diagnostics. Since implementing e-stroke at UHW, more than 600 patient scans have been processed and there has been a clear increase in the number of patients receiving thrombolysis and being referred for thrombectomy.

Pre-hospital Video Triage (PVT) for Stroke: Innovation project with Welsh Ambulance Service NHS Trust (WAST). Development of a secure platform hosting PVT, connecting WAST clinicians and the hospital stroke consultant, allowing the stroke pathway to begin right at the scene of the 999 call. So far there have been 20 successful PVT calls; 7 of these progressed on the stroke pathway on arrival to hospital and 4 received thrombolysis or thrombectomy. 13 patients were diagnosed with a stroke mimic event before conveyance to hospital and were managed on the optimal pathway for their needs.

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The use of these digital pathways requires the optimal workforce model to be in place.

4.5 Current and Proposed Clinical Models for Stroke and TIA

Current workforce model for acute stroke:

UHW Stroke Consultant workforce:	Mon – Fri 8am - 5pm	Mon – Fri 5pm – 10pm	Sat – Sun 8am - 5pm	Sat – Sun 5pm- 10pm	Overnight by telephone 10pm – 8am	Workforce
Acute stroke unit, Ward C4, UHW	X1 daily ward round and MDT board round		X1 daily ward round and MDT board round			**10** DCC sessions
Emergency stroke assessment pathway	x 4 sessions in person attending to code stroke calls (1 unfunded at present) x 6 remote advice by telephone (3 of these can convert to in person in a new clinical model)				3 sessions currently job planned	**9** DCC sessions
Pre-hospital video triage calls	No dedicated sessions					**0** DCC sessions
MSDEC stroke and TIA assessment	2 sessions in current clinical model are able to convert to a new model					2 DCC sessions
					Total Stroke Consultant DCC sessions at UHW 3.0 WTE stroke consultants in current workforce	**21** DCC sessions

Junior Doctor workforce:	Mon – Fri 8am - 5pm	Mon – Fri 5pm – 10pm	Sat – Sun 8am - 5pm	Sat – Sun 5pm- 10pm	Overnight 10pm – 8am	Workforce
Acute stroke unit, Ward C4, UHW	1.0 WTE Stroke Trainee 2.0 WTE foundation grade					3.0 WTE
					Total Junior Doctor Workforce for stroke, UHW	**3.0 WTE**

Stroke CNS workforce:	Mon – Fri 7am – 7.30pm	Sat – Sun 7am – 7.30pm	Overnight 7.30pm – 7am	Workforce required
Emergency stroke assessment pathway	Establishment of 3.8 WTE for UHW	Temporary extension of rota to include weekends		3.8 WTE
			Total CNS Workforce	**3.8 WTE**

Key issues with the current workforce model:

- **Consultant cover to code stroke** started in 2015 as an improvement initiative in implementing the thrombolysis urgent treatment pathway.
- No further resource has been allocated to the stroke consultant body since then; sessions have been reinvested from elsewhere in the pathway to reach the current level of cover.

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- There are currently only 4 sessions per week of in person consultant attendance to emergency code stroke calls in ED.
- At all other points of the week, and out of hours, a consultant is only available for clinical advice by telephone, and during the week this is often as a secondary task alongside other clinical duties.
- The out-of-hours stroke rota, and weekend morning ward round shifts are staffed by those in substantive stroke consultant posts (5 individuals) plus volunteers from acute medicine and neurology with an interest in stroke. Approximately 20 weeks of the year are unable to be filled by this substantive rota; these weeks are covered on a voluntary basis at additional cost to Medicine Clinical Board of £8,500 per week.
- **There is no dedicated middle grade junior doctor for stroke**; the stroke bleep is delegated to one of the medical team in the on-call take team to hold.
- This doctor needs to respond as quickly as possible to code stroke in amongst their busy caseload of emergency medical referrals and the corresponding competing priorities this brings.
- Currently all thrombectomy referrals, image transfer and patient transfer arrangements fall to the medical registrar to coordinate outside of the CNS working hours.
- **The Stroke CNS team** have temporarily extended their rota to cover weekends (at a cost pressure to Medicine Clinical Board)
- Their establishment is not sufficient for 7-day cover and does not include allowance for annual leave and sickness. Only one CNS is able to be on shift on most days and there is no cover for breaks during the day
- As there is no CNS to handover to at shift end, the team frequently (average once per week) work over their shifts to ensure patients receive the best possible care.
- **TIA patients** are currently seen within the planned care stroke outpatient clinics. There are 16 new TIA appointments available per week, and the service receives between 20 and 25 referrals in an average week. There is a wait to be seen currently of 8-12 weeks.
- TIA is for many patients a warning event and possibly pre cursor of stroke and should be treated as a medical emergency in an emergency pathway. A proportion of TIA patients require time sensitive vascular surgery assessment, with surgical intervention most effective within 14 days of the TIA event.
- In others, detecting conditions such as atrial fibrillation requiring prophylactic anticoagulation treatment is time sensitive and urgent.
- To mitigate delays, currently the stroke consultants screen each referral to arrange urgent investigations in advance of a TIA clinic appointment, checking results intermittently so as to expedite referrals to other services.

4.6 Demand on the Service

Year	Code Stroke Calls	Admitted to C4 on the stroke pathway	Confirmed stroke cases	TIA clinic referrals
2022	1971	1056	744	1173
2023	2031	1022	694	1234

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4.7 Evidence for Change

The evidence for the optimal stroke pathway and service standards is collated in the National Clinical Guidelines for Stroke for the UK and Ireland (2023), linked here National Clinical Guideline for Stroke (strokeguideline.org)

Staffing recommendations are included in these guidelines - for a centre providing hyperacute stroke care, consultant ward rounds on the stroke unit are recommended twice daily, with emergency access to a stroke consultant 24/7 and a minimum of 6 thrombolysis-trained physicians on a rota. Assumptions in this recommended model are that the emergency assessment pathway is supported by a team of junior doctors and specialist nurses or advanced clinical practitioners, and that a TIA service sits alongside or as part of the hyperacute stroke pathway. Suspected TIA patients should be treated with high dose aspirin immediately, unless contraindicated, and assessed urgently within 24 hours by a stroke specialist clinician.

In September 2023, Health Inspectorate Wales (HIW) published the National Review of Patient Flow: a journey through the stroke pathway (hiw.org.uk) The report highlighted where the optimal stroke pathway was not being followed. This was recognised as largely due to pressures across the system but also identified gaps in resource such as the CNS workforce and a dedicated emergency stroke medical team to facilitate thrombolysis and thrombectomy treatments.

Medicine Clinical Board have, with support of colleagues in Patient Flow and Site Services and the Integrated Discharge Service, raised actions against HIW's recommendations; completion of these actions is reliant however on resource allocation in support of delivering an appropriate clinical model.

The evidence base for stroke management is expected to be represented in national stroke service specifications for Wales, due to be published in 2024.

Benchmarking

Most UK stroke services consistently achieving the top grades in SSNAP, including those in the London Integrated Stroke Delivery Network (ISDN), have a dedicated emergency stroke team delivering the recognised optimal pathway. Whilst this is a well-established model in the NHS England ISDNs, benchmarking elsewhere in Wales is not felt particularly useful at this point as no stroke centres in Wales operate in the described optimal model. All stroke services in Wales are currently involved in regional programmes to review the delivery of stroke crossing traditional Health Board boundaries to provide a centralised Comprehensive Regional Stroke Centre.

A useful exemplar is Southmead Hospital, North Bristol NHS Trust which runs a busy hyperacute stroke service and superregional thrombectomy centre, reporting 1211 confirmed stroke cases on SSNAP from October 2022 to September 2023. The out of hours stroke rota there is populated by 21 consultants, supported 24/7 by dedicated middle grade doctors and a well-established Advanced Practitioner and CNS team on a 24/7 rota.

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4.8 The Proposed New Clinical Model for Stroke at UHW

The Stroke Service, with guidance from the Executive Management team and constructive support from colleagues around the health board at summit meetings, have designed the optimal clinical model for stroke at UHW. This includes:

- A dedicated consultant role for C4 acute stroke unit, able to provide twice daily ward rounds, phasing up to 7 days per week.
- A dedicated middle grade doctor or stroke trainee for the emergency code stroke pathway, plus extended CNS working hours, both phasing up to 24/7 cover.
- A dedicated Stroke Consultant role taking pre-hospital video triage calls for stroke, seeing TIA and stroke patients in Medical SDEC and providing senior support to the emergency code stroke team.
- This will be on a 'consultant of the day' daily rota pattern, and in a phased approach extend its hours to 8am-10pm 7 days per week, with overnight telephone support to the code stroke team.

This model will ensure that all patients presenting to UHW with suspected stroke are assessed either:

- In the emergency code stroke pathway if their symptoms are within 24 hours of onset on arrival to hospital, maximising opportunities to deliver thrombolysis and thrombectomy
- In MSDEC if their symptoms are older than 24 hours, either by GP referral, 111 advice or self-presenting to hospital with suspected stroke
- In addition, TIA cases will be seen in an emergency 'hot clinic' in MSDEC, phasing up to 7 days per week, meeting the 24-hour assessment standard for TIA.

In addition, TIA cases will be seen in an emergency 'hot clinic' in MSDEC, phasing up to 7 days per week which will meet the 24-hour assessment standard. Additional benefits of this model include:

- In those with confirmed TIA, expedited investigations and earlier identification of stroke risk factors; research indicates that expediting treatment has a significant impact on secondary prevention of stroke after TIA.
- Opportunity to treat risk factors in those who have experienced TIA, expediting secondary prevention, reducing risk of further episodes after TIA and thus reducing avoidable harm
- For those having treatment of risk factors after TIA, there is an expected reduction in the rates of subsequent stroke, reducing avoidable harm and leading to an overall reduction in the disabling impact of stroke achieved through optimal management of the TIA pathway.
- Early ruling out of TIA in cases where it is not the diagnosis, supporting patients to access the most appropriate pathways for their condition instead of remaining on an inappropriate planned care waiting list

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4. Option Appraisal – 3 Options of how to deliver the proposed clinical model are presented for consideration:

Option 1 – Do nothing: Do not change the clinical model, continue to deliver stroke and TIA as per the current service.

Option 2 – Implementation of the Proposed Clinical Model for UHW:

Stroke Consultant:	**Mon – Fri 8am - 5pm**	**Mon – Fri 5pm – 10pm**	**Sat – Sun 8am - 5pm**	**Sat – Sun 5pm- 10pm**	**Overnight 10pm – 8am**	**Workforce required**
Acute stroke unit, Ward C4, UHW	x2 daily ward round and MDT board round		x2 daily ward round and MDT board round			**14** DCC sessions
Emergency stroke assessment pathway	Consultant available for emergency consultation for emergency code stroke cases				On call by telephone	**35** DCC sessions
Pre-hospital video triage calls	Consultant available to take pre-hospital video triage calls					
MSDEC stroke and TIA assessment	Consultant based in MSDEC for all sessions, provides cover to the above as part of the 'consultant of the day' front door stroke consultant role				On call by telephone	
Total Consultant DCC sessions Required = **49**		Current DCC sessions in place = **21**		Gap in DCC sessions = **28** 4.03 WTE (1 post as associate specialist, remainder as consultant).		

Junior Doctor:	**Mon – Fri 8am - 5pm**	**Mon – Fri 5pm – 10pm**	**Sat – Sun 8am - 5pm**	**Sat – Sun 5pm- 10pm**	**Overnight 10pm – 8am**	**Workforce required**
Acute stroke unit, Ward C4, UHW	1.0 WTE Stroke Trainee 2.0 WTE foundation grade		Junior doctor cover to weekend ward round as per weekend rota			3.0 WTE
Emergency stroke assessment pathway	24/7 cover to code stroke team					6.0 WTE
MSDEC stroke and TIA assessment	Support to Stroke clinic in MSDEC offered by either MSDEC junior doctors or one of the stroke team on a needs led basis					-
Total Junior Doctor Workforce required = **9.0 WTE**		Current workforce in place = **3.0 WTE**		Gap identified = **6.0 WTE**		

CNS:	**Mon – Fri 8am - 5pm**	**Mon – Fri 5pm – 10pm**	**Sat – Sun 8am - 5pm**	**Sat – Sun 5pm- 10pm**	**Overnight 10pm – 8am**	**Workforce required**
Emergency stroke assessment pathway	24/7 cover to code stroke team					8.52 WTE
Total CNS Workforce required = **8.52 WTE**		Current workforce in place = **3.8 WTE**		Gap identified = **4.72 WTE**		

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<u>Option 3</u> – Full scale implementation of the Proposed Clinical Model for UHW to operate as a Comprehensive Regional Stroke Centre:

Stroke Consultant:	**Mon – Fri 8am - 5pm**	**Mon – Fri 5pm – 10pm**	**Sat – Sun 8am - 5pm**	**Sat – Sun 5pm- 10pm**	**Overnight 10pm – 8am**	**Workforce required**
Acute stroke unit, Ward C4, UHW	x2 daily ward round and MDT board round		x2 daily ward round and MDT board round			**14** DCC sessions
Emergency stroke assessment pathway	Consultant based within code stroke team for all sessions				On call by telephone	**35** DCC sessions
Pre-hospital video triage calls	Dedicated 2 sessions per day to take calls					**14** DCC sessions
MSDEC stroke and TIA assessment	Consultant based in MSDEC for all sessions				On call by telephone	**28** DCC sessions
Total Consultant DCC sessions Required = **91**		Current DCC sessions in place = **21**			Gap in DCC sessions = **70**	

Junior Doctor:	**Mon – Fri 8am - 5pm**	**Mon – Fri 5pm – 10pm**	**Sat – Sun 8am - 5pm**	**Sat – Sun 5pm- 10pm**	**Overnight 10pm – 8am**	**Workforce required**
Acute stroke unit, Ward C4, UHW	1.0 WTE Stroke Trainee 2.0 WTE foundation grade		Junior doctor cover to weekend ward round as per weekend rota			3.0 WTE
Emergency stroke assessment pathway	24/7 cover to code stroke team					6.0 WTE
MSDEC stroke and TIA assessment	Support to Stroke clinic in MSDEC					3.5 WTE
Total Junior Doctor Workforce required = **12.5 WTE**		Current workforce in place = **3.0 WTE**			Gap identified = **9.5 WTE**	

CNS:	**Mon – Fri 8am - 5pm**	**Mon – Fri 5pm – 10pm**	**Sat – Sun 8am - 5pm**	**Sat – Sun 5pm- 10pm**	**Overnight 10pm – 8am**	**Workforce required**
Emergency stroke assessment pathway	24/7 cover to code stroke team Additional cover by day offering increased support to thrombectomy cases and CNS support to the stroke unit					7.5 WTE
MSDEC stroke and TIA assessment	Support to Stroke clinic in MSDEC					2.0 WTE
Total CNS Workforce required = **9.5 WTE**		Current workforce in place = **3.8 WTE**			Gap identified = **5.7 WTE**	

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5.2 Appraisal of the Options

Evaluation Criteria Score 0 – option does not meet criteria 1 – option partially meets criteria 2 – option fully meets criteria	**Option 1**	**Option 2**	**Option 3**
Provides 7 day cover to C4 acute stroke unit (twice daily ward rounds)	1	2	2
Provides 'Consultant of the Day' role in MSDEC 8am-10pm	0	2	2
Provides In-person Consultant support to Code Stroke 8am-10pm	1	1	2
Provides Consultant cover to Pre-Hospital Video Triage	1	1	2
Provides dedicated Stroke middle grade junior doctor cover to code stroke (phased by recruitment)	0	2	2
Provides 24/7 Stroke CNS cover (phased by recruitment)	0	2	2
Supports TIA clinic in MSDEC 7 days per week	0	2	2
Supports performance against SSNAP A grade targets	1	2	2
Supports implementation of the Single Stroke Pathway	0	2	2
Supports provision of TIA patient pathway – assessment within 24 hours	0	2	2
Supports future development as Comprehensive Regional Stroke Centre	0	1	2
Supports future development as South Wales Thrombectomy Centre	0	1	2
Short term deliverability of clinical model (recruitment to new posts)	0	2	1
Long term deliverability of clinical model	0	2	2
Total score	4	24	27
Estimated of cost of option	£0	£1.39m	£2.84m

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5. The Preferred option

6.1 Outcome of the Options Appraisal

Option 1 is not supported as it does not enable the implementation of the agreed optimal clinical model for stroke.

Option 2 is supported as the preferred option from this appraisal exercise. It is felt that this option would most reasonably and most prudently support implementation of the optimal clinical model described in this business case. A phased approach to this model is felt to be more reasonably achievable than for Option 3; it is hoped that this model would take only 2 phases to reach full operation, covering the out of hours period in a shorter timescale with less resource required to reach this.

Assumptions in this option are that demand would be such that a dedicated consultant session for each of the code stroke team, MSDEC and pre-hospital video triage elements is not required and that the same consultant would perform each of these clinical duties when in the 'consultant of the day' role, if supported by the middle grade junior doctor and Stroke CNS roles.

It is felt that this option will enable the implementation of a new clinical model for stroke at UHW, offering many transferrable benefits across Medicine, particularly in ED but also providing a strong foundation stroke service on which regional stroke services and the South Wales Thrombectomy Centre can be built.

Option 3 on reflection represents the requirements of a regional service; this model is too large a service for the demand in stroke at UHW alone. Phasing up to this model will require 3 to 4 phases over 1 to 2 years, in line with thrombectomy service developments. The draft timeline for this is presented in Appendix 2.

6.2 Dependencies on Other Services

- Medical SDEC will need to accommodate the MSDEC based stroke and TIA pathway.
- Middle grade rotas will need to be developed which provide dedicated cover to code stroke. There is a need for the stroke service to collaborate with colleagues across medicine and neurology, and to review provision of training posts with HEIW.
- The consultant workforce requirement for this model has been calculated in direct care sessions and as a representative WTE - stroke as a specialty suits mixed specialty job planning and contribution of sessions from other clinical teams will be welcomed.
- In fact, the service is unlikely to recruit individuals who want to work exclusively in stroke. Collaboration with other services outside of Integrated Medicine (primarily Neurology and Acute and Emergency Medicine) will be essential in order to reach the most effective workforce format.

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6.3 Additional Impact on Other Services

- This clinical model is predicted to impact positively on most other services, namely Emergency and Acute Medicine, Radiology, Stroke Rehabilitation services and those providing long term care and support.

- As a result of this clinical model, it is expected that more patients will survive stroke and with less severe disability. This will have a positive impact on rehabilitation and community services with ultimately reduced demand on long term care provision.
    - It is difficult to predict the true demand change on rehabilitation services – it is expected that more patients will survive with reduced secondary complications of stroke e.g. stroke associated pneumonia. This may present a larger than current cohort of patients requiring inpatient or community rehab, but with a large proportion of those having good potential to recover well and regain independence through rehabilitation, optimising outcomes.
    - The stroke rehabilitation demand will be monitored as the new acute stroke clinical model is introduced; this should be considered in any future inpatient stroke rehabilitation and community service review or redesign.
- It is acknowledged that there may be changes in demand on other clinical services, such as Pharmacy, Clinical Diagnostics and Therapeutics and Medical SDEC and so there will be a requirement to evaluate the implementation of this service at around 6 months, reviewing its impact in real time.
    - It is difficult to predict the true demand change on scanning and diagnostic tests - whilst suspected stroke patients may undergo additional scans as more patients will be considered on the thrombolysis and thrombectomy treatment pathways, those with suspected TIA will only undergo necessary urgent investigations in the MSDEC setting, and a reduction in unnecessary imaging and diagnostic tests is expected in those with stroke mimicking conditions.
    - This activity will be monitored for changes in demand in both outpatient and Medical SDEC settings.
    - It is possible that moving TIA clinic into the MSDEC model will place additional demand on the in-hospital pharmacy service; this activity will be monitored for changes in demand.
- It is expected that the changes to TIA management, bringing forwards the point of definitive diagnosis and secondary prevention treatment planning, will have a positive impact on medications usage and management.
    - Patients will be placed onto correct secondary prevention sooner, or a decision not to treat with medication made sooner, reducing unnecessary harm.
    - This will improve efficiency by reducing the 'treat until seen' approach currently adopted given the length of the referral to treatment times.
    - There will be expedited communication with primary care clinicians compared with the current outpatient model as an MSDEC attendance supports generation of a Discharge Advice Letter from an unscheduled care contact, more readily available to GPs for review.
- It is expected that moving to this clinical model for stroke will have positive impact on the current emergency and acute medical model at UHW. Suspected stroke cases make up approximately 15-20% of the demand for urgent medical assessment at UHW - doctors are often called away from other sick patients to attend to a stroke case due to the urgency required in stroke assessment.

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- This model will support more timely assessment of stroke, supporting flow across the acute and emergency medical footprint and also freeing the medical team to see other patients more efficiently and safely. Medical trainees will still have contact with stroke patients and training opportunities, but in a more supportive environment which will enhance their experience.
- 24/7 presence of the CNS team will support the patient pathway to thrombectomy, particularly with referral to Bristol out of hours.

6.4 CAVUHB People and Culture Plan

People feel valued, developed, supported and engaged: This investment will promote the development of our stroke workforce in line with this principle. UHW will become recognised as a centre of excellence for stroke, a place where people feel valued and supported to deliver best care. Training opportunities will be maximised and people will feel invested in, valued and supported, having a positive impact on staff health and wellbeing.

Attract and recruit people with the right skills, abilities, values and experiences to meet the health and social care needs of our population: Developing this new clinical model will attract new staff, promoting UHW as a stroke specialist centre and a specialist training offer. This will extend outside of the stroke service, supporting opportunities for those with an interest in stroke from across acute and emergency medicine and neurology as well as those in core medical training. There will be opportunities for leadership roles across all professional groups with advanced practice development, supporting all staff to work to the top of their licence.

Ensure our services are provided by the right team: a workforce that is affordable, sustainable and integrated to meet current and future service needs and reflects our population: The stroke service is acutely aware of the need to plan the growth, development and succession of its staff group. The individuals making up the current consultant body are all very experienced, senior consultants and collectively they will likely have all retired in the next 15 years. Stroke as a specialty attracts individuals from different clinical backgrounds and suits fitting into job plans as a special interest speciality. For example, stroke sessions could be contributed by those in Neurology consultant roles, or Emergency and Acute Medicine physicians with an interest in stroke. Moving to a new clinical model will offer more opportunity for these hybrid roles to develop and contribute stroke sessions. This offers flexibility, supports individuals to job plan around other commitments or around a retirement plan for example, supporting the Health Board as employers to implement the flexible working and flexible retirement policies and to build the right capacity in our future workforce.

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7. Benefits

Quantifiable benefits	*Non-quantifiable benefits*
Quality of care Compliance with stroke pathway standards as measured by SSNAP. Specifically: - Time to scan - Time to stroke unit admission - Time to specialist stroke consultant and nurse assessments Access to emergency treatments - Thrombolysis rates - Thrombectomy rates - Time to treatment - Time to TIA assessment from referral Patient Outcomes - 30-day mortality - Reduction in rates of stroke after TIA - level of dependency on discharge - length of hospital stay Cost releasing benefits - Reduction in bed days needed across the stroke pathway - potential for reduction in spend on long term rehabilitation and care needs beyond hospital - Reduction in unnecessary medication use in TIA pathway Staff recruitment, retention and wellbeing - Centre of Excellence status - Applications into stroke training programmes - Vacancy and sickness rates across professions - Reduction in agency staffing Patient Experience - Civica - Tendable - Compliments & Concerns - External audits / Health Inspectorate Wales	Quality of care Improved governance processes as Stroke will be delivered by a defined team Support to the thrombectomy referral and transfer process, particularly out of hours Reduction in referral to treatment times for TIA Patient Outcomes Compliance with stroke pathway standards is expected to deliver improvements in healthy life expectancy and contribute significantly to secondary prevention. Patient reported experience Staff recruitment, retention and wellbeing Staff reported experience Service reputation - Attraction as an employer - Reputaiton as a good medical training experience - Reputation as an exemplar stroke service to others in Wales

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7.1 Benefits tracker

Benefit	Metric	Baseline (December 2023)	Target	Timeline / Ambition
Improved patient experience	Stroke PREMs qualitative data	Limited baseline data – dataset on June 22 to June 23 cohort obtained by South Central Wales regional stroke programme team		By December 2025
Improved compliance with stroke pathway standards as measured by SSNAP	Median time to first scan (hours:minutes)	**0:53**	**0:45**	By March 2025
	Median time to stroke unit admission (hours:minutes)	**3:54**	**3:00**	By March 2025
	Median time to specialist stroke consultant assessment (hours:minutes)	**13:55**	**4:00**	By March 2025
	Median time to specialist stroke nurse assessment (hours:minutes)	**3:07**	**0:30**	By March 2025
Improved access to emergency treatments	Thrombolysis rates (% of stroke admissions)	**15.9%**	**20.0%**	By March 2025
	Thrombectomy rates (% of stroke admissions)	**4.8%**	**10%**	By December 2025
	Median door to needle time in thrombolysis	**1:19**	**0:45**	By March 2025

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	treatment (hours:minutes)			
	Referral to TIA appointment time	11 weeks	<48 hours	By December 2024
Patient Outcomes: population level	Crude Mortality	12% (SSNAP data 2019-2020)	10.5%	By December 2025
Patient Outcomes: service level	Median level of dependency on discharge from UHW for those with confirmed diagnosis of stroke (Modified Rankin score)	**3**	**2**	By December 2025
	Median length of hospital stay at UHW for those with confirmed diagnosis of stroke (days)	**3.52**	**3.0**	By December 2025
Staff recruitment, retention and wellbeing	Number of Stroke trainee posts (deanery training places) within the stroke service	**1.0 WTE**	**2.0 WTE**	By December 2025
	Vacancy and sickness rates	**Stroke CNS team sickness 8.84% in month (3.36% cumulative 2023)**	**5% in month (<3.36%cumulative 2024)**	By December 2025

The service will work in collaboration with finance colleagues to model the expected impact on acute bed occupancy as a result of meeting these stroke pathway standards. The median and mean will be used to predict the impact.

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Additonal Impact Tracker

Population / Service	Potential Impact	Monitoring Method
Patients having subsequent stroke after TIA	Expected to reduce, having significant impact on healthy life expectancy	Audit patient group referred after first TIA episode
Diagnostics	Number of stroke & TIA related scan episodes	Audit scan requests for stroke and TIA in outpatients, MSDEC and ED
Pharmacy	Increased dispensing demand on UHW Pharmacy from MSDEC	Monitor MSDEC pharmacy dispensing activity
Patient Experience	Expected improvement in the TIA, emergency stroke and acute pathways	There are limitations with current baseline data; 2023 PREMs survey was pathway wide and so does not provide a true baseline. The service will explore opportunities to learn more about patient experience in this model
Healthy life expectancy by 2035 The gap in life expectancy between the most and least deprived areas of the Health Board is 8 years for women and 9 for men, this has increased over the last decade. The healthy life expectancy gap is 18 years for women and 14 for men. Evidence suggests low socioeconomic status and ethnicity is associated with an increased risk and incidence of stroke and TIA. Improvement in the acute stroke pathway is therefore expected to contribute to the Health Board's objective of narrowing health inequalities.		
Financial model The service will work in collaboration with finance colleagues to review the costs of the acute pathway by using the PBR tariff as the benchmark. Using this model, we intend to forecast the cost implications of the change in pathway.		

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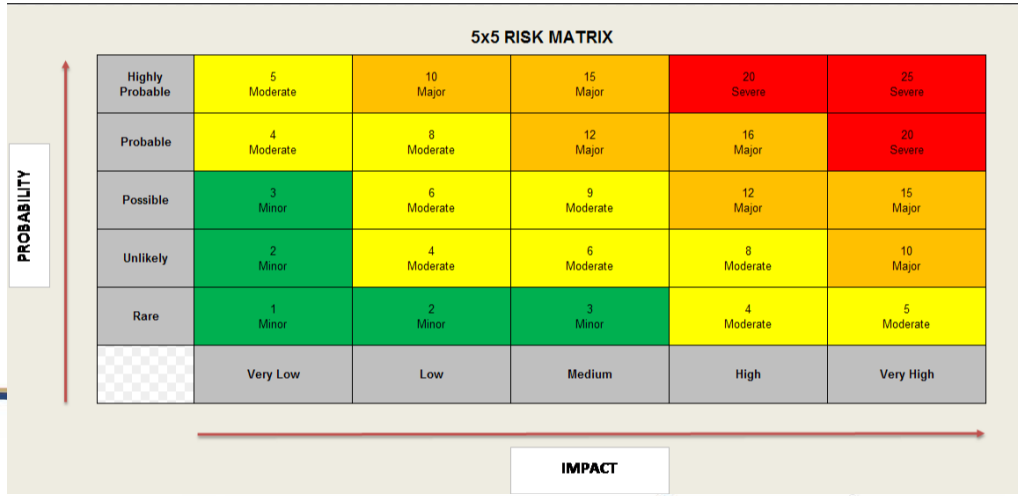
7.2 Risk

TH = Dr Tom Hughes, Clinical Director for Stroke. NT = Niki Turner, Stroke Service Manager

Risk Title	Descriptor	Probability (1-5)	Impact (1-5)	Total risk score (PxI)	Mitigating Action	Owner
Recruitment	There is a risk that additional posts will not be recruited to, or there will be a delay to recruitment	3	4	12	Phasing of clincal model can only progress in line with recruitment	TH
Demand	There is a risk that demand on the service will increase beyond that currently experineced and there will be unexpected impact on other services	2	4	8	Stroke service to monitor activity. Close working with Acute and Emergency Medicine colleagues	NT / TH
Thrombectomy Centre	UHW becoming the South Wales Stroke Thrombectomy Centre may place increased demand on and destabilise the acute stroke and TIA service in its newly established clincial model	3	4	12	Clearly agreed timescales and phasing of thrombectomy centre Clear pathways and referral processes for thrombectomy	TH
Neighbouring stroke services	Sustainability of currently fragile neighbouring stroke services may impact on UHW's demand	3	5	15	Clear regional partnership working and engagement in the regional stroke programme. Foresight on any likely demand changes	Regional Stroke Programme Board

Key: 5x5 risk matrix



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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)	654,236	1,385,852	1,385,852
TOTAL NON RECURRENT (not formula driven - complete)	0	0	0

Assumed start date	June 2024
Funding Source Revenue:	Health Board Core funds
Funding Source Capital:	

Annex a: Workforce implications

Revenue Direct Pay Staff Costs	**WTE**	**Band / Scale**	**Recurrent / Non-Recurrent**	**Cost year 1** *proportionate by recruitment	**Cost year 2**	**Cost year 3**
Consultant sessions 28 direct care clinical sessions split between:						
Associate Specialist *incl 52 week cover	1.24*	Top of scale	R	£104,733	£139,645	£139,645
Stroke Consultant *incl SPA time, 52 week cover, out of hours intensity banding	2.79*	Top of scale	R	£129,820	£432,733	£432,733
				£234,553	**£572,378**	**£572,378**
Middle grade Junior Doctors** Cost at middle scale	6.0	MN37	R	**£248,904**	**£497,825**	**£497,825**
Clinical Nurse Specialists	4.72	Top of scale band 6	R	**£130,215**	**£256,803**	**£256,803**
Admin & Clerical						
TIA clinic coordinator	1.0	Top of scale Band 3	R	£20,352	£30,529	£30,529
Support Secretary	0.6			£12,212	£18,318	£18,318
				£32,564	**£48,847**	**£48,847**
TOTAL PAY				**£646,236**	**£1,375,852**	**£1,375,852**

** middle grade costs may be reduced if these posts can be supported by training programmes / HEIW funded posts

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Annex b: Non-pay, support service, infrastructure

REVENUE	WTE	Band/ Scale	Recurrent/ Non Rec	Cost Year 1 Part Year	Cost Year 2	Cost Year 3
Direct Non Pay	**WTE**		**R / NR**	**£**	**£**	**£**
Non-pay additional set-up costs				8,000	10,000	10,000
Impact on Support Departments						
Infrastructure						

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TOTAL PAY				**£654,236**	**£1,375,852**	**£1,375,852**

Annex c: Capital requirements

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**
Space within MSDEC – no capital estates works needed but accommodation not yet allocated	**£**	**£**	**£**
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

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APPENDICES

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Appendix 1. Extract of Patient Story

Nia's words:

"It was a bad day the day my stroke happened, everybody did what they needed to do and went above and beyond. The staff in the hospital, the people on the ward, and everything. I was extremely lucky on that day.

I'm a teacher of 25 years. On the day it happened I felt fine. I was in my class teaching, all of a sudden, my head banged and I felt lightening in my head, like the sun was in my eyes. I kept dropping my pen. My colleague noticed something was wrong, I fell on the floor and the next thing I know people were all around me and talking to me but I couldn't speak to them at all. All I could say was "I'm fine".

An ambulance was called but we were told it would be 3-4 hours, so I got myself up on a chair, I then walked out of the school and into a staff members van which took me to the Heath Hospital. When I arrived at the hospital, my brothers were there and I didn't understand why. I remember going in for a scan and then in a side room, people were asking me questions but I don't remember anything. All of a sudden, they called my brothers in and I was taken into theatre as soon as possible for treatment. I kept saying I was fine. I remember waking up and knowing something was wrong but I couldn't explain what was happening.

I remember the nurses saying I was young for this to happen but I don't remember much more than that.

It's taken a while for it to sink in about having a stroke. I didn't really understand what was happening to me or what was going on. My brothers explained and the nursing staff had explained but I still didn't understand what had happened. I knew something had happened with my head but I didn't know what. I feel that everything is now more sensitive with my head, is it a headache? Is it something else? It'll be something that'll be there for the rest of my life. I feel that something is wrong with my body and I panic, I have that fear that I'll have a stroke again.

The Doctors don't know why the stroke happened, there seems to be no reason for it. I'll have to live the rest of my life without knowing.

I'm not the person that I was, I'm different now. I don't know what the future is or what it holds. I hope that I'll be able to get back to driving, I'd like to get back to working in some capacity. I just want to be happy and realise who I am now. What I was before isn't there now.

Without the team I wouldn't be here. If it hadn't been for the treatment, support of family, friends, and therapists I wouldn't be where I am today.

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Several months after her stroke, Nia returned to meet the Interventional Neuroradiology team and the stroke team who looked after her at UHW.

A full digital patient story about Nia's experience is still in production with colleagues from the Patient Experience team.

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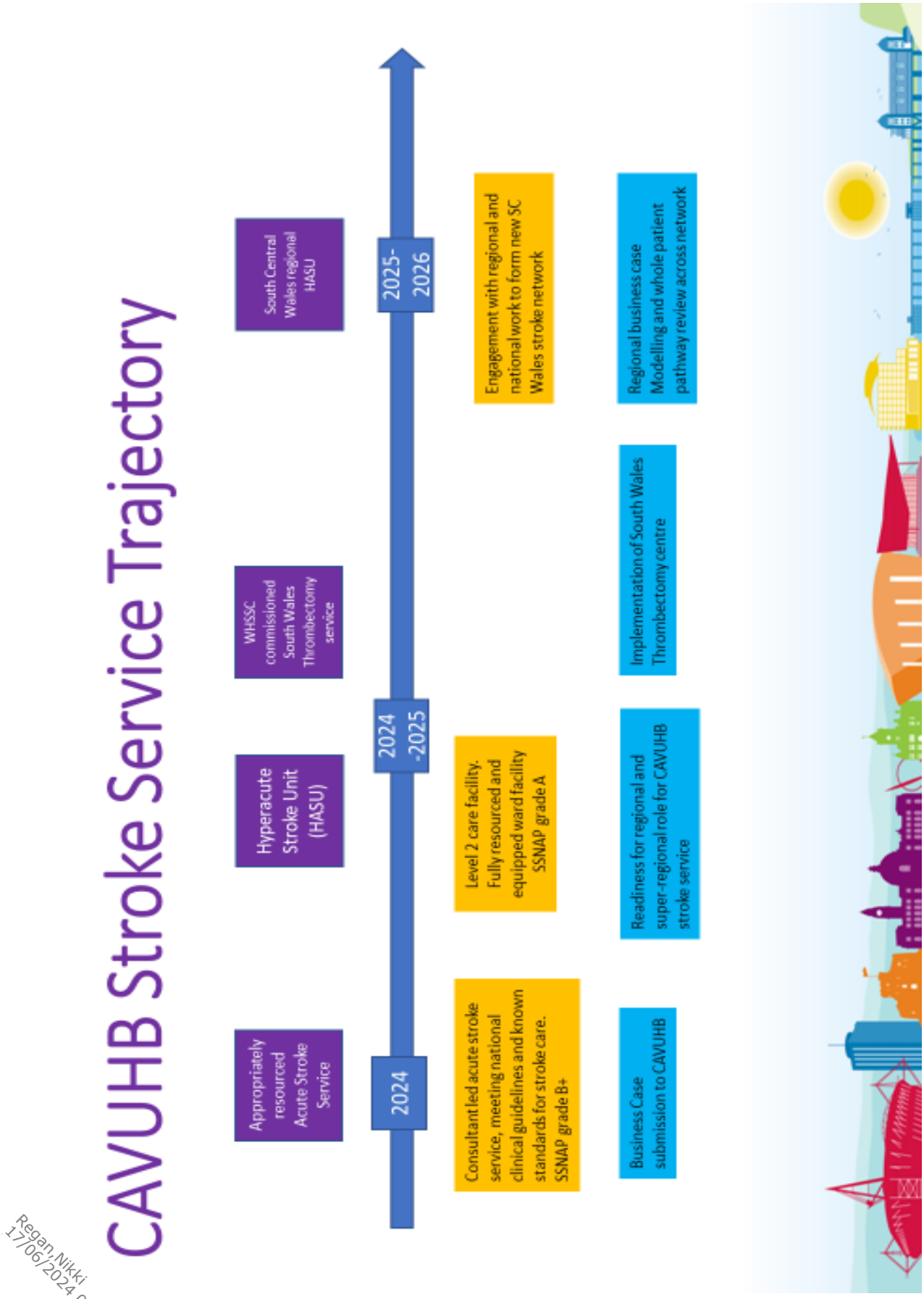
Appendix 2. Timeline of CAVUHB Stroke Service Developments



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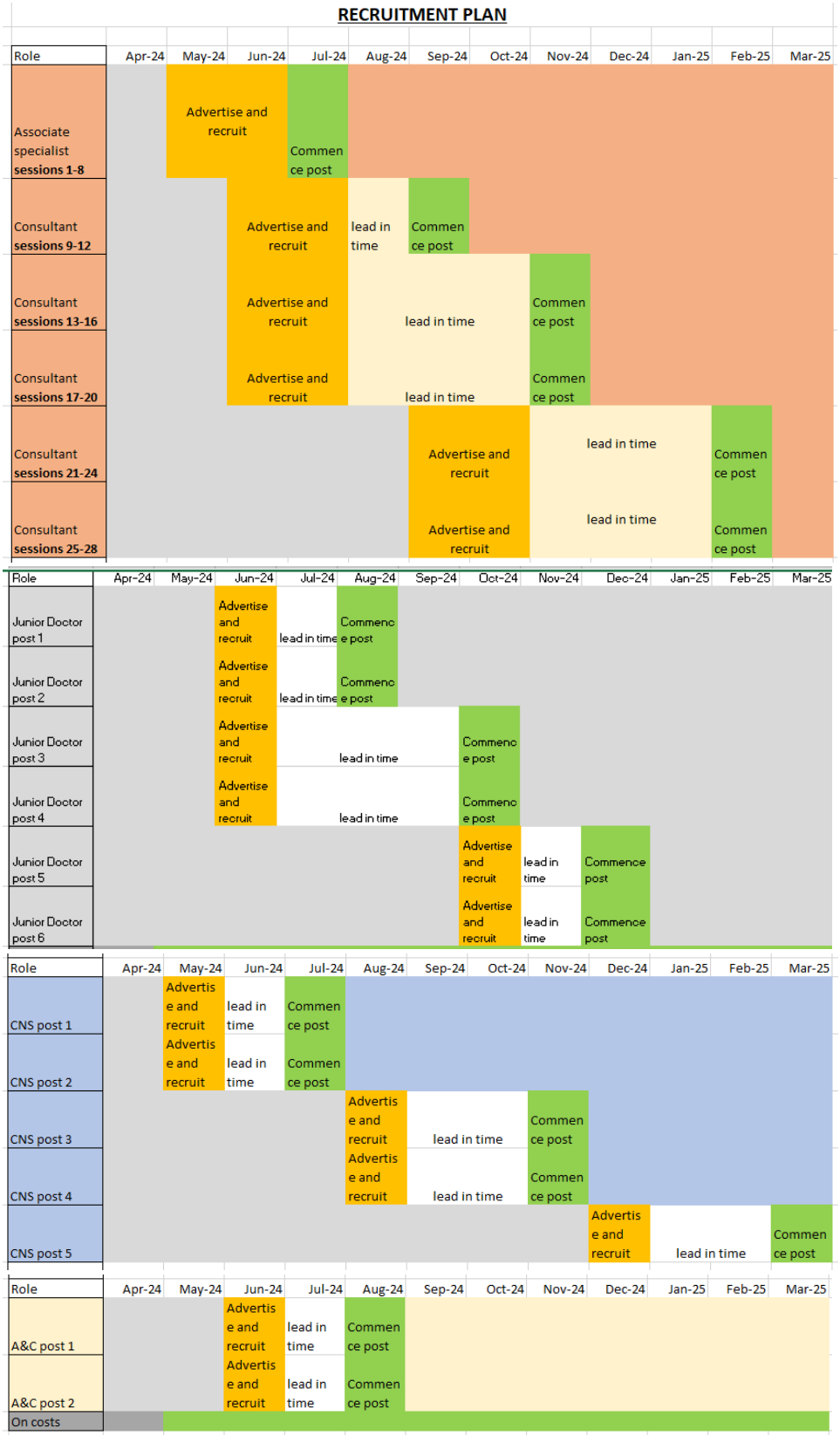
Appendix 3. Proposed Option – Year 1 Implementation Plan & Cost Projection

*updated for May 2024 IG



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MODEL IMPLEMENTATION PLAN

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Consultant sessions on ward	10	10	10	10	10	12	12	14	14	14	14	14
Consultant sessions in new MSDEC model	4	4	4	12	12	16	16	24	24	24	32	32
Phasing in of model				weekday MSDEC 9-5				weekend full day cover		Extend into evening		Consultant to 10pm 7/7
								CNS 6am to 10pm				24/7 CNS
							Middle grade 9am to 5pm 5 days			Middle grade 9am to 5pm 7 days		Middle grade 6am to 10pm 7 days

COST PROJECTION YEAR 1
Stroke Business Case Implementation

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total spend on staff group in year 1
Medical staff - senior	0	0	0	11637.08333	11637.08333	18849.28	18849.28	26061.48	26061.48	26061.48	47698.08333	47698.08	234553.33
Medical staff - junior	0	0	0	0	13828	13828	27656	27656	41484	41484	41484	41484	248904
Nursing staff	0	0	0	9067.9	9067.9	9067.9	9067.9	18135.8	18135.8	18135.8	18135.8	21400.24	130215.04
A&C staff	0	0	0	0	4070.58	4070.58	4070.58	4070.58	4070.58	4070.58	4070.58	4070.58	32564.64
non pay costs	0	0	0	1000	0	1000	0	2000	0	2000	0	2000	8000
Cost for month (£)	0	0	0	21704.98333	38603.56333	46815.76	59643.76	77923.86	89751.86	91751.86	111388.4633	116652.9	654237.01
											Cost for year 1 (£)	654,237.01	

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Report Title:	CAV Health Inclusion Business Case			Agenda Item no.	3.2
Meeting:	F&P	Public	X	Meeting Date:	19th June 2024
		Private			
Status *(please tick one only):*	Assurance		Approval	x	Information
Lead Executive Title:	Paul Bostock, Chief Operating Officer				
Report Author (Title):	Adam Wright, Director of Operational Planning and Performance				

Main Report
Background and current situation:

Inclusion health is a research, service, and policy agenda that aims to readdress extreme health and social inequities among the most vulnerable and marginalised in a community. The concept of inclusion health typically encompasses people experiencing homelessness, vulnerable migrants, sex workers, Gypsies and Travellers and those in contact with the criminal justice service. These marginalised populations share common overlapping risk factors for poor health that include poverty, adverse life experiences, discrimination, violence, and complex trauma. These risk factors, accompanied with multiple barriers and negative experiences when attempting to access health and care services, result in significantly poorer health outcomes, putting those affected beyond the extreme end of the gradient of health inequalities.

Within Cardiff and Vale, we have the Cardiff and Vale Health Inclusion Service, CAVHIS, which is a directorate within the PCIC Clinical Board. The importance of the Health Inclusion agenda has been confirmed in recent years at the UHB Board and it was highlighted as one of the organisations key priorities for 2024/25 through our annual planning process. This is not least because the gap in life expectancy between those living in the least and most deprived areas in Wales is increasing. In Cardiff and Vale, healthy life expectancy for males living in the most deprived areas (Adamsdown) is 55 years, compared with 74 years in the least deprived (Lisvane); for females, these figures are 58 and 75 years respectively.

Health inclusion groups have long experienced markedly worse health outcomes than the general population. What defines and unites inclusion health groups are common experiences of sustained social and economic marginalisation. Poorer health outcomes for these populations are the result of several inter-related factors across the life course, including wider determinants of health, such as income insecurity, unemployment, lack of community support, and poor living conditions.

Under the sponsorship of the Chief Operating Officer, Multi-agency Health Inclusion Programme Board and support from Senior Partnership Boards (including Public Services Board and the Regional Partnership Board) the business case outlines the proposed expansion of the Cardiff and Vale Health Inclusion Service (CAVHIS) to deliver a **Tier 3 Health Inclusion Service**: a coordinated, integrated, responsive health and social care service model for those individuals who are at the 'cliff edge' of inequality. A Tier 3 Health Inclusion Service is a no wrong door service which is fully aligned and integrated with partnership services

The case is requesting £1.4m full year effect. The pay costs are a range of multidisciplinary staff and administrators. The table on page 30 highlights the current staff in post and the planned staff in post, it is essentially an additional 20WTE at a cost of £1.1m per annum. The non-pay costs are a combination of consumables, security, charitable support and travel. A number of the pays and costs including in the case have previously been funded on a non-recurrent basis and this case seeks to make those investment substantively in addition to an expansion of the service.

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The case sets out the known demand on the service and is also clear that there is likely to be a significant level of hidden demands which the service will seek to meet. Delivering the service as described would make Cardiff and Vale the leading organisation within the UK for this innovative approach to Health Inclusion. The £1.4m will ensure there 1st tier of the programme can be achieved - Universal Primary Care for these marginalised group. Future expansion of the service, in line with the vision set out, will lead to the provision of a multi-disciplinary, multi-agency comprehensive, 'no wrong door' service, which is targeted at individuals at the cliff edge of inequality and whose needs are so complex.

Benefits of delivering this model include:

- Improved patient access to health care
- Increased uptake on screening programmes and appropriate aftercare for positive cases.
- In conjunction with partner organisations, contribute to reducing the gap in life expectancy and health life expectancy in Cardiff and the Vale
- Reduction in preventable EU attendances and reattendances
- Reduction in the unplanned admissions and readmissions and total bed days
- Motivated and Sustainable workforce that have access to training and development.

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

- Health inclusion groups have long experienced markedly worse health outcomes than the general population
- This business case is described as the first phase of delivering a Tier 3 Health Inclusion Service
- Health Inclusion has been confirmed as one of the organisations key priorities for 2024/25 through our annual planning process
- Investment Group and SLB have supported the investment on the proviso that costs are largely only incurred from Q4 in 2024/25

Recommendation:

The Committee is requested to:

a) Approve the business case for the expansion of the Cardiff and Vale Health Inclusion Case

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	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing	X	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	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	X	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	X	Long term	X	Integration	X	Collaboration	X	Involvement	X

Impact Assessment:
Please state yes or no for each category. ***If yes please provide further details. This section must be completed***

Risk: No

Safety: No

Financial: Yes

Phase the spend from Q4 24/25

Workforce: Yes

Workforce planning underway in PCIC

Legal: No

Reputational: No

Socio Economic: Yes

The case is uniquely aimed at those who suffer socio-economic disadvantage

Equality and Health: Yes/No

Equality Health Impact Assessments (EHIA) are typically undertaking when developing or reviewing Health Board strategies, policies, plans, procedures or services. Do the proposals contained within the report necessitate the requirement for an EHIA to be undertaken? If so, please include the detail of any EHIA undertaken or the plans are in place to do so.
Useful guidance on the completion of an EHIA can be found at the following link: EHIA toolkit - Cardiff and Vale University Health Board (nhs.wales)
(If this has been addressed in the main body of the report, please confirm)

Decarbonisation: 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	*Cardiff and Vale Health Inclusion Service Expansion: Phase 1*
Clinical /Service Board or Department	*Primary, Community and Intermediate Care Board*

Expected funding source (highlight/delete as appropriate)	Primary source of funding- UHB, with potential for joint funding from Cardiff Council where identified

Approval and scrutiny route	
Has this case been signed off by the Clinical Board / Corporate Departments senior team?	Yes-Rachel Lee/Clare Evans
Has this case been signed off by the Clinical Board / Corporate Departments finance and workforce business partners?	Chris Markall/Nicola Robinson
Clinical Boards: Has the COOs office signed off this document? **Corporate Departments:** Has the relevant Executive sponsor signed off this document?	Executive sponsor- Paul Bostock

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1. Executive Summary

Inclusion health is a research, service, and policy agenda that aims to readdress extreme health and social inequities among the most vulnerable and marginalised in a community. The concept of inclusion health typically encompasses people experiencing homelessness, vulnerable migrants, sex workers, Gypsies and Travellers and those in contact with the criminal justice service. These marginalised populations share common overlapping risk factors for poor health that include poverty, adverse life experiences, discrimination, violence, and complex trauma. These risk factors, accompanied with multiple barriers and negative experiences when attempting to access health and care services, result in significantly poorer health outcomes, putting those affected beyond the extreme end of the gradient of health inequalities.

The impact of this extreme structural exclusion impacts on the ways in which health inclusion groups try to access care, often presenting reactively to urgent and emergency care services with complex presentations involving multiple, chronic conditions that are poorly controlled. This creates significant costs for public services, in addition to the human costs for individuals and their families. Yet inequitable access to healthcare and poor health outcomes are not inevitable or unalterable and can be prevented, or mitigated, by health and social care services working in partnership to provide tailored care that addresses the patient's total health, care, and social needs. Health, and its partners, have both a fundamental role and moral obligation to develop and invest in inclusion health interventions.

Under the sponsorship of the Chief Operating Officer, Multi-agency Health Inclusion Programme Board and support from Senior Partnership Boards (including Public Services Board and the Regional Partnership Board) this business case outlines the proposed expansion of the Cardiff and Vale Health Inclusion Service (CAVHIS) to deliver a **Tier 3 Health Inclusion Service**: a coordinated, integrated, responsive health and social care service model for those individuals who are at the 'cliff edge' of inequality. The proposed model will provide these individuals with timely accessible, proportionate, and personalised primary care treatment, thus reducing the risk of deterioration to a point where acute hospital assessment and/or admission is required.

To meet the full Tier 3 Health Inclusion Service aspiration, the phased development of a hub and spoke service model is proposed:

- **Phase 1** (24/25): Resourcing required to make permanent and expand the 'spoke elements' of the model (In-Reach and Outreach services), which can be delivered within existing accommodation/use of council facilities.
- **Phase 2** (25/26): Resourcing required to deliver a further step change and extension to the model by creating a centralised 'service hub' in a new facility, which will deliver both enhanced and extended hours of service, through colocation and integration with wider UHB, council and third sector services.
- **Phase 3** (26/27): Commissioning of intermediate care beds-which potentially could be included as part 2 if suitable accommodation could be identified or alternatively, in a council provided residential facility.

In line with the above plan, this business case is seeking funding for phase 1 in 2024/25 and a commitment to prioritise funding to complete service expansion through 2025-2027 (additional business case will be submitted).

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NB: This business case excludes any costs related to current or future Asylum Seeker and Refugee Resettlement Programmes which are coordinated via the Home Office/Welsh Government.

The proposal offers the opportunity to progress towards an integrated health, housing and social care model that could drive substantial and relatively rapid health gains for these groups as well as bringing significant 'offsets' for health and social care services by supporting the Health Board's ambitions to improve access to primary care, reduce pressure on urgent and emergency care and reduce health inequalities.

From benchmarking both within the UK and on an international level, the proposed model offers Cardiff and the Vale and involved Partner Organisations the opportunity of a 'flag ship' service by which to demonstrate its commitment to addressing health inequalities.

Phase 1 Funding Requirements:

Annual Revenue Requirement	**Current Year (£) 24/25**	**Recurrent (£)**
	£846,543*	£1,426,777
Capital Requirement (£)	£50,000	

** Current year net revenue requirement includes Winter funding assumptions of £100k in line with the financial plan. The PYE reflects recruitment plans and an associated financial profile.*

2. Introduction and Background

Addressing health inequalities is a key priority for Cardiff and Vale UHB and partner organisations. Health inclusion groups are amongst the most vulnerable of individuals within our community and it is these individuals who often experience the poorest of health and higher levels of mortality. These groups include Asylum Seekers and Refugees, the homeless, sex workers, prison levers and Gypsy Roma Travellers (GRT).

People in health inclusion groups struggle to utilise traditional models of primary care, which are not easily accessible to them or appropriately commissioned to deal with their complex needs. This results in individuals developing significant levels of chronic and acute illness, often at a young age, with an increased risk of major health decline.

Health inclusion groups often present to the Emergency Department for conditions which should/could be managed in a community setting. On assessment, these individuals often prove complex to manage due to the multi-faceted aspects of their needs and are often discharged back into the community without robust arrangements for appropriate follow up and onward management. The potential for hospital reattendance following initial assessment/treatment is therefore high. If admission is required, the process by which to facilitate discharge can again be complex and result in extended lengths of hospital stay.

There is however significant potential by which to improve the care provided to health inclusion groups and address the issues identified through **the expansion of the UHB's Cardiff and Vale Health Inclusion Service to deliver a Tier 3 Health Inclusion Service** for those individuals with the highest level of needs, whose lifestyle choices and challenges mean that they cannot/will not engage with traditional healthcare services.

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Originally, commissioned to provide initial assessment and public health screening for asylum seekers and refugees only, CAVHIS has been gradually working to widen its remit and to trial (through opportunities for temporary funding) new models of care by which to better support the needs of wider health inclusion groups. A significant amount of this work has involved

integrated working with Cardiff Council and local third sector organisations, who are also committed to tackling inequalities in health.

Having provided the UHB Executive Board with evidence as to the level of need within Cardiff and Vale in 2022, a multi-agency Health Inclusion Programme Board was established in January 2023, chaired by the UHBs Chief Operating Officer. Over the past year and based on the benefits identified through a range of short-term initiatives, this Board has been encouraging the service to develop a proposed model of care for health inclusion which spans primary, community and secondary care. Hence the development of this business case.

The proposed model of care has also gained full support from a series of strategic planning Boards including:

- Public Service Board
- Homeless and Vulnerable Person Board
- Regional Partnership Board
- UHB Executive Board

Having defined the service model and identified the expansion of CAVHIS as a priority within its IMTP, the Primary, Community and Intermediate Care Board is submitting this business case to secure investment to:

a) make permanent aspects of service which have been operating on a temporary basis over the past 2 years and

b) to further expand the 'spoke elements' of model, as a first step toward the development of a comprehensive specialist service for health inclusion groups with the greatest need in Cardiff and the Vale of Glamorgan.

3. Strategic Context – Alignment to UHB strategic direction

Reducing and addressing health inequalities is the subject of a range of legislation and policy objectives, at both a national and regional level and is key priority for the Regional Partnership Board in Cardiff and the Vale of Glamorgan.

The proposed expansion of the existing CAVHIS model aligns with the principles of Shaping our Future Wellbeing, A Healthier Wales, Value in Health, Welsh Health Circular and supports both the Six Goals for Urgent and Emergency care and @Home programme. It also supports the four strategic objectives of the UHB (see Table 1).

Investment in health inclusion is also an important element of both value- based care and proportionate universalism. Both concepts are envisioned as key elements of future health and care strategy in Wales. This model also aligns with a wide range of partner strategic goals– 'everything is connected to everything else' (see Appendix 1).

Table 1: Business Case Alignment with UHB Four Strategic Objectives

Objectives	How does this proposal support any of these objectives
Putting People First	• The model has been developed in conjunction with people with lived experience, providing the direct opportunity for them to inform and shape its development. • The model recognises the fact that for some individuals access and use of traditional health care services is extremely difficult. The model is predicated on a 'team around the individual' approach, delivering holistic, person-centred care at 'touch points of opportunity' – recognising the uniqueness of lifestyle, challenges, and routines amongst health inclusion groups.

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	• The model takes a trauma informed, strengths- based approach, with skilled practitioners working with individuals to enable them to lead healthier lives, through the provision of timely, accessible, and well-coordinate care with the long-term vision of an integrated health, council and third sector service model. • The model has public health protection at its core. • The model is reflective of the unique population needs within Cardiff as a Capital City. • For staff, this model offers the opportunity to develop skills in a new and unique field of healthcare and as a service model, this development offers practitioners from a range of partner organisations to work collaboratively on delivery of a shared vision. • The model recognises the importance of engagement with third sector as well as statutory services and investment in new roles.
Providing Outstanding Quality	• Data and research demonstrate that health inclusion populations engage in unhealthy behaviours, present in crisis, have extremely poor health outcomes, and struggle to access health care because of barriers created by service design. • The expansion of CAVHIS aims to improve the quality of care for individuals with multiple, complex needs and who find access to and use of traditional health services difficult. • This model has been informed through benchmarking at national, UK and international level, a local Health Needs Assessment and by NICE guidelines. • The model is predicated on prevention, early intervention and easy access to health, council and third sector services- through a 'one stop shop/no wrong door' approach. • There is limited baseline data collected within the UHB as to outcomes for health inclusion groups. However, over the past 2 years, CAVHIS has been proactively seeking and developing ways in which to prove and support a case for change and provide a baseline or monitoring outcomes going forward. • The service has used quality improvement methodology to trial and evaluate different aspects of the proposed service model- all of which have demonstrated improved outcomes for individuals and positive impacts for the UHB and Council. • The Project Team leading the development includes representatives of the UHBs Change Hub and Value in Health Team. • Pathways (the UK's leading homeless healthcare charity) has been commissioned to support the development of the homelessness in-reach pathway and ensure best practice. • The model has been developed in conjunction with Cardiff Council and affiliated third sector organisations, to ensure maximum opportunities for integration, alignment, and service efficiencies. • The model contributes to the UHB's approach to continuous quality to improvement by taking a strategic systems approach to understand how to best utilise resources, reduce waste, and work with partners to implement a model that reduces pressure on the current system, save lives and importantly improve health life expectancy.
Delivering In the Right Places	• The model aligns fully with the UHBs Shaping Our Future Wellbeing in the Community Strategy and Six Goals Programme, in that the model seeks to provide more care closer to where individuals from health inclusion groups live/frequent. • Through the delivery of both outreach and in-reach services, CAVHIS aims to take essential services 'to the individual' rather than rely on them to attend a service /stay for a protracted period awaiting treatment, which is often an unreliable expectation amongst health inclusion groups. • This model is aimed at diverting individuals away from hospital services, where clinically appropriate and/or support timely turnaround/discharge through

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	provision of alternative coordinated MDT care at a community level over 7 days.
Acting for the Future	• As the first development of its kind in Wales, the proposed expansion of CAVHIS represents a flag ship opportunity for the UHB. • The model has already sparked the interest of the Bevan Commission and Cardiff University, resulting in the opportunity for engagement in national and international research projects along with investment opportunities. • The model supports the Health Board's contribution to the foundational economy by improving access to services, placing services together, creating opportunities for employment and reducing health inequalities.

4. Summary of Current Service Provision

4.1 The Core Service

CAVHIS is situated in CRI, operating between the hours of 0830-1700hrs (Monday-Friday, excluding bank holidays). It is accommodated in a shared space which is used by CAV247 overnight. There are also several other services/clinics which share the space throughout the week.

The original CAVHIS Model (previously known a Cardiff Health Access Practice) was only commissioned to provide:

- Public Health Screening for Asylum Seekers and Refuges arriving via the Home Office/Ready Homes pathway, including GP registration and access to medical, Health Visiting and Midwifery care for up to 3-4months and whilst individuals are supported in transitioning into traditional primary care services.
- A limited level of specialist nursing to work with the homeless in and around Cardiff Councils' Housing Options Centre (now working from the Huggard Centre)
- An Alternative Treatment Service (Thursdays only, 1600-1830hrs) for individuals who have been de-registered from GP Practices due to risk of verbal and/or physical abuse but still require access to general medical services.

The care pathway for Asylum Seekers is as follows:

- CAVHIS is notified by the Home Office/Council Accommodation Provider of any new Asylum Seekers arrivals to Cardiff.
- CAVHIS then offers appointments to all new arrivals for public health screening in line with agreed clinical standards.
- Patients are then registered on a temporary basis for GP care in CAVHIS whilst the awaiting the outcome of health screening and until they are transitioned into core primary care (takes 3-4 months).
- Where clinically required, patients are referred onto specialist infectious disease services e.g., TB and/or mental health services.
- Whilst under temporary registration in CAVHIS, patients also have access to a midwife and health visitor.

The care pathway for the homeless is as follows:

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- The Homeless Specialist Nurses are based in the Huggard Centre and provide daily drop in clinics for individuals located in and around the Centre.
- The majority of their work is undertaken onsite, but they are have the capability to follow individuals into the community

- The service operates 8.30-4.30pm/Monday to Friday

The care pathway for ATS patients is dictated by the All Wales Alternative Treatment Service protocol:

- All patients either immediately or given 7 days' notice of de-registration are referred to the ATS provided by CAVHIS.
- These individuals are required to remain in the service for a minimum of 12 months.
- Following this time, a decision will be made as to whether their behaviour can be managed within core primary care or not and they will either be released to register with a GMS practice or retained within the scheme.

4.2 Service Evolution

Over the past 2 years, in response to identified needs, CAVHIS has sought to extend its remit within the field of health inclusion. Through a range of opportunities for closer working with Cardiff Council, successful grant applications and UHB Winter Funding bids, the service has had the opportunity to:

- Amalgamate with homeless nursing services to strengthen both governance arrangements and improve service efficiency.
- Provide more direct health input into the Councils Single Assessment Centre Homelessness MDT through secondment of a specialist Homeless Nurse
- Introduce and trial the benefits of GP Outreach Clinics within some of the Council's High Needs Homeless Hostels.
- Work with the third sector to better support the needs of asylum seekers who require specialist support to transition from CAVHIS into traditional primary care.
- Introduce and trial the benefit of have specialist Health Inclusion Nurses based in the Emergency Unit to support the management and timely turnaround of individuals who do not require admission.

As requested by the Health Inclusion Programme Board, all of these initiatives remain in operation, however, permanent funding is required to secure their future.

4.3 Additional Service Demands

a) Resettlement Programmes: Over the past 3 years, CAVHIS has also been required to respond, at very short notice, to several resettlement programmes associated with wars in both Afghanistan and the Ukraine. The latest of these programmes is the Afghan Relocation Assistance Programme based in St Athan, which is necessitating the delivery of a further CAVHIS outreach service into the Vale. This business case *does not* include and resources/costs relating to current or future resettlement programmes.

b) Serving Needs within the Vale of Glamorgan

To date, CAVHIS has focused its activity on meeting the needs in Cardiff as this is where most of its patients reside. However, there are growing numbers of Asylum Seekers now being accommodated in the Vale of Glamorgan and GP Practices are raising concerns in terms of their ability to meet the needs of this patient cohort. CAVHIS is therefore being requested to consider options by which to serve the Vale as well as Cardiff.

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4.4 Baseline Staffing Establishment and Budget

A range of practitioners are employed within the current service including salaried GPs, Adult and Paediatric trained registered nurses, a Health Visitor and Midwife, managerial and administration staff and third sector workers. Full details of whole time equivalents and budget are provided overleaf.

Table 2: Baseline Staff Establishment and Budget

	WTE Budget	Budget
STAFF		
Admin B2	2.22	£162,042.00
Admin B3	1.00	
Admin B4	1.00	
Admin B5	1.00	
GP Clinical	1.26	£204,830.00
GP Strategic	0.20	
Nurse B8a	1.00	£418,214.00
Nurse B7	2.36	
Nurse B6	4.40	
HCSW B3	0.84	£23,115.00
Project Manager/Pathway Partnership		£54,404.00
STAFF TOTAL	**15.28**	**£862,605.00**
NON STAFF		
Clinical Service and Supplies		£49,200
General Supplies and Services		£3,891
Establishment Expenses		£7,727
Premises and Fixed Plant		£2,221
Miscellaneous (e.g., Translation)		£66,808
SLA Velindre		£102
Third Sector Support		£26,292
NON STAFF TOTAL		**£156,241**
INCOME		-£1,000
Total		**£1,017,846.00**

5. Case of change - *The evidence*

5.1 The Overall Picture- Research and Evidence

The gap in life expectancy between those living in the least and most deprived areas in Wales is increasing. In Cardiff and Vale, healthy life expectancy for males living in the most deprived areas (Adamsdown) is 55 years, compared with 74 years in the least deprived (Lisvane); for females, these figures are 58 and 75 years respectively.

Whilst a consistent association has been found between ill health and increasing levels of social deprivation, such analyses do not adequality assess the extent of health inequity faced by individuals who experience considerable social exclusion. Chart 1 shows the SMR disparity between different neighbourhoods and excluded groups.

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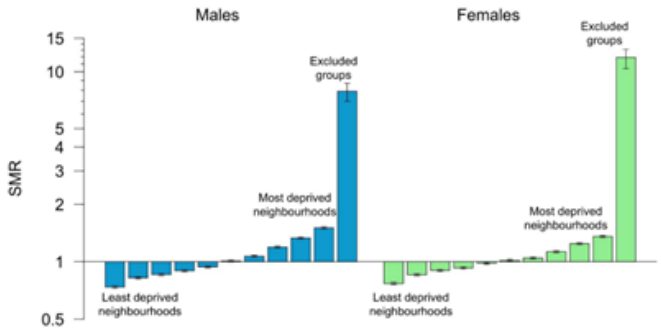
Chart 1: Standardised Mortality Rates by Deprivation and Exclusion

Standardised mortality ratios by deprivation and exclusion

Standardised mortality ratio (SMR) for the general population in England, 2015, by neighbourhood deprivation, compared to SMR for excluded groups, with 95% confidence intervals.



Notes

1. SMRs for the general population are calculated using ONS mid-year population estimates by IMD decile for 2015 and ONS number of deaths in 2015 by IMD decile. Standardisation is conducted using 5-year age groups. The reference population is the whole population of England in 2015.
2. SMRs for excluded groups are taken from *Aldridge RW, Story A, Hwang SW, et al. Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis. Lancet 2017; 6736: 1–10.* Note that these estimates are made from studies from a number of high-income countries, while the SMRs for the general population are for England only. Also note that the studies that contribute to the SMR estimate for excluded groups use a range of comparison groups.

The graph demonstrates that whilst health outcomes across the general population are distributed across a social gradient, excluded groups instead experience a **'cliff-edge'** effect. The excess mortality rates shown is extreme, displaying that health inequity seen within health inclusion groups greatly exceed populations in the least and most deprived areas.

Health inclusion groups have long experienced markedly worse health outcomes than the general population. What defines and unites inclusion health groups are common experiences of sustained social and economic marginalisation. Poorer health outcomes for these populations are the result of several inter-related factors across the life course, including wider determinants of health, such as income insecurity, unemployment, lack of community support, and poor living conditions.

There are varying levels of data available for each inclusion health group, with large research gaps due to issues with accessibility. However, the available evidence of poor health outcomes is compelling:

- Average age of death for homeless men is 45 and 43 for women (ONS, 2021).
- In 2021, across England and Wales, there were an estimated 741 deaths of people experiencing homelessness, an increase of 7.7% since 2020. The estimated number of deaths among homeless people has increased by 54% since records began in 2013 (ONS, 2021).
- Annual number of people dying whilst under probation services in Wales increased exponentially by 194% between 2018/19 and 2020/21 (PHW 2023). Accidental drug deaths were the leading cause of death.
- Gypsy, Roma and Traveller (GRT) people face life expectancies between 10 and 25 years shorter than the general population. Whilst the health of GRT person in their 60s is comparable to an average White British person in their 80s (Watkinson et al., 2021).
- An international systematic review found that among adult asylum seekers and refugees, the prevalence of PTSD was 31.46% and depression was 31.5%, compared to the general population which is 3.9% for PTSD and 12% for depression.
- Sex workers are at disproportionate risk of poor physical and mental health outcomes, with one study reporting that 68% of street based sex workers interviewed met the criteria for post-traumatic stress disorder – this is in the same range as victims of torture and combat veterans undergoing treatment (Litchfield et al., 2010).

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A particular concern of the health inclusion agenda is healthcare access and quality. Health inclusion populations typically experience care characterised by crisis management at multiple

disconnected points of episodic intervention. Difficulties accessing appropriate primary care results in heavy use of EU and acute secondary care. The high rate of EU attendance for people experiencing homelessness is well documented. Whilst reported attendance rates vary (Bowen et al., (2019) report as high as 60 times that of the general population) all studies agree a disproportionate and avoidable use of emergency services. Accessing care through this means is also a common theme for other identified health inclusion groups (e.g., sex workers attend 2.5 times the rate of the general population (Jeal and Sailsbury 2004)). These populations are also characterised by poor health expectations and low uptake of primary and preventive services, such as routine general practice, routine dental practice, screening programmes, and immunisations.

It is evident that health inclusion groups current health care provision is not cost-effective or prudent, leading to increased pressure on unscheduled care, increased length of hospital stays and failed discharges, all of which contributes to the widening of health inequalities across the city. The cost and consequences of these crisis presentations are striking. Public Health Wales estimated that, over a 6-month period, EU use by people experiencing homelessness in Wales cost £11 million more in healthcare costs than a general comparator group (PHW, 2021).

To address health inequalities and poorer health outcomes, inclusion health approaches are increasingly being used in higher income countries.

5.2 Understanding the Local Need

a) Demand

The level of baseline data in respect of health inclusion groups is very limited because these patients do not engage well with existing services and when they do, they are not coded correctly within Patient Administration Systems at either GP or hospital level. Therefore, it is difficult to accurately describe or predict the level of demand that exists within health inclusion groups.

However, to better understand the local picture, a series of data review exercises have been undertaken to indicate level of need/demands amongst the 5 health inclusion groups specific to this business case (please see Appendix 2 for additional data):

Review 1:

- UHB Business Intelligence System (BIS) reviewed 349 homeless patients' EU and secondary activity between 2018-2023.
- 85% had attended EU and were at least 8 times more likely to attend than a general comparator group.
- Over the 5-year period, 19.5% of patients did not wait in EU.
- In 22/23, the cohort made 741 visits to the EU and had 152 inpatient admissions totaling 1965 bed days.
- 22/23 costs: Accident and Emergency £200,178, admitted patient care £1,366,146, outpatient £66,633.

Table 3: NHS Activity for 349 Patients experiencing homelessness.

	EU	Outpatient			Admissions			Community		
	EU Visits	Attended	DNA	DNA Rate	Inpatient	Daycase	Bed Days	Attended	DNA	DNA rate
2018/2019	487	278	242	47%	128	7	748	738	156	17%
2019/2020	567	309	204	40%	123	13	935	612	169	22%
2020/2021	622	414	259	38%	140	9	1437	592	200	25%
2021/2022	627	511	311	38%	139	8	2799	748	199	21%
2022/2023	741	406	294	42%	140	12	1965	924	194	17%

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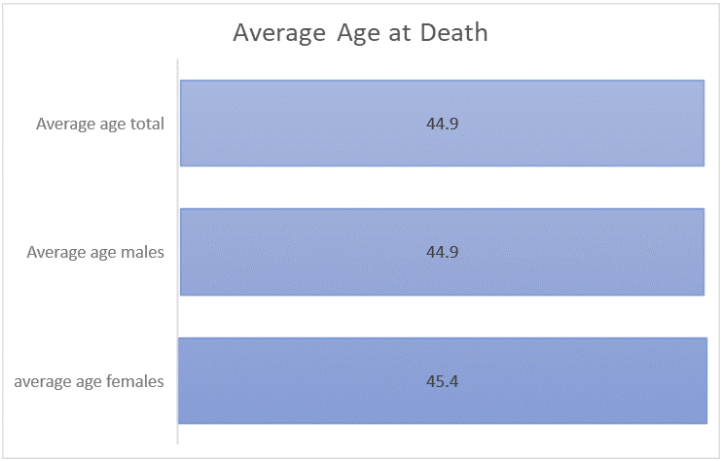
Review 2:

- In-depth review to understand public service costs associated with 25 people experiencing homelessness.
- 92% had one or more reported mental health condition, 100% were engaging in substance use, 72% had physical/chronic illness and 84% had been arrested at least once.
- Costs for temporary accommodation, emergency and secondary care activity, substance misuse support, benefits, mental health support and engagement with the criminal justice system were estimated at approximately £2,446,167 over a two-year period (March 2022-2024). It was estimated that £593,638 of this total was spent on emergency and secondary care.

Review 3:

- A review of Cardiff Council's Single Person Gateway (SPG) and Young Person Gateway (YPG) revealed that between January 2020 and March 2024 there was a total of 84 individuals closed to the SPG and YPG with the end reason 'deceased'.
- The **average age of death was 45.**

Chart 2: Average Age of Death



Review 4:

- UHB BIS reviewed 2,221 asylum seekers and 1,234 refugees (Ukrainian and Afghanistan) NHS activity between 2022-2023.
- Transient nature makes it difficult to paint an accurate picture. However, asylum seekers were, at least, 2 times more likely than a general comparator group to attend EU. Refugee EU attendance mirrored the general population.
- Community activity was exclusively mental health, with virtually all this activity linked to asylum seekers.
- 22/23 costs: EU £96,669 and admitted patient care £561,154.

Review 5:

- An analysis of the CAV Health Inclusion Needs Assessment, CAVHIS led surveys and Regional Partnership Board Population Needs Assessment has revealed the health priorities for both health inclusion patients and key stakeholder. The health inclusion Needs Assessment for and the Vale conducted in 2022, estimated that there is a stable population of 5,500-6,700 within the health inclusion groups previously listed. However, this proposal recognises that there is a spectrum of need and variation in individual's ability to navigate systems of care- not all individuals within these groups will require a specialist service.

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Review 6:

- An analysis of data and research, alongside stakeholder engagement, has provided a greater understanding of sub populations who are at the 'Cliff Edge' and who would benefit from a more specialist service in Cardiff and the Vale (see table 4 below).

Table 4: Estimate of 'Cliff Edge' Population Sizes

Population Type	Population Size (approx.)	Source/Comment
People experiencing homelessness who are multiply excluded	Up to 1250	Approximate number of supported accommodation and emergency units within the single person/young person gateway with the majority considered to be high/complex needs with a high turnover.
People leaving prison on short term sentencing (including IOM)	400	Current caseload in March 2024, provided by Her Majesties Prison and Probation Service (HMPPS).
People engaged in high-risk sex work	300	Figure provided by Street Life (third sector organisation working with sex workers).
People seeking asylum and Refugees	Up to 1,400	Analysing peaks in demand from CAVHIS data.
Gypsy, Roma, and Travelling (GRT) people	350	Current number officially recorded on Council static GRT sites (Rover Way and Shirenewton). Mobile GRT approx. 3-4 unauthorized encampments a year. Scoping work ongoing to further establish need and demand.
ATS	40	CAVHIS data.
TOTAL	**Approx 3,500**	

5.3 Current Capacity

CAVHIS is not monitored in line with Referral to Treatment times. There are no specific waiting time standards associated with the caseloads served by CAVHIS as it is a demand led service. Therefore, all staff capacity is used flexibly to meet variations in demand and patient need. The capacity levels outline below represents average activity levels across the various components of the current core model.

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Table 5: Current CAVHIS Capacity and Performance within the Core Service Only (i.e. excludes activity associated with temporary initiatives)

	CAVHIS Baseline Service	Number of available appointments per year	Waiting time (average)
CRI (Nurses)	Monday-Friday (0830-1700hrs): • Public Health Screening for Asylum Seekers/Refugees (Adult/Paeds) • Limited Health Visiting and Midwifery Care	Public Health Screening: Adult: 1,768 Paediatrics: 832 Midwifery: 312 Health Visitor: 780	11 working days for public health screening
CRI (GP)	Monday-Friday (0830-1700hrs): • x9 GP clinics for Refugee/Asylum • x1 GP admin session	3,952	12 working days
ATS	Thursday (1600-1830hrs): • x1 GP clinic	416 face-to-face 52 telephone	5 working days
Homeless GP Outreach	Once a week (9am-1pm): • x1 GP clinic (Ty Tres/Huggard)	520 (varies depending on complexities of patient-based on 25 minutes per appointment)	N/A- drop in/same day appointments
Homeless Nurse Outreach	Monday-Friday (0800-1600hrs): • Homeless nurse drop in clinics in Huggard/Ty Tresilian Support provided by Homelessness MDT Nurse-Complex needs funded (Monday-Friday 0800-1600hrs)	Demand led. Average 12 seen per day.	N/A- drop in/same day appointments

For further information on service outcomes, and future outcome measures, please see Appendix 3.

5.4 CAVHIS Caseloads

CAVHIS Overall Caseloads:

- Increased exponentially by 149% from April 2022 (n=462) to January 2024 (n=1027)- attributed to increasing levels of individuals seeking asylum through WG Resettlement Programmes, poverty within the city resulting in homelessness and more challenging patients being de-registered by GP Practices and referred to ATS.

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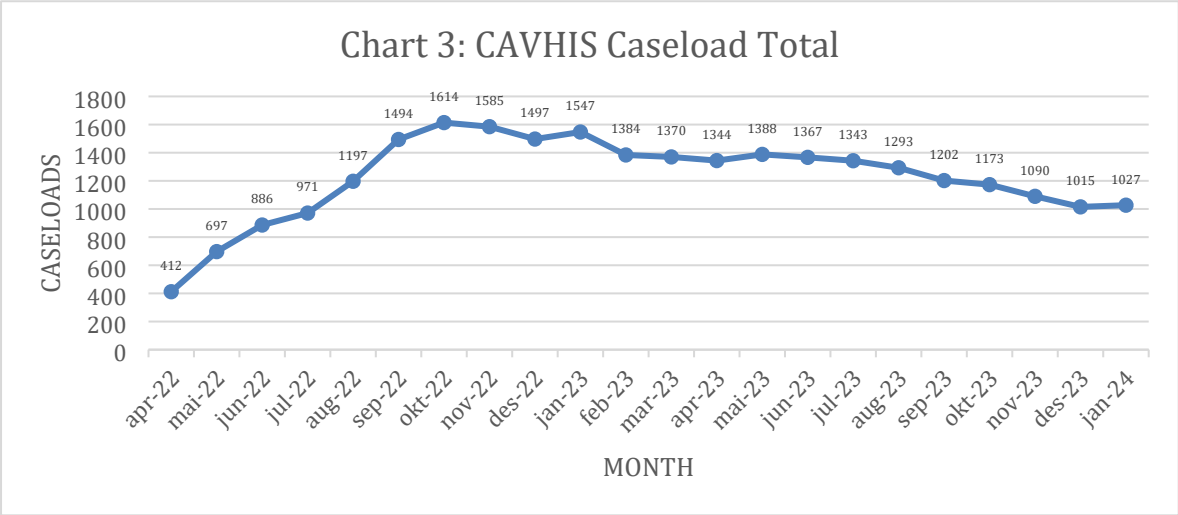
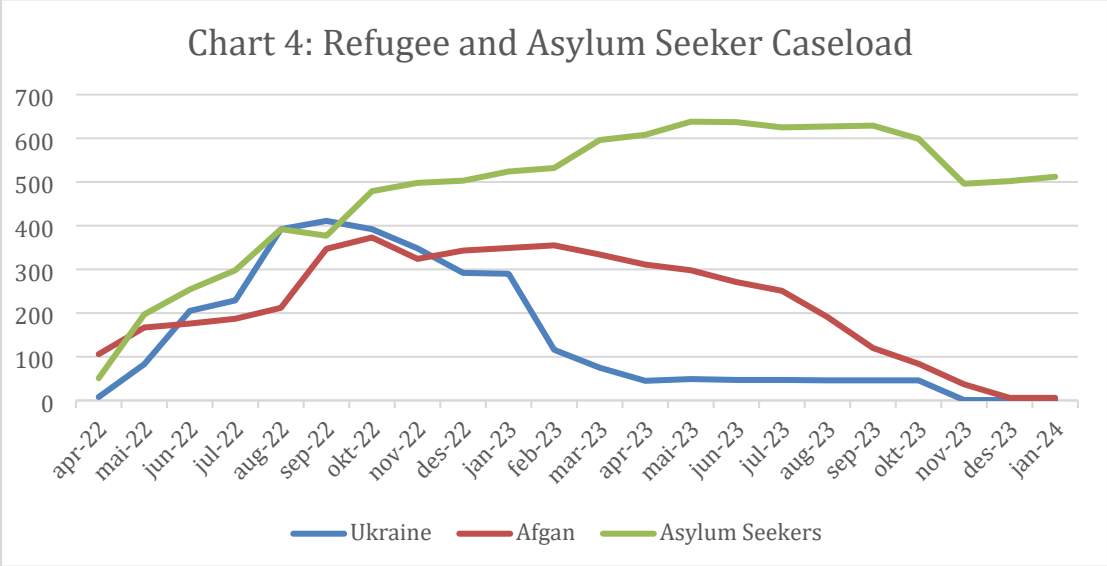


Asylum Seeker/Refugees:

- Varying activity levels linked to people being displaced due to war/conflict and changes in Home Office process (e.g., the recent fast tracking of asylum claims).
- The needs of arrivals are becoming more complex, leading to a rise in onward referrals, longer appointment times, safeguarding issues, and staff pressures (including attending safeguarding meetings etc.).



Alternative Treatment Service:

- Increased by 46% between February 2022 (n=26) and January 2024 (n=38).
- Significant increase in complexity of case management, highlighting limitations of the current service model in terms of both access (i.e. the clinic only operates x 1 week) and the concerns around the safety of the current model.

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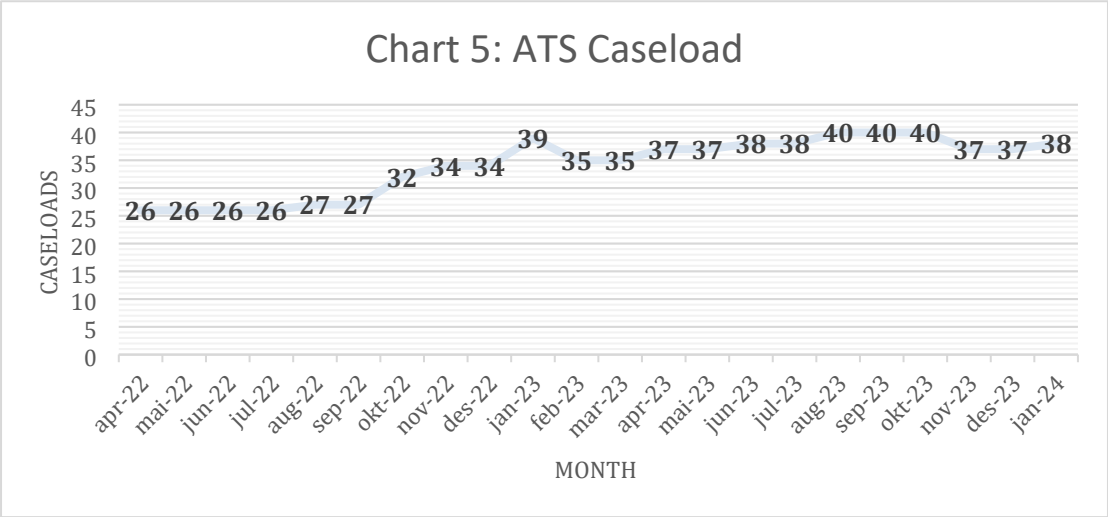
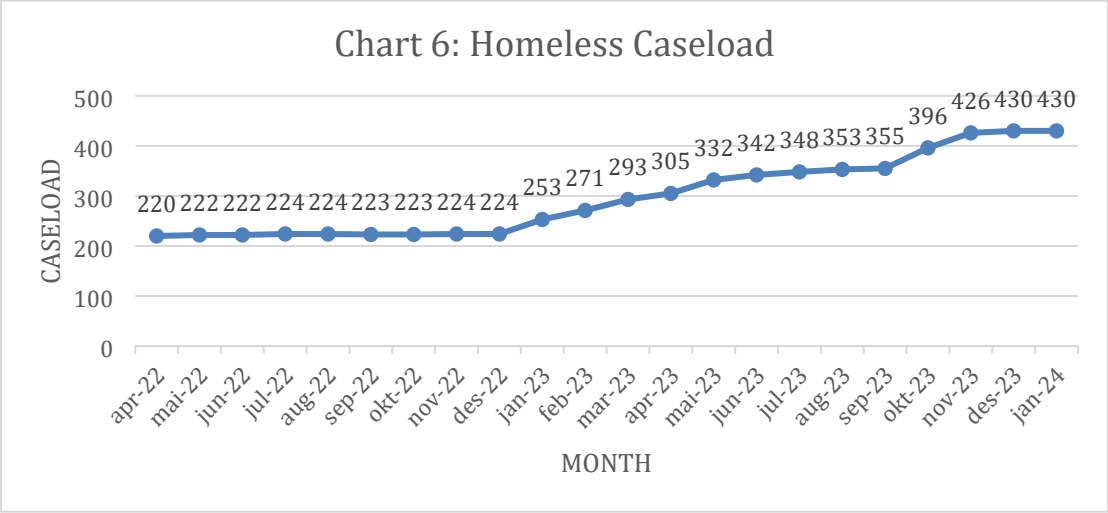


Homelessness:

- Since April 2022, CAVHIS homelessness caseloads have risen by 96% (from 220 patients to 440).
- 6 month data analysis of 311 CAVHIS homeless patients: 64.6% required an appointment time longer than the average 10 minute slot, 34.4% presented with complaint related to substance misuse and 53.5% required 1 or more services to be contacted (please see figure appendix 4).
- In response to rising homelessness presentations, Cardiff Council has increased emergency accommodation units by 400% since 2020.
- Data gathered from showed the highest number of EU homeless presentations in a period of a week (30th April- 7th May 2023) was 53. However, number will be higher as not all hostels were listed and does not include 'hidden homelessness' (e.g., sofa surfing.
- On the 1st of March 2024, the Homelessness MDT had a total of 716 cases open, meaning that 716 homeless individuals were accessing one or more service within the team.
- The average case length for homelessness MDT (in days) has grown by 131.5% since 2020. In addition, 346 individuals were referred more than once to the MDT, demonstrating several 'revolving door' cases- linked to complexity of cases, lack of move, time required to build rapport.



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5.5 Benchmarking

There is no known comparable service operating in the UK or internationally by which to directly benchmark, however, the following benchmarking exercises and research have been completed:

- Review of a practice located in City and South Cluster of CAVUHB. Activity and workforce analysis showed that practice had a capitation of 3271 (correct as of 1/1/24) with the following workforce: 2 WTE GPs (plus 0.8 WTE locum support), 1 WTE Nurse, 3.7 WTE Admin and 1 WTE Manager. Activity information is provided in Appendix 5.
- ATS: all Health boards in Wales operate different models of service, some are commissioned through a GP practice, and some operate a service from with a Police Station. Irrespective of how the delivery models differ, the provision of only one clinic a week for management of ATS patients is at variance to all other areas in Wales where access is provided on a 5- day basis.
- Pathway Team (UK wide Programme) has provided guidance on the size and composition for an in-reach team. It recommends that areas with 400+ homeless patients a year, the team should include 5-6 WTE staff members. This figure is based on seeing inpatients only and additional capacity is required to cover EU, step-down and teams covering multiple hospital sites. At a minimum, the hospital team needs to include input from a GP, a fulltime Band 7 nurse and housing input. Further information team design recommendations (including information for teams receiving over 300 referrals per year) is provided in Appendix 6.
- Visit to Brighton and Hove's Faculty for Homeless and Health Inclusion (specialist, homeless multidisciplinary in-reach Pathway team).
- Benchmarking meeting with Glasgow Complex Needs Service-provided guidance on their experience of integrated working.

Further research has shown that:

- Although there are 'pockets of excellence', there is no evidence of a sustainable, widespread, integrated service for health inclusion groups, meaning that only aspects of the proposed model are comparable to other services.
- Favourable health outcomes were achieved if models were well integrated with health and social care providers and homelessness sector services.
- Mobile outreach teams with no dedicated GP had less beneficial scores and poorer coordination between services. This led to multiple nurse contacts, but no management of chronic disease, preventative care, or medication reviews.
- Mobile teams are more effective if they operated as part of a general practice, rather than a separate service.
- Mobile teams cover a wide geographical area and maintain contact with people who are unsettled or reluctant to attend a GP practice.
- People's health needs are closely intertwined with their housing and support needs, and the solutions require the involvement of the NHS, local authorities, and community sector.

5.6 The Proposed Service Model- A Tiered Approach

A three- tiered approach is required to better meet the needs of health inclusion groups within Cardiff and the Vale of Glamorgan (see figure 1). Although this business case is focused on the provision of a specialist service, action is also required at both a primary care and cluster level:

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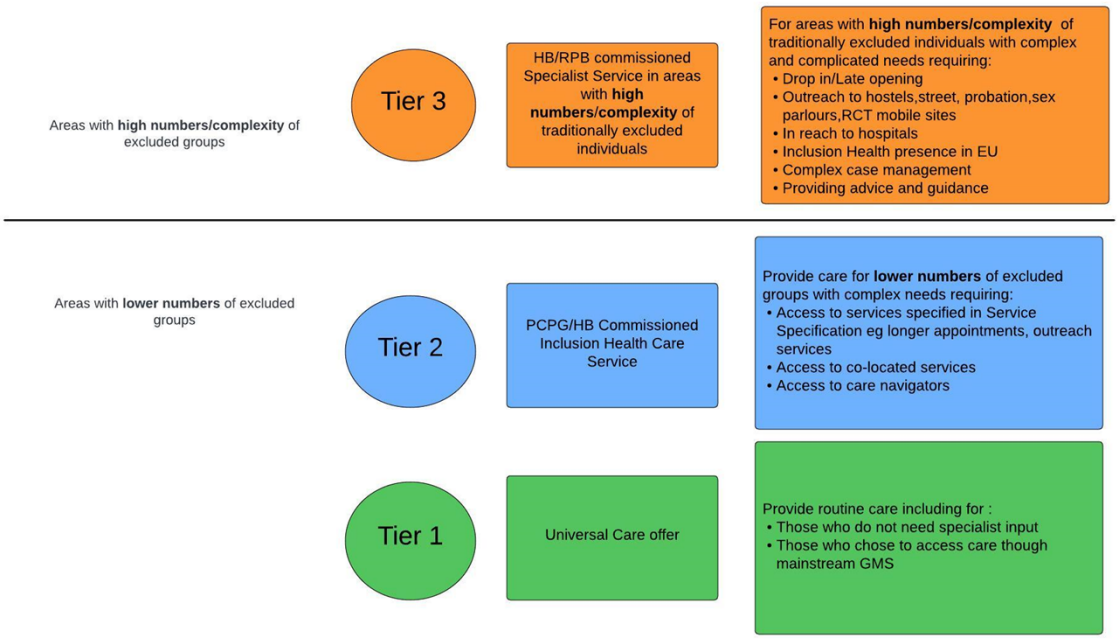
Tier 1 -Universal Primary Care Level- The ability for GPs to provide enhanced levels of service to health inclusion groups needs to be improved and encouraged via the UHB. The level of enhancements required will be dependent on the geographical area, health inclusion

population sizes and resources available. Although an enhanced service is available for practices which serve the homeless and asylum seeker populations, they are very limited and do not allow for optimal management of patients with multi-faceted needs. This is a matter for Welsh Government and the Directors of Primary Care who are responsible for contract negotiations.

Tier 2- Intermediate Care, Cluster level-as demonstrated in one cluster within Cardiff and Vale, there is more that can be undertaken at cluster level to improve the support networks for health inclusion groups and assist them in maintaining health and wellbeing in the community – e.g., investment in more third sector capacity to develop community assets, training, and education of staff to better support individuals. The Pan Cluster Planning Groups should encourage clusters to include consideration of Health Inclusion as part of their Integrated Medium Terms Plans.

Tier 3 – Specialist Level Care- the provision of a multi-disciplinary, multi-agency comprehensive, 'no wrong door' service, which is targeted at individuals at the cliff edge of inequality and whose needs are so complex that they cannot be met by tier 1 and tier 2 services, either on an intermittent/short term or permanent basis. The development of this element of the model falls to the UHB and associated Local Authorities.

Figure 1: Provision of healthcare at universal Tier 1, intermediate Tier 2, and specialist Inclusion health service Tier 3 service



5.7 The Tier 3 Service Model Explained

a) Overview of the Model

The Tier 3 service model is founded on research and benchmarking both nationally and internationally. It has been further informed through initiatives that have been introduced and evaluated by CAVHIS over the past 2 years. An illustration of a proposed Tier 3 service is provided in figure 2 overleaf. In summary, in order to meet the needs of all health inclusion groups at the 'cliff edge' of need, CAVHIS needs to be resourced, expanded and re-configured to:

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- Provide a ‘one stop/no wrong door service hub’, co-located and integrated with other relevant health, council and third sector organisations- operating extended hours to maximise opportunities for patient access.
- Deliver better and more timely access to a wider range of health care services that span the community, the Emergency Unit and Ward level and offer the potential for improved seamlessness and efficient pathways of care for individuals with highly complex needs
- Provide enhanced levels of public health screening/health protection, at an earlier stage with the aim of reducing levels of acute and chronic ill health, which without treatment, will result in escalating health problems

The above is predicated on continued and enhanced collaboration across the UHB, Cardiff and Vale Councils and the third sector, considering the ability to maximise/remodel existing services wherever possible, utilise the skills and experience of all staff working in the field of health inclusion, ensuring prudency, and considering Value for Health.

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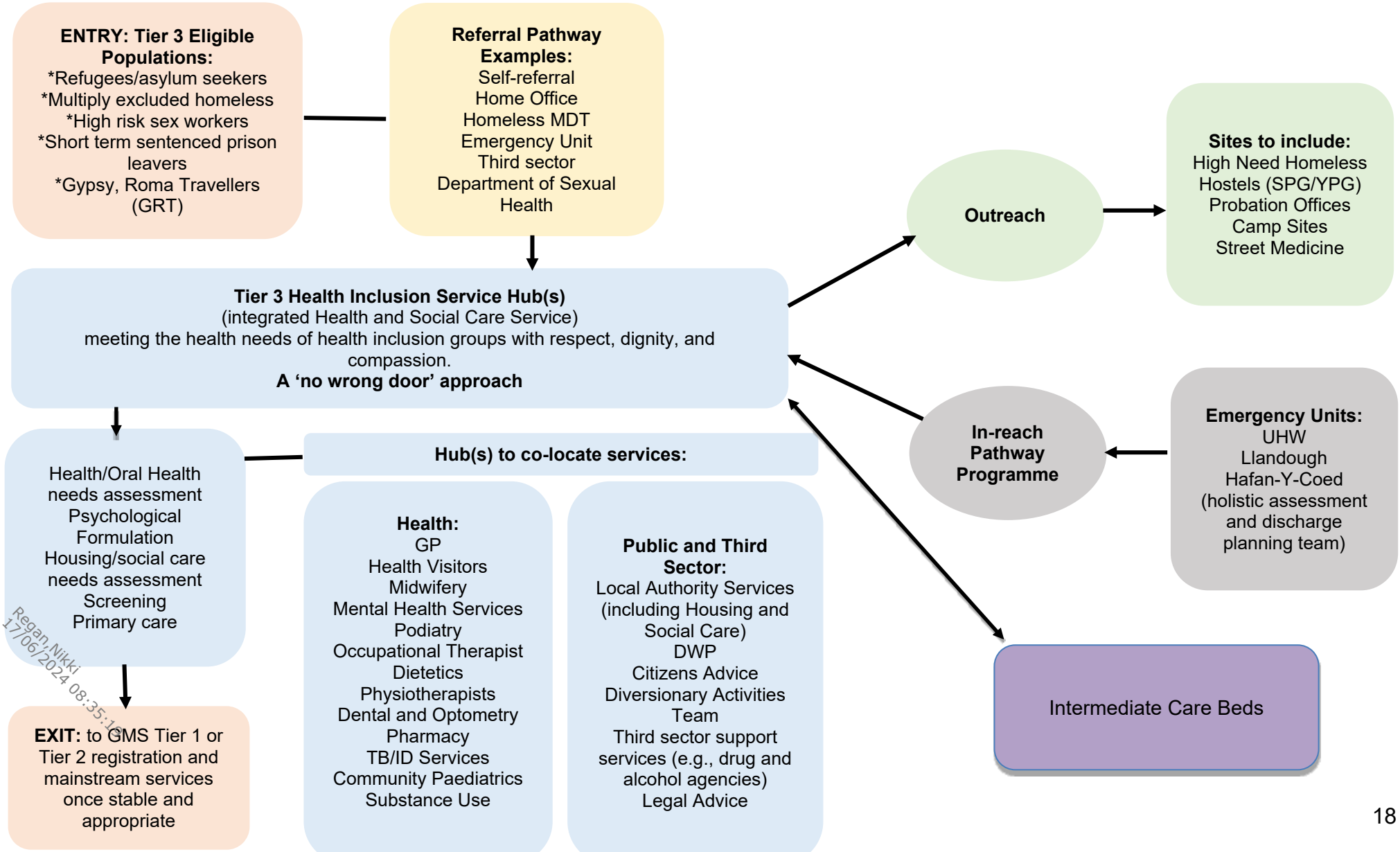
Figure 2: Proposed Tier 3 Health Inclusion Service Model for CAV



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b) Key Components of the Tier 3 Model

As illustrated in Figure 2, the Tier 3 service is based on a hub and spoke model;

The hub will act as the coordination centre for provision of care for individuals in all 5 health inclusion groups at tier 3 level (see appendix 7). The hub will accommodate an extended MDT and relevant service provided by the UHB, Council and third sector. This co-location will offer the potential to provide improved levels of integrated and responsive patient care and service efficiencies.

Services based in the hub will be expected to interface seamlessly with those elements of service provided on an in-reach and outreach basis. With those staff based in the 'spokes' being able to access and coordinate the provision of wrap around and ongoing care via staff and services based on site.

The hub will offer:

- Provision of suitable community- based facility, that will facilitate service expansion and integration with related council and third sector services. The facility will need to deliver the potential for disaggregated management of the individual patient cohorts (i.e. for safety and public acceptability reasons, patient cohorts will require separate entrance/reception facilities). *NB: The potential for all services to be accommodated within one facility offers the most opportunities for service integration, critical mass efficiencies and efficient coordination of care. If a one site option proves unachievable, consideration could be given to use of 2 facilities within proximity of each other, however this will have an impact on costs for phase 2.*
- Provision of a 5 -day, extended hour service from 0800-1830hrs, Monday to Friday to meet the needs of all health inclusion plus ATS patients (including General Medical Service Registration)
- Access to a wider range of allied health professionals from health, council and third sector, working as a 'team around the individual)
- Access to wider health services including dental, optometry, and pharmacy services.
- Additional specialist community clinics e.g. infectious diseases

The Spokes of the Model include**:**

CAVHIS Inreach:

- Specialist health inclusion nurses working in the Emergency Department, 7 days a week, between the hours of 8am and 8pm. These nurses will be responsible for the identification and case management of individuals who require the tier 3 service to assist their timely turnaround after clinical assessment, ensuring proactive follow up to minimise the risk of reattendance.
- A specialist multi-agency team from CAVHIS (GP, Housing Officer, and Nurse) will attend the wards 3 days a week to support with the discharge of complex patients who would benefit from CAVHIS support to reduce the risk of readmission.
- Both of these services will have direct communication and care pathways which integrate with other key service provided by the council and third sector.

CAVHIS Outreach:

- The provision of drop in health clinics run by GP/Nurse at high need hostels (Monday-Friday, excluding bank holidays), with access to EU consultants for specialist opinions/fast track diagnostics, where required.

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- Introduction of drop in health clinics run by GP/Nurse at probation sites including Westgate Street and Castle Street (agreed days between Monday-Friday, excluding bank holidays).
- Both of these services will have direct communication and care pathways which integrate with other key service provided by the council and third sector.
- Provision of street- based medicine to those who are unable to attend drop in clinics i.e. entrenched rough sleepers, mobile Gypsy Roma Travellers who have stopped for short periods etc.
- The potential to provide a level service to the Vale population is also included within the proposal.

CAVHIS Intermediate Care Beds

Based on benchmarking undertaken in Brighton, the potential to provide intermediate care beds offers system benefits in terms of diverting admissions/expediting hospital discharge for those individuals with complex needs. In Brighton, 7 beds are commissioned for a population size like Cardiff and the Vale. The average length of stay in 6 weeks. Whilst in the beds, council services operate to support the socio-economic needs of the patient, whilst health care services seek to optimise recovery/treat acute issue and plan for ongoing health care management.

Depending upon the size of estate identified for the hub, there is the potential to commission intermediate care beds as an integrated component of the model and include in phase 2 or alternatively, seek to provide beds from within existing council commissioned residential units.

c) Development of the Tier 3 Model- A Phased Approach

Given the extent of service aspirations outlined above a phased development approach is proposed spanning 2024-2027:

- **Phase 1** (24/25): Make permanent and expand the 'spoke elements' of the model (In-Reach and Outreach services), which can be delivered within existing accommodation/use of council facilities
- **Phase 2** (25/26): Develop the centralised 'service hub' in a new facility, which will deliver both enhanced and extended hours of service, through colocation and integration with wider UHB, council and third sector services
- **Phase 3** (26/27): Commission intermediate care beds-which potentially could be included as part 2 if suitable accommodation could be identified or alternatively, in a council provided residential facility.

This business case is specifically seeking funding for implementation of phase 1 in 2024/25 and a commitment to prioritise funding to complete service expansion through 2025-2027. Indicative costings associated with phase 2 of the project are provided in section 7.3.

5.8 How the Proposal will Help to Reduce Strategic and Operational Risks

Strategic Risks:

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- This proposal supports the UHB and Regional Partnership Board's aspirations to reduce health inequalities and levels of homelessness in Cardiff and the Vale.
- This proposal supports the principles of delivering more care in the community and closer to home.

- This model is predicated on the principle of prevention and early intervention, with the overall aim of improving health outcomes for the most vulnerable of people living in the region.
- This model supports the principles of multi-agency collaboration, planning and integrated working, bringing benefits in terms of patient experience, improved level of care, service efficiency and financial savings.
- The model supports wider partner strategies i.e., 'White Paper on Ending Homelessness' which seeks to ensure that homelessness is rare, brief, and non-reoccurring by providing holistic, targeted prevention to those with complex needs.

Operational Risks:

- This proposal will provide the required levels of staff and service hours to meet core service demands and sustain a consistent level of service, within Cardiff and the Vale of Glamorgan.
- This proposal will provide more specialist community base capacity, thus reducing demands on the CAV247 and the Emergency Unit.
- This proposal will support the timelier discharge of patients from hospital and reduce the risk of readmission.
- There are growing concerns with regards to the safety of staff who work within the service, especially given the volitivity of some patients who attend ATS- attempt to access CAVHIS outside of ATS hours.
- The proposal includes allowance for annual leave and sickness- current allowance does not include.

An outline of actions taken to date to mitigate, where possible, operational, and strategic risks is outlined in Appendix 8.

6. Option Appraisal

In relation to Phase 1 of the proposed CAVHIS expansion, 3 options have been identified:

Option 1: Do nothing: The level of health inequalities across Cardiff and the Vale is stark and unacceptable. It is clear from the evidence, that patients with multiple needs cannot utilise traditional model of care within the community and as a result, they have poorer health outcomes and an escalated use of secondary care services. Deciding to 'do nothing' would not only halt the progress made by CAVHIS to work toward redressing this imbalance but would necessitate the withdrawal of those services, which were originally funded via temporary funding/slippage and have proven beneficial in terms of improving patient outcomes and reducing demands on secondary care services. CAVHIS is struggling to respond to the demands being placed on it. Given the precarious and escalating situation in Russia and Ukraine and in the Middle East, it would be remiss of the UHB to ignore the fact that Cardiff as the Capital City of Wales, will continue to be called upon to respond to humanitarian crises going forward.

Whilst the service continues to work hard to address health inequalities and respond to the fluctuating demands that are placed on it, the reality is that the current provision is cannot work to its optimum within current resources.

Option 2: Implement CAVHIS Outreach or CAVHIS In-reach Spoke Only

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Although it would be feasible to implement one or other of the service 'spokes', the benefit realisation associated with the delivery of seamless service model spanning the community and hospital will be limited. There will be limits in terms of being able to safely manage

individuals in the community and without direct access to the care pathways proposed as part of the phase 1 development.

Option 3: Implement Both CAVHIS Outreach and In-Reach

This option proposes investment in both the outreach and in-reach elements of phase 1, which will mitigate the limitations outlined in option 2 and:

- Take essential services 'to the individual' rather than rely on them to attend a service/stay for a protracted period awaiting treatment, which is often an unreliable expectation amongst health inclusion groups.
- Deliver right care, at the right time, in the right place via specialists in the field of health inclusion.
- Increase targeted, preventative care the community and divert individuals away from hospital services where clinically appropriate.
- Make more efficient use of resource, through coordination of care between the community and hospital.
- Support timely turnaround/discharge through provision of alternative coordinated MDT care at a community level over 7 days.
- Maximise benefits realisation (see section 7.1.1).

7. The Preferred option

The preferred option is to implement Option 3 and invest funding to make permanent and expand those services associated with both the CAVHIS Outreach and In-Reach Components.

a) Impact on Other Services

In developing this service model, efforts have been made to engage with all relevent services (UHB, Council and third sector) to a) assess what they may be able to offer into the model and b) to ientify any risks on unintended impact/consequences. These discussions have proved beneficial in terms of identify areas of duplication, opportunities for shared use of staff resources, opportunities for streamling and potential opportunities in terms of other sources of potentail funding (e.g. Health Protection Funding, Area Planning Board funding and other grant opportunities). No significant impacts/risks to deliver have been identified to date.

b) Dependencies: Partnership Working

Clearly, CAVHIS could not have expanded to its current level without close alignment and shared opportunities provided and encouraged by Cardiff Council. The delivery of phase 1 is totally reliant on the continued close working relationship between the council's Homelessness, Housing and Social care teams as well as seamless working between CAVHIS and other relevent health provided services e.g. Infectious Diseases, Community Addictions and Mental Health Services.

c) Dependencies: Commitment to full Tier 3 Model

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Although this business case is seeking funding for phase 1 service expansion only, it is important to advise at this early stage, that the full potential of the model can be only be optimised through investment in the provision of the CAVHIS Hub, primarily because not all services required by health inclusion groups can be provided via an in-reach/outreach model

from the perspective of both coordination and delivery of care but also on the basis of cost effectiveness.

The ability to develop a CAVHIS Hub, will depend upon the provision of alternative accommodation as well as further revenue investment and discussions are ongoing with Cardiff Council and associated third sector organisations to identify potential opportunities for collaboration and joint investment.

The service is aware of the need to develop a further business case by which to progress to phase 2 in 2025/26.

7.1 Benefits

a) Additional Clinical Capacity/Outcomes to be Delivered

Details of the proposed staffing model are provide in section 7.3. Investment in Phase 1 will provide a range of additional clinical capacity to that which is currently provided through existing budget as detailed in table 6 below.

NB: *It is recognised that performance metrics will need to be developed for some elements of service which are completely new to the model. Work is already underway to develop PARIS/Council systems to be able to better report/monitor activity.*

Table 6: Phase 1 additional capacity provided and Outcomes.

	Phase 1 Investment	**Additional Capacity/Activity/Annum**
CRI	Monday-Friday (0830-1700hrs): • Additional Health Visiting and Midwifery Care • High Intensity Therapist • Adult Social Worker (potential joint post with Cardiff Council).	Midwifery: 780 contacts Health Visitor: 1560 contacts *Will be developed to include number of patient contacts, outcomes, length of intervention etc..*
CRI	Once a fortnight: • x1 clinic Adult ID • x1 clinic Paeds ID • Support from Pharmacy	120 Adult ID clinic appointments *Will include core Health Protection Measures eg Hep C levels with patient cohort*
Outreach	Monday-Friday (between 0900-1300hrs) GP/Health inclusion nurse clinics: • x5 GP clinics in high need Hostels (Ty Gobiath, Ty Ephraim, Adams Court, Single Assessment Centre, Northlands) • x3 GP clinics in Westgate Street (Probation). • x1 GP clinic in Castle Street (Safer Wales- Women's	5,200 patient contacts *Will, where possible, include PROMS and PREM measures Will include performance against key Health Protection Measures* *Will include numbers of Individuals diverted away from Hospital Assessment*

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	Services including Probation and Street Life) • x1 GP clinic in Nelsons Trust Office (Women's Probation Centre) Flexibility to for GP/Nurse outreach to mobile campsites/static caravan sites/parlours/street medicine.	
In-reach	7 days a week (0800-2000hrs): • Health inclusion nurse based in EU. 3 days a week to attend hospital wards: • 3 GP sessions • Housing Officer (Council Funded) • Health inclusion nurse	*Based on reported number of EU attendances, potential input into 50-60 cases per week who attend the EU* *Based on benchmarking, potential to support with 400+ cases per year*
Dentistry	3 days a week (0845-1700hrs) • Dedicated service utilising existing facility (Butetown Dentist Practice and Mobile Dental Van).	1,872

b) Additional Benefits Associated with Phase 1:

Following a benefits mapping exerecise, involving members of the UHB, Council, third sector and individauls with lived expereince, the following additional quantitative and qualitative benefits have been identified:

Quantifiable benefits	***Non-quantifiable benefits***
Staff recruitment, retention, and wellbeing: • Skill development- number of courses attended. • Applications into health inclusion- a new and unique field of healthcare. • Inclusivity of workforce. • Vacancy and sickness rates amongst staff. • Staff complaints/concerns. • Staff safeguarding incidents. **Cost releasing benefits:** • Potential for reduction in the numbers of unnecessary EU attendances/reattendances. • Potential for reduction in admissions/readmissions (including bed days).	**Patient experience:** • Building of rapport and trust. **Health Inclusion Awareness:** • Raising awareness of the health inclusion, by highlighting the magnitude and consequences of extreme inequity. • Reduce stigmatization. • Improved understanding of the relationship between socio-economic deprivation, poverty, and social injustice. **Staff recruitment, retention, and wellbeing:** • Foster positive cultural change. • Improved understanding of risk factors.

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• Potential for a reduction in the self-discharge rate (linked to reattendance/readmission). • Increased engagement with primary care health services. **Patient Experience:** • Patient reported satisfaction. • Engagement rates (number attending clinics). • Compliments/concerns. • Personalised care planning. **Patient Outcomes:** • Uptake on national screening programmes. • Access to primary care. **Partnership Working:** • Pathways between primary and secondary care. • Joint funding/posts. • Health Inclusion Programme Board attendance. • Shared systems and data sharing agreements. **Data:** • Baselines to monitor performance. • Evaluation and performance measures. • Utilisation of data to inform service development. • Data quality and availability. **Wider Partner Benefits:** • Temporary accommodation tenancy abandonments/evictions. • Revolving door homelessness cases. • Number rough sleeping.	• Ability to embrace change and move away from outdated processes. • Reputation as an exemplar for health inclusion. **Future Service Development:** • Impact on future policy and practice. • Promote a whole of society approach to addressing health inequities and reversal of exclusionary processes. • Encourage other areas to take action to improve outcome for health inclusion groups. • Modernise ways of working through new approaches to delivery of care.

7.1.1 Benefits tracker

It is difficult to obtain a comprehensive picture of health inclusion groups due to lack of visibility of these groups within standardised datasets, making it complex to provide baseline data, targets, and timelines. However, a key benefit of this development is to provide more granular, routine information and data on these identified cohorts.

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Benefits outlined below utilise data reviews outlined in section 5.2. Another baseline cohort which will be used is EU frequent attendees- work is ongoing to establish health inclusion cohorts within this group and to understand their NHS activity.

PHASE 1: BENEFITS TRACKER					
Benefit Type	**Benefit**	**Metric- how measuring**	**Baseline**	**Target**	**Timeline / Ambition**
Improve patient access.	Increase access and engagement for Tier 3 populations via outreach.	% of individuals engaging with CAVHIS via outreach pre and post phase 1 implementation. Patient feedback to monitor experience of accessing healthcare.	Current caseload figures for homeless population supported via outreach e.g., January 2024-430 (includes patients supported via temporary extensions)	50% increase in current caseload figures.	Increase caseload figures by the end of March 2025.
Improve patient access.	Increased access to midwifery and health visiting	% of individuals seen pre and post phase 1 implementation.	Midwifery: 312 Health Visitor: 780	50% increase in current caseload figures.	Increase caseload figures by the end of March 2025.
Improve prevention.	Increased uptake on screening programmes and appropriate aftercare for positive cases.	% of individuals screened for BBV and proportion positive. % of individuals screened for STI and proportion positive. % of individuals screened for Latent and Active TB and proportion positive.	Working with PHW to understand if baseline data can be extracted from Harm Reduction Database.	50% increase in screening uptake for individuals open to CAVHIS.	Increased number of screening tests conducted by December 2025.
Improve prevention. Better Patient Outcomes.	In conjunction with partner organisations, contribute to reducing the gap in life expectancy and health life expectancy in Cardiff and the Vale	Public Health Needs Assessment ONS data PHW information Data re deaths rates amongst the homeless /per annum	As detailed in business case	Sustained reduction in number of deaths amongst the homeless/per annum from baseline 2023/24 Demonstrable increase in average life expectancy and health life expectancy amongst cohorts served by expanded CAVHIS	Likely to be 10 years based on availability of data sources, unless interim Health Needs Assessment is commissioned at an earlier point in time

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Improve prevention.	Reduction in preventable EU attendances and reattendances.	% of EU attendances pre and post in-reach team. % of EU reattendances pre and post in-reach team. % of DNW pre and post in-reach team.	EU Attendances: 741 EU Reattendance with 7 days: 29% DNW: 19.5% Data based on 349 homeless patients in 22/23.	Reduction rates vary depending on in-reach research studies, e.g., between a 11-37% reduction on attendance	To reduce unnecessary pressure on EU and provide more cost-effective care by December 2025.
Improve prevention. **Better Patient Outcomes.**	Reduction in the unplanned admissions and readmissions and total bed days.	% of admissions pre and post in-reach team. % of readmissions pre and post in-reach team. Number of bed days.	Inpatient admissions: 152 Readmission within 30 days: 15.8% Bed days: 1965 Data based on 349 homeless patients in 22/23.	Reduction rates vary depending on in-reach research studies examples included: *66% reduction in admissions *62% reduction in re-admissions within 28 days *11% reduction in bed days	To reduce unnecessary pressure on UHW and provide more cost-effective care by December 2025.
Better patient outcomes.	Safer, and more effective discharges from hospital for homeless patients.	% of inpatients receiving a holistic assessment. % of patients sleeping rough or sofa surfing on discharge from hospital. % of patients assisted to register with GP to access on discharge. Patient feedback to understand experience of in-reach pathway.	No in-reach team in EU-baselines are therefore unavailable.	Examples of outcomes from in-reach teams: 85% of inpatients receive a holistic assessment. 100% of consenting homeless patients seen are assessed by the LA. 85% of patients who do not have a GP are assisted to registered with a GP.	To reduced barriers to effective hospital discharges, thereby reducing delayed discharges.
Improve Workforce.	Motivated and Sustainable workforce that have access to training and development.	% of sickness absence rate of staff. Turnover rate for registered staff. % of staff who have had personal appraisal and development reviews.	CAVHIS sickness rate 8%	Turnover rate under 10% Value based appraisals between 75-78% Sickness less than 6%	To achieve the UHB key milestone by 2027.

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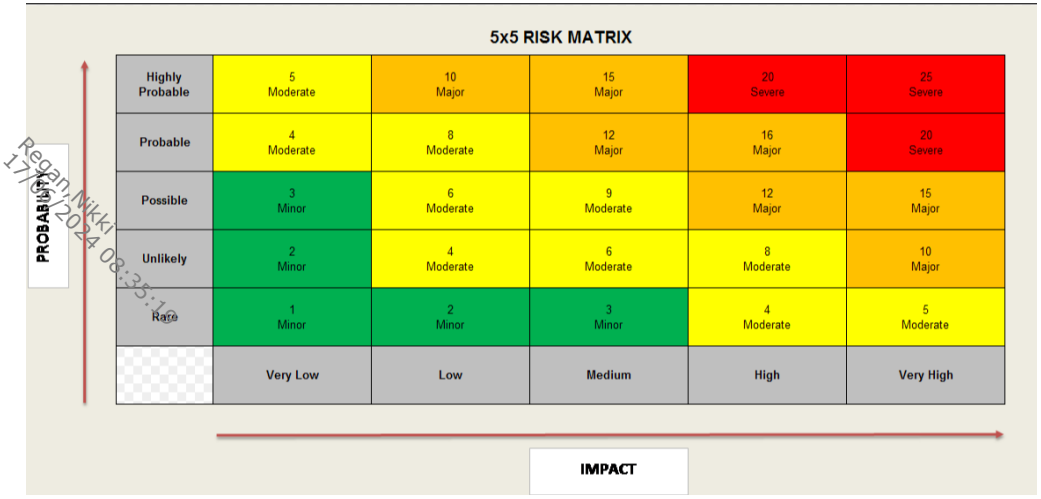
7.2 Risks: Risk Assessed as Scored 12 and Above

Risk Title	Descriptor	Probability (1-5)	Impact (1-5)	Total risk score (PxI)	Mitigating Action	Owner
Adressing Health Inequalities	The level of inequalities in heath within Cardiff and the Vale in unaccepatble and without advances in services specific to health inclusion groups, this problem will not be redressed.	5	5	25	Continued investment on a phased basis in specialist services for health inclusion groups to eventually deliver a tier 3 service	UHB
Funding	If funding is not agreeed for phase 1 service development, a number of initiatives that have been triallled by CAVHIS over the past 2 yearrs in support of improving health outcomes, reducing hospital admissions and ensuring timely turnaround of patients from the EU will have to be withdrwan.	5	5	25	To continue to work with partners to provide evidence of need and performance on fixed term funded roles where necessary. Continue to meet with partners regularly to understand any future risks attached to posts and action plan accordingly. Submit investment cases to secure permanent funding	UHB
Funding	The core CAVHIS budget (nor this business case) includes any additionality to deal with surges in activity assoicated with National Resettlement Programmes	4	4	16	PCIC Clinical Board will need to identify measures/routes by which to deal with such situations	PCIC Clinical Board
Workforce	This business case also includes some additional infrastructure costs associated with maintenance of CAVHIS staff safety in CRI ie Security staff and CCTV	5	4	20	Reporting and escalation of key risks via appropriate channels, offer wellbeing support, involvement of case management team, additional security, risk assessments and regular reporting to staff.	Capital and Estates/PCIC CB

7.3



7.3 Total Cost - Resource Implications and Affordability

Phase 1 : Additional Investment Required to Deliver Phase 1

These costs are based on the recruitment plan as described in Appendix 10- noting that a number of staff are already in post as part of continuation of previous temporary schemes and some posts will be new.

Type	Cost Year 1- part costs 24/25	Cost Year 2 25/26	Cost Year 3 26/27
Recurrent: Revenue Direct Pay Staff Costs	£745,009	£1,187,566	£1,187,566
Recurrent: Revenue Direct Non Pay	£186,534	£239,111	£239,211
Non Recurrent: Revenue Direct Non Pay	£15,000	£0	£0
Non Recurrent: Capital	£50,000	£0	£0
Winter funding	-£100,000	TBC	TBC
Total Required	**£896,543**	**£1,426,777**	**£1,426,777**

Assumed start date	Full Phase 1 implementation: October 2024
Funding Source Revenue:	Health Board Core Funds
Funding Source Capital:	

NB: The phase 1 investment outlined above, does not consider costs associated with phase 2 (i.e. the development of a new CAVHIS hub/intermediate care beds). Further investment will be required. Indicative revenue costs for phase 2 are circa £1m, however there may be opportunities for cost efficiencies based on the level of integration that can be achieved with Cardiff Council. A second business case will be submitted.

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Annex a: Workforce implications

Revenue: Direct Pay Staff Costs

Area	Role	Banding	Total Phase 1 WTE reqd	WTE Secured for 24/25	WTE Gap	Cost Year 1- part year 24/25	Cost Year 2 25/26	Cost Year 3 26/27
Clinical CRI Hub (includes ATS)	Service Manager	8a	0.50	0	0.50	£18,414	£36,824	£36,824
	GP Clinical	GP Scale	1.38	1.16	0.22	£16,457	£28,206	£28,206
	GP Strategic Sessions	GP Scale	0.40	0.2	0.20	£25,642	£25,642	£25,642
	Nurse Manager	8A	1.00	1	0.00	£0	£0	£0
	Team Lead Nurse	7	1.25	1	0.25	£8,016	£16,031	£16,031
	Adult Nurse	6	3.25	2.4	0.85	£23,124	£46,246	£46,246
	Paeds Nurse	6	1.88	1.5	0.38	£10,338	£20,675	£20,675
	Midwife	7	1.25	0.4	0.85	£31,794	£54,504	£54,504
	Health Visitor	6	1.25	0.5	0.75	£23,800	£40,805	£40,805
	HCSW	3	2.30	0.84	1.46	£22,284	£44,572	£44,572
	High Intensity Therapist	7	1.25	0	1.25	£40,074	£80,153	£80,153
	Adult Social Worker	G8	0.63	0	0.63	£16,500	£33,000	£33,000
	Pharmacist ID	8a	0.05	0	0.05	£3,682	£3,682	£3,682
	Paediatric Consultant ID	Cons	0.05	0	0.05	£7,599	£7,599	£7,599
	Adult Consultant ID	Cons	0.05	0	0.05	£7,599	£7,599	£7,599
Admin CRI Hub	Receptionist	2	2.00	0.22	1.78	£35,555	£48,965	£48,965
	Receptionist (2 WTE uplift B2-B3)	3	2.50	2	0.50	£10,182	£20,362	£20,362
	Care Navigator	3	1.88	1	0.88	£13,434	£26,866	£26,866
	Assistant Manager	4	1.00	1	0.00	£0	£0	£0
	Manager	6	1.00	1	0.00	£0	£0	£0
Outreach	GP Clinical	GP Scale	1.38	0.1	1.28	£117,101	£164,110	£164,110
	Adult Nurse	6	2.38	0	2.38	£65,826	£129,489	£129,489
	Team Lead Nurse	7	0.75	0.6	0.15	£4,812	£9,618	£9,618
Inreach	GP Clinical	GP Scale	0.38	0	0.38	£28,420	£48,720	£48,720
	Adult Nurse*	6	2.80	0	2.80	£161,778	£188,745	£188,745
	Team Lead Nurse	7	1.00	0.75	0.25	£8,016	£16,031	£16,031
Dental	Senior Dental Officer	LD11	0.20	0	0.20	£11,352	£22,699	£22,699
	Dental Therapist	XR06	0.40	0	0.40	£10,884	£21,763	£21,763
	Dental Nurse	XR05	0.60	0	0.60	£13,170	£26,345	£26,345
	Administrative Support	XR03	0.60	0	0.60	£9,156	£18,317	£18,317
	TOTAL		**35.33**	**15.67**	**19.66**	**£745,009**	**£1,187,566**	**£1,187,566**

NB:

- *It should be noted that some of the above resource has been supported via Winter funding. This funding is assumed and netted down in the financial assessment.*
- *Where required, TOS costed roles include out of hours enhancements.*
- *The above additional WTE reflects leave and sickness cover for key clinical roles to ensure service sustainability (current baseline establishment has never included any recognition of leave).*

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Annex b: Non-pay, support service, infrastructure

Revenue: Direct Non Pay Costs

Direct Non Pay	Rec/Non Rec	Cost Year 1- part year 24/25	Cost Year 2 25/26	Cost Year 3 26/27
Additional staff equipment	Non rec	£15,000	£0	£0
Clinical Service and Supplies (25% increase)	Rec	£6,078	£12,153	£12,153
Travel expenses	Rec	£8,500	£12,000	£12,000
Training	Rec	£20,000	£20,000	£20,000
British Red Cross	Rec	£48,854	£73,708	£73,708
Security	Rec	£72,000	£72,000	£72,000
Dentistry Ihalation and sediation equipment/servicing	Rec	£1,002	£2,000	£2,000
Dentistry Consumables	Rec	£17,250	£34,500	£34,500
Van costs (Tax, Diesel, MOT, running costs etc.)	Rec	£12,850	£12,850	£12,850
Impact on support deparments- non identified		£0	£0	£0
Infrastructure- non identified		£0	£0	£0
Total		£201,534	£239,211	£239,211

Please see appendix 10 for Recruitment Plan and Cost Projection Year 1 23/24.

Annex c: Capital requirements

Capital Costs

Capital	Cost Year 1- part year 24/25	Cost Year 2 25/26	Cost Year 3 26/27
CCTV	£50,000	£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
21 November 2023	28 November 2023	5 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
14 December 2023	3 January 2024	10 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

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Appendices

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Appendix 1: Health Inclusion Expansion Strategic Fit

National Health Strategy:
A healthier Wales: Long term plan for health and social care (2018)
Six Goals for Urgent and Emergency Care (2021-26)
Welsh Value in Health (2024)
Welsh Health Circular (2022-23)

Regional Health Strategy:
CaV Shaping Our Future Wellbeing Strategy (2023-35)
CaV UHB IMTP (2023-26)
CaV Health Protection Plan (2023)
CaV Heb and C Joint Recovery Plan (2023-25)
CaV Population Needs Assessment (2022)
CaV Local Public Health Plan (2023-26)
@Home Programme

Health Inclusion Expansion

Wider Strategic Context:
South Wales Police & Crime Plan (2022-26)
C3SC Strategic Business Plan (2022-25)
HMPPS Business Strategy: Shaping Our Future
Ending Homelessness White Paper
Substance Misuse Delivery Plan (2019-22)
Cardiff Wellbeing Plan (2023-2028)
Wales Public Bodies Equality Partnership's Strategic Equality Plan 2020-24
Nation of Sanctuary – Refugee and Asylum Seeker Plan

Legislative Policy:
The Wellbeing of Future Generations Act 2015
Social Services Wellbeing (Wales) Act 2014
Social-Economic Duty 2021
Equality Act 2010
Human Rights Act 1998
Public Health (Wales) Act 2017

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Appendix 2: Understanding the Local Need

Review 1: 349 patients experiencing homelessness.

Table 7: EU Outcome Average

	5 Years	EU Activity
EU Outcome	Patients	Distribution
Discharged	1837	60.3%
Did Not Wait	593	19.5%
Admitted	454	14.9%
Other	97	3.2%
Redirected	60	2.0%
Died In EU	3	0.1%
Total	3044	100%

Table 8: All Inpatient Admissions (Inpatient and Day case)

	Inpatient Admissions			
Year	Patients	Admissions	Bed Days	ALOS
2018/2019	71	135	748	5.5
2019/2020	61	136	935	15.3
2020/2021	73	149	1437	19.7
2021/2022	79	147	2799	35.4
2022/2023	73	152	1965	26.9

Table 9: Readmissions with 30 days of discharge

Row Labels	Readmissions within 30 Days	Total Admissions	% Readmissions
2018/19	17	135	12.6%
2019/20	21	136	15.4%
2020/21	22	149	14.8%
2021/22	25	147	17.0%
2022/23	24	152	15.8%
Grand Total	109	719	15.2%

Table 10: Reattendances within 7 days of discharge

Year	Reattendances within 7 Days	Total Attendances	% Reattendances
2018/19	120	487	24.6%
2019/20	140	567	24.7%
2020/21	139	622	22.3%
2021/22	144	627	23.0%
2022/23	215	741	29.0%
Grand Total	758	3044	24.9%

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Review 2: 25 people experiencing homelessness

Table 11: Estimated public service costs attributed to 25 people experiencing homelessness.

Department	Item costed	Source	Estimated Costs
Homelessness	Homeless Accommodation	Single Person Gateway	£782,056
Health	Emergency and secondary care activity	UHB Business Intelligence System	£593,648
Substance Misuse	Contact with service	Crisis (2016) Study	£44,880
DWP	Universal Credit with limited capability for work- and work-related activity	DWP annual figures	£417,021
CJS	Contact with CJS	Crisis (2016) study	£503,622
Mental Health	Contact with mental health	Crisis (2016) study	£104,950
		Total Estimated Cost between 22-24	**£2,446,177**
		Annual Average Cost	**£1,223,088**
		Estimated Cost Per Person, Per Year	**£48,923**

Breakdown of Health Costs:

Table 12: NHS Activity Cost for 25 individuals experiencing homelessness in Cardiff 22-23

	EU	Community Services	Day cases	Inpatients	Outpatients	Total
22/23 Activity	72			34	18	124
22/23 Average Cost Per Attendance	£272.86			£3,458.56	£303.34	
22/23 Cost	£19,646	£19,977	£3,309	£117,591	£5,460	**£165,983**

Table 13: NHS Activity cost for 25 individual experiencing homelessness in Cardiff 23-24.

	EU	Community Services	Day cases	Inpatients	Outpatients	Total
23/24 Activity April-Dec 2023	192	Unknown	Unknown	70	29	291
23/24 Estimated Cost April-Dec 2023	£52,388			£242,099	£8,797	£303,284
23/24 Estimated Full Year Cost	£69,851	£19,977*	£3,309*	£322,799	£11,729.07	**£427,665**

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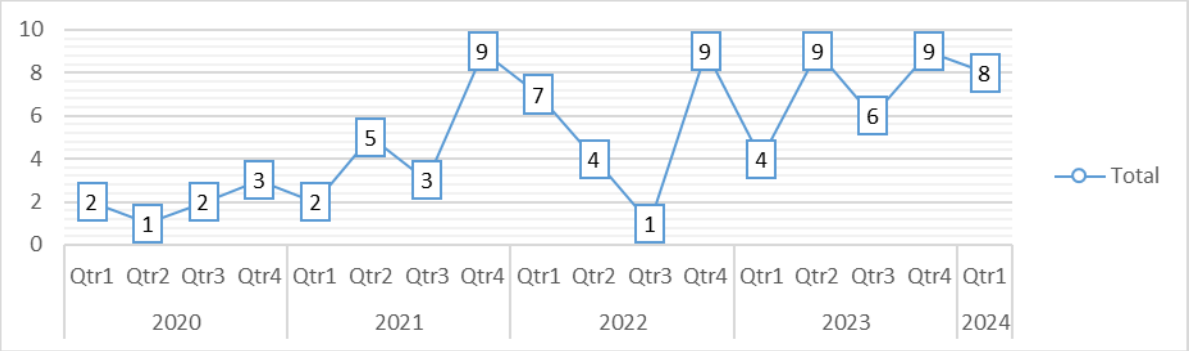
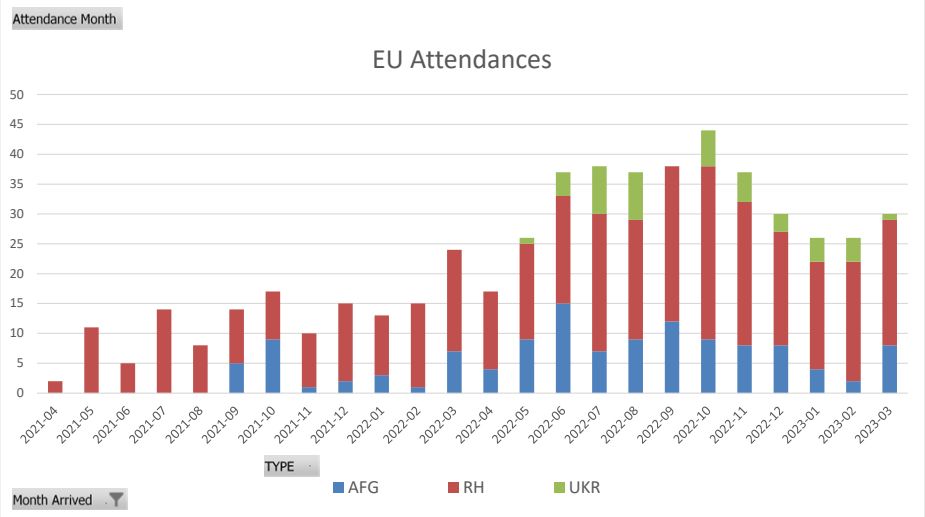
Review 3: Homelessness Deaths

Chart 7: Reported SPG and YPG Deaths by Qtr 2020-2024



Review 4: 2,221 Asylum Seeker and 1,234 Refugees patients.

Chart 8: EU attendances broken down into Refugees (Afghan/Ukrainians) and Asylum Seekers (RH)



Review 5: Health Priorities

Table 14: Summary the health priorities of surveys and interviews from health excluded populations and relevant professional stakeholders.

Priority Area	Health Inclusion Population Priorities	Professional Stakeholder Priorities
Health Needs	Mental health (specifically severe mental health disorders and traumatic stress) Dental health Management of chronic conditions	Mental health (specifically severe mental health disorders, traumatic stress, suicide, and substance/alcohol misuse) Dental health Reproductive/maternal health STIs, BBV and TB
Health Barriers	Stigma and Discrimination Access without fixed address Healthcare system complexity Lack of continuity of care Long waiting times	Stigma and Discrimination Lack of trauma awareness Street lifestyles Poor service location Low health education/expectations

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	Inconvenient opening hours Primary care access	Literacy/language barriers Fragmentation of services Referral difficulties/waits Fixed, normal opening hours
Health Facilitators	Walk-in appointments Flexible opening hours Case management and advocacy Staff friendliness Continuity of care	Walk-in appointments Flexible opening hours Case management and advocacy GP outreach Co-location of services Opportunistic testing and treatment provision

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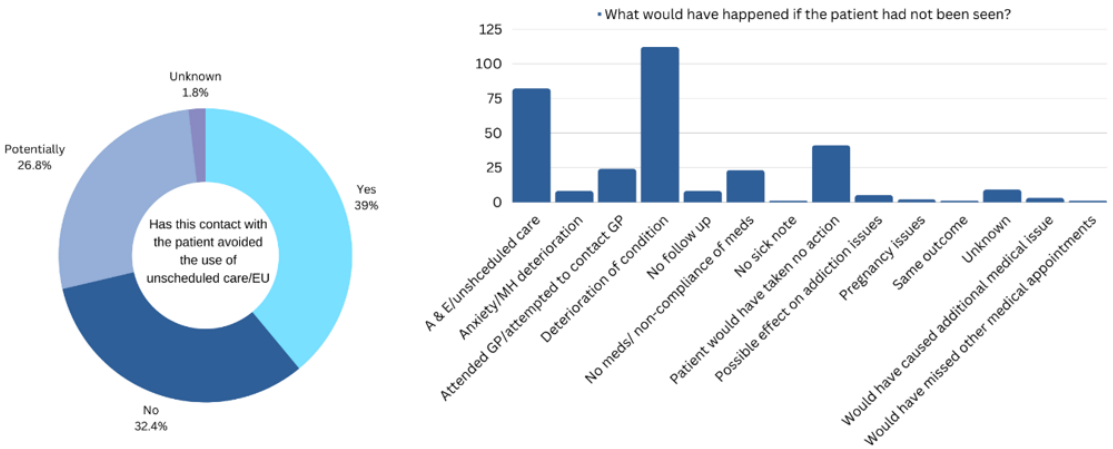
Appendix 3: Future Service Performance

As part of the development, CAVHIS is working closely with partners (e.g., Cardiff Council, Pathways etc.) to develop a quality framework to measure future service performance. This will ensure there is a clear approach to measuring value, quality, safety, patient, and staff experience across the model. The framework will incorporate a mixed method service evaluation, including Patient Reported Outcome Measures (PROMs), Patient Reported Experience Measures (PREMs) and Clinical Reported Outcome Measures (CROMs) and staff feedback. Joint reporting processes will be required and regularly reviewed to inform decisions, agree further actions, become data driven and incorporate the principles of co-production.

CROMs will include the number of avoided EU presentations/admissions and the cost saving attached. The 6-month data analysis of 311 homeless patients seen by the GP provides an indication of current performance. Figure 5 shows that the GP contact prevented (or potentially prevented) 65.8% individuals from using unscheduled care/EU. Using the average cost of an EU presentation, this would have saved £27,766.70 (n=106) and potentially saved £19,122.35 (n=73).

Figure 3: GP Homelessess Appointment Outcome



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Appendix 4: Service Demand

Figure 4: Homeless GP appointment information

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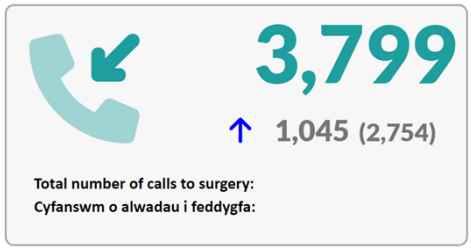
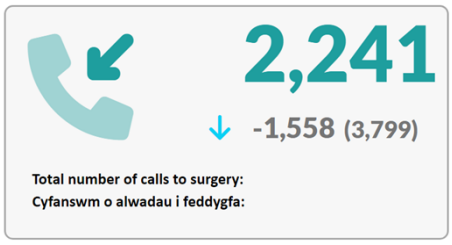
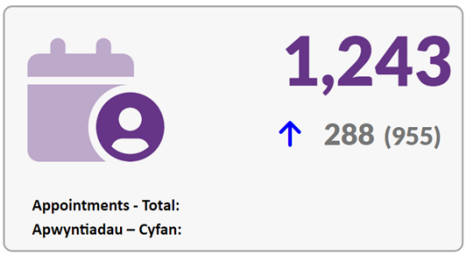
Appendix 5: Benchmarking (Activity Data for January and February for a Practice in Cardiff and Vale)

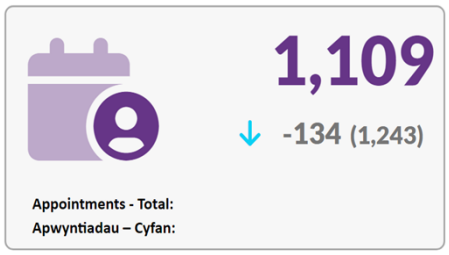
January 2024 *February 2024*

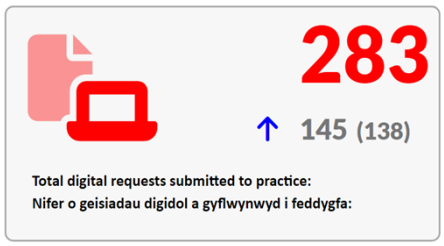
(note: arrows denote the trend from previous month)

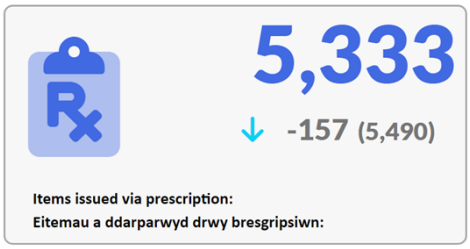


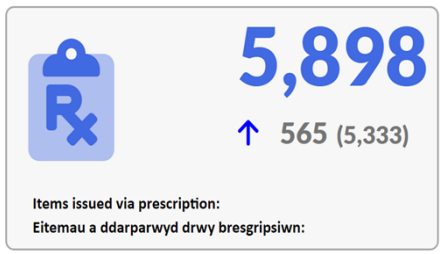


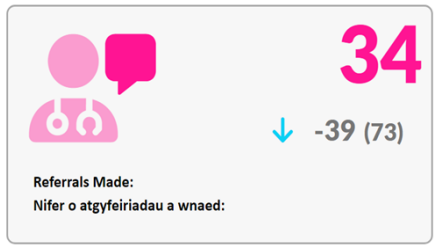


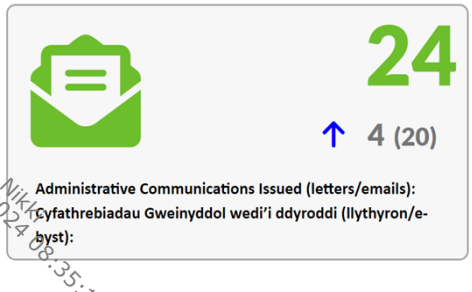












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Appendix 6: Benchmarking (Pathway Guidance (in-reach))

Table 15: Pathway In-reach Team Size Guidance

Homeless patients per year	Recommended staff numbers
200 to 300	3-4 FTE
300 to 400	4-5 FTE
400+	5-6 FTE

N.B. These estimates are based on seeing inpatients only. Extra capacity is needed to cover A&E patients, step down, teams covering multiple hospital sites, and where teams are providing extra community follow up. Staff numbers may need to be doubled or even trebled to cover these operational areas.

Team Design:
At a minimum, a Pathway hospital team needs to include:

- Input from a GP with experience of, or training in, homeless and/or inclusion health
- A full time Band 7 nurse or equivalent (for example, an occupational therapist or social worker)
- A housing sector specialist with advocacy capacity and ability to follow up with the most high-risk patients.

Outside of the core Pathway team defined above, and depending on workload:

- Ideally there should be 4 – 6 sessions GP input per week
- Pathway Occupational Therapists should have significant experience of cognitive assessments, functional assessments, and ideally experience in mental health.
- Pathway Social workers should be experts in Ordinary Residence disputes, Care Act, Domestic Violence, Safeguarding, Learning Disabilities, and Deprivation of Liberty Safeguards (DOLS)
- A peer support element can add significant value – befriending and supporting patients on the wards can reduce self-discharge and improve hospital systems and culture by engaging ward staff regularly.
- Where teams are receiving around over 300 referrals per year, it is recommended that service leads consider adding additional capacity to the team. For example:
    - A full time Band 8a service lead
    - Band 6 roles can be added (nurse, OT, social worker)
    - Additional staff with mental health experience
    - Additional housing workers
    - Pathway Care Navigators (people with lived experience of homelessness)
    - Admin support
    - Volunteers and capacity to manage them

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Appendix 7: Tier 3 Eligible Populations

Tier 3 eligible populations will include:

1. **People experiencing homelessness who are multiply excluded and in the Cardiff Council's Single Person/Young Person's gateway:**

Multiple Exclusion Homelessness (MEH) is defined as homeless and experiencing one or more of the following domains of deep social exclusion:

- Institutional care (prison, local authority)
- Substance misuse
- Street culture activities (street drinking, begging, survival shoplifting or sex work)

2. **People leaving prison on short term sentencing (including the Integrated Offender Management Cohort):**

- Individuals who go through a regular cycle of admission and discharge from secure estates with rapidly changing accommodation.
- Individuals leaving prison into homelessness/front line hostels.
- Individuals leaving prison who are known to the Homeless MDT (adult and young person), Single Persons Gateway and Young Person Gateway.

3. **People engaged in high-risk sex work:**

- Those engaged in street-based sex work.
- Those working in sex parlours with unclear immigration status and fear of authorities/Home Office.
- Sex workers experiencing homelessness.
- Sex workers with substance misuse problems.

4. **People seeking asylum and Refugees**:

Initial public health and health screening to be offered to all people seeking asylum and refugees. However, Tier 3 asylum Seekers and refugees will include:

- Individuals seeking asylum who are under section 98 of the Immigration and Asylum Act 1999
- Individuals seeking asylum who are under section 95 of the Immigration and Asylum Act 1999 but who are not stable enough or too vulnerable to be able to navigate traditional GMS, e.g., those with active infectious disease who DNA, present a risk to themselves and a public health risk, deteriorating mental health linked to asylum system and need co-located third sector support, active safeguarding problems involving linking in with multiple external partners.
- Destitute asylum seekers
- Homeless refugees
- Individuals with 'No recourse to public funds'

5. **Gypsy, Roma, and Travelling people:**

- Those will mobile lifestyles who camp for short periods of time before moving on.
- Those who live in static accommodation (please note, scoping work is ongoing with this population to further establish health needs).

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Appendix 8: Service Improvement and Joint Working

The following actions have been completed to, where possible, improve efficiency, partnership working and manage increasing demand to the health inclusion service:

Table 16: Service Improvement Actions

Action	Outcome
Improved partnership working with Homelessness MDT: *Absorption of previously isolated homelessness MDT nurse *Securing of x1 GP outreach clinic *Pilot of x4 temporary GP outreach clinic	Provides better governance and allows for limited outreach primary care to high needs hostels.
Whole system review undertaken, which included engagement with key stakeholders and patients.	Developed a new hub and spoke model which meets UHB's strategic priorities.
Extended the hours for ATS provision.	Decreased wait times for ATS from 2 weeks to 1 week. However, extending ATS provision as reduced the asylum seeker and refugee service provision and is therefore an unsustainable long-term solution.
Safer, more robust panel has been developed for ATS.	Ensures appropriate individuals are being accepted onto service. This has resulted in a decrease of inappropriate referrals being accepted onto scheme.
Developed the model of care for asylum seekers and refugees	Support now includes evidenced based screening, colocation of infectious disease clinics and appointment of third sector support.
Additional clinical room has been built within CAVHIS.	Additional space clinic space, yet this still does not provide enough clinical or administrative space to conduct a full service.
Purchased a van and remodelled to include medical equipment.	Support future outreach opportunities.
Identified training needs to up-skill Band 6 Nurses.	Allow make best use of resource by allowing for rotation across the services ensuring coverage.
Utilised existing resource to pilot a health inclusion nurse presence in the EU.	Understand demand and being to support safe turnaround in EU.
Developed a Programme Operational Group (POG) and Health Inclusion Programme Board.	Engages key stakeholders to provide strategic and service accountability.
Commissioned Pathways to support the development of the homelessness in-reach	Development of the in-reach aspect of the model is based on best practice.

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Appendix 9: Examples of Tier 3 Model Benefits (Full Model)					
Benefit Type	**Benefit**	**Metric- how measuring**	**Baseline**	**Target**	**Timeline / Ambition**
Better patient outcomes.	Reduce pressure on traditional primary care services (Tier 1) unable to the meet the need of Tier 3 individuals.	% of Tier 3 individuals registered at Tier 1 pre and post full model implementation.	Current CAVHIS figures suggest approx.2,500 Tier 3 patients are registered with Tier 1.	100% of Tier 3 patients in Cardiff registered with the Tier 3 service.	Dependent on funding.
Better patient outcomes	Reduce preventable, premature deaths.	% of the number in preventable, premature deaths in Tier 3 populations.	Homeless average age of death: 45 years.	To reduce preventable, premature deaths.	Dependent on funding.
Improve prevention.	Improve identification, and reduce late presentations, of the five conditions driving premature mortality and morbidity.	% of cancer, cardiovascular, musculoskeletal, neurological, and mental disorders identified and referred for appropriate treatment.	Working ongoing to establish baseline figure.	Decrease relative rates of morbidity and mortality.	Dependent on funding.
Ending homelessness (wider partner benefits)	Reduction in revolving door homelessness, ensuring that people do not experience multiple episodes of homelessness.	% of people who receive a relief duty (S.73 or S.75) who alter submit a further homeless application.	Work ongoing to establish baseline figure.	Reduction in the number of people representing to the Council as homeless.	Dependent on funding.
Ending Homelessness	Reduction in street homelessness.	Number people street homeless in a month. Number of new people street homeless in a month	March 2024: 22 people sleeping rough. March 2024: 11 first case of rough sleeping.	Reduction in the number of people sleeping rough.	Dependent on funding

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Appendix 10: Recruitment Plan and Cost Projection Year 1 23/24

Recruitment Plan

a	Roles	Banding	WTE Gap	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Clinical CRI Hub (includes ATS)	Service Manager	8a	0.50				Recruitment			Commence Post					
	GP Clinical	GP Scale	0.22				Recruitment		Commence Post						
	GP Strategic Sessions	GP Scale	0.20	In Post											
	Team Lead Nurse	7	0.25				Recrtruitment			Commence Post					
	Adult Nurse	6	0.85				Recrtruitment			Commence Post					
	Paeds Nurse	6	0.38				Recrtruitment			Commence Post					
	Midwife	7	0.85				Recruitment		Commence Post						
	Health Visitor	6	0.75				Recruitment		Commence Post						
	HCSW	3	1.46				Recruitment			Commence Post					
	High Intensity Therapist	7	1.25				Recruitment			Commence Post					
	Adult Social Worker	G8	0.63				Recruitment			Commence Post					
	Pharmacist ID	8a	0.05	In Post											
	Paediatric Consultant ID	Cons	0.05	In Post											
	Adult Consultant ID	Cons	0.05	In Post											
Admin CRI Hub	Receptionist	2	1.78	In Post-0.6 WTE			Recruitment-1.18 WTE		Commence Post (Full WTE)						
	Receptionist	3	0.50				Recruitment			Commence Post					
	Care Navigator	3	0.88				Recruitment			Commence Post					
Outreach	GP Clinical	GP Scale	1.28	In Post-0.4 WTE			Recruitment-0.88 WTE		Commence Post (Full WTE)						
	Adult Nurse	6	2.38				Recruitment			Commence Post					
	Team Lead Nurse	7	0.15				Recruitment			Commence Post					
Inreach	GP Clinical	GP Scale	0.38				Recruitment		Commence Post						
	Adult Nurse	6	2.80	In Post-2 WTE			Recruitment -0.8 WTE			Commence Post (Full WTE)					
	Team Lead Nurse	7	0.25				Recruitment			Commence Post					
Dental	Senior Dental Officer	LD11	0.20				Recruitment			Commence Post					
	Dental Therapist	XR06	0.40				Recruitment			Commence Post					
	Dental Nurse	XR05	0.60				Recruitment			Commence Post					
	Administrative Support	XR03	0.60				Recruitment			Commence Post					

Recruitment- refers to advertisement, recruitment and lead in

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				24/25 Expenditure Profile: Staff												
Area	Role	Banding	WTE Gap	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Clinical CRI Hub (includes ATS)	Service Manager	8a	0.50	£0	£0	£0	£0	£0	£0	£3,069	£3,069	£3,069	£3,069	£3,069	£3,069	£18,414
	GP Clinical	GP Scale	0.22	£0	£0	£0	£0	£0	£2,351	£2,351	£2,351	£2,351	£2,351	£2,351	£2,351	£16,457
	GP Strategic Sessions	GP Scale	0.20	£2,137	£2,137	£2,137	£2,137	£2,137	£2,137	£2,137	£2,137	£2,137	£2,137	£2,137	£2,137	£25,642
	Team Lead Nurse	7	0.25	£0	£0	£0	£0	£0	£0	£1,336	£1,336	£1,336	£1,336	£1,336	£1,336	£8,016
	Adult Nurse	6	0.85	£0	£0	£0	£0	£0	£0	£3,854	£3,854	£3,854	£3,854	£3,854	£3,854	£23,124
	Paeds Nurse	6	0.38	£0	£0	£0	£0	£0	£0	£1,723	£1,723	£1,723	£1,723	£1,723	£1,723	£10,338
	Midwife	7	0.85	£0	£0	£0	£0	£0	£4,542	£4,542	£4,542	£4,542	£4,542	£4,542	£4,542	£31,794
	Health Visitor	6	0.75	£0	£0	£0	£0	£0	£3,400	£3,400	£3,400	£3,400	£3,400	£3,400	£3,400	£23,800
	HCSW	3	1.46	£0	£0	£0	£0	£0	£0	£3,714	£3,714	£3,714	£3,714	£3,714	£3,714	£22,284
	High Intensity Therapist	7	1.25	£0	£0	£0	£0	£0	£0	£6,679	£6,679	£6,679	£6,679	£6,679	£6,679	£40,074
	Adult Social Worker	G8	0.63	£0	£0	£0	£0	£0	£0	£2,750	£2,750	£2,750	£2,750	£2,750	£2,750	£16,500
	Pharmacist ID	8a	0.05	£307	£307	£307	£307	£307	£307	£307	£307	£307	£307	£307	£307	£3,682
	Paediatric Consultant ID	Cons	0.05	£633	£633	£633	£633	£633	£633	£633	£633	£633	£633	£633	£633	£7,599
	Adult Consultant ID	Cons	0.05	£633	£633	£633	£633	£633	£633	£633	£633	£633	£633	£633	£633	£7,599
Admin CRI Hub	Receptionist	2	1.78	£1,399	£1,399	£1,399	£1,399	£1,399	£4,080	£4,080	£4,080	£4,080	£4,080	£4,080	£4,080	£35,555
	Receptionist (2 WTE uplift B2-B3)	3	0.50	£0	£0	£0	£0	£0	£0	£1,697	£1,697	£1,697	£1,697	£1,697	£1,697	£10,182
	Care Navigator	3	0.88	£0	£0	£0	£0	£0	£0	£2,239	£2,239	£2,239	£2,239	£2,239	£2,239	£13,434
Outreach	GP Clinical	GP Scale	1.28	£4,274	£4,274	£4,274	£4,274	£4,274	£13,676	£13,676	£13,676	£13,676	£13,676	£13,676	£13,676	£117,101
	Adult Nurse	6	2.38	£0	£0	£0	£0	£0	£0	£10,971	£10,971	£10,971	£10,971	£10,971	£10,971	£65,826
	Team Lead Nurse	7	0.15	£0	£0	£0	£0	£0	£0	£802	£802	£802	£802	£802	£802	£4,812
Inreach	GP Clinical	GP Scale	0.38	£0	£0	£0	£0	£0	£4,060	£4,060	£4,060	£4,060	£4,060	£4,060	£4,060	£28,420
	Adult Nurse*	6	2.80	£11,234	£11,234	£11,234	£11,234	£11,234	£11,234	£15,729	£15,729	£15,729	£15,729	£15,729	£15,729	£161,778
	Team Lead Nurse	7	0.25	£0	£0	£0	£0	£0	£0	£1,336	£1,336	£1,336	£1,336	£1,336	£1,336	£8,016
Dental	Senior Dental Officer	LD11	0.20	£0	£0	£0	£0	£0	£0	£1,892	£1,892	£1,892	£1,892	£1,892	£1,892	£11,352
	Dental Therapist	XR06	0.40	£0	£0	£0	£0	£0	£0	£1,814	£1,814	£1,814	£1,814	£1,814	£1,814	£10,884
	Dental Nurse	XR05	0.60	£0	£0	£0	£0	£0	£0	£2,195	£2,195	£2,195	£2,195	£2,195	£2,195	£13,170
	Administrative Support	XR03	0.60	£0	£0	£0	£0	£0	£0	£1,526	£1,526	£1,526	£1,526	£1,526	£1,526	£9,156
	TOTAL		**19.66**	**£20,617**	**£20,617**	**£20,617**	**£20,617**	**£20,617**	**£47,053**	**£99,145**	**£99,145**	**£99,145**	**£99,145**	**£99,145**	**£99,145**	**£745,009**

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	24/25 Expenditure profile: Non Staff												
Item	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Additional staff equipment	£0	£0	£15,000	£0	£0	£0	£0	£0	£0	£0	£0	£0	£15,000
Clinical Service and Supplies (25% increase)	£0	£0	£0	£0	£0	£0	£1,013	£1,013	£1,013	£1,013	£1,013	£1,013	£6,078
Travel expenses	£0	£500	£500	£500	£500	£500	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£8,500
Training	£1,667	£1,667	£1,667	£1,667	£1,667	£1,667	£1,667	£1,667	£1,667	£1,667	£1,667	£1,667	£20,000
British Red Cross	£2,000	£2,000	£2,000	£2,000	£2,000	£2,000	£6,142	£6,142	£6,142	£6,142	£6,142	£6,142	£48,854
Security	£6,000	£6,000	£6,000	£6,000	£6,000	£6,000	£6,000	£6,000	£6,000	£6,000	£6,000	£6,000	£72,000
Dentistry Ihalation and sediation equipment/servicing	£0	£0	£0	£0	£0	£0	£167	£167	£167	£167	£167	£167	£1,002
Dentistry Consumables	£0	£0	£0	£0	£0	£0	£2,875	£2,875	£2,875	£2,875	£2,875	£2,875	£17,250
Van costs (Tax, Diesel, MOT, running costs etc.)	£1,071	£1,071	£1,071	£1,071	£1,071	£1,071	£1,071	£1,071	£1,071	£1,071	£1,071	£1,071	£12,850
Total	£10,738	£11,238	£26,238	£11,238	£11,238	£11,238	£19,935	£19,935	£19,935	£19,935	£19,935	£19,935	**£201,534**

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Report Title:	Regional Partnership Board Funding Stream Q4 reports 2023-24 and Financial Plans for 2024-25			Agenda Item no.	4.1
Meeting:	Finance and Performance Committee	Public	X	Meeting Date:	19.06.24
		Private			
Status *(please tick one only):*	Assurance		Approval		Information X
Lead Executive:	Executive Director of Strategic Planning				
Report Author (Title):	Head of Partnerships and Assurance				

Main Report
Background and current situation:

Regional Partnership Board Funding Stream Q4 reports 2023-24

The Cardiff and Vale of Glamorgan Regional Partnership Board (RPB) was established in response to requirements of the Social Services and Well-being (Wales) Act 2014. Its purpose is to manage and develop services to secure better joint working between local health boards, local authorities and the third sector; and to ensure effective services, care and support that best meet the needs of our population. Cardiff and Vale UHB plays the role of 'banker' for RPB funding streams on behalf of the region.

In 2023-24, the Regional Partnership Board oversaw the following funding streams on behalf of the region:

- Regional Integration Fund (RIF) (£19,361k)
- Wales Community Care Information System (WCCIS) (£190k)
- Short Breaks for Unpaid Carers (£172k)
- Neurodiversity (£501k)
- Regional Innovation Co-ordination Hub (RICH) (£250k)
- Early Years (£1,016k)
- IRCF (Capital Fund) Revenue (£700k)
- **Total: £22,190k.**

A full description of each fund to together with the end of year reports which have been prepared in line with Welsh Government expectations are accessible via this hyperlink to the private page of the Cardiff and Vale RPB website. Please use the password: APRIL2024!

A high-level overview of the emerging financial and performance status provided within the reports for each funding stream is attached as ***Appendix 1.*** In addition to the Welsh Government reports, the RPB team have also prepared a set of Dashboards for local information and assurance. These contain particular information relating to the financial allocations by partner for each element of the RIF and are available on the same webpage noted above.

Financial Plans for 2024-25

Welsh Government have allocated a range of funding streams to the RPB for use in 2024-25. Overall allocations along with the anticipated expenditure by partner and programme are outlined below.

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i Regional Integration Fund (RIF)

Forecast 24/25 - Partner Expenditure Plan		Programme Expenditure 2024/25 £					
Programme	Allocation £	UHB	Cardiff LA	Vale LA	Third Sector	Total	Variance
RPB Infrastructure		710,000	20,000	20,000	0	750,000	
At Home		2,130,331	5,131,785	1,619,087	382,528	9,263,731	
emPower		1,120,779	2,181,549	622,926	200,100	4,125,354	
Complex Health and Learning Disability		487,079	174,938	158,310	0	820,328	
Learning Disabilities		181,270	1,020,493	515,771	140,000	1,857,534	
Unpaid Carers		13,042	0	0	469,602	482,643	
ICF Autism		397,728	0	0	0	397,728	
ICF Dementia		1,050,885	226,115	88,000	135,000	1,500,000	
Short breaks		0	0	0	172,237	172,237	
Social Value		60,000	0	0	0	60,000	
Carers		60,000	0	0	0	60,000	
Total	19,362,904	6,211,114	8,754,880	3,024,095	1,499,466	19,489,555	126,651

The Partner expenditure profiles present a variance against allocation which is not considered a material risk across partner organisations and is expected to be managed via slippage through the financial year.

ii Other funding streams

Forecast 24/25 - Partner Expenditure Plan		Programme Expenditure 2024/25 £					
Programme	Allocation £	UHB	Cardiff LA	Vale LA	Third Sector	Total	Variance
WCCIS	190,000	90,000		100,000		190,000	0
Neurodiversity	635,232	630,646	25,000			655,646	20,414
RIC Hub	250,000	250,000				250,000	0
Total	1,075,232	970,646	25,000	100,000	0	1,095,646	20,414

All funding streams have structures in place to ensure effective management with overall assurance provided via the Strategic Leadership Group.

Colleagues will note an anticipated over-commitment within the proposed expenditure for RIF Neurodiversity funding streams. As with the RIF above, partners have made an explicit commitment that any consequent end of year overspend will need to be managed locally by individual partners.

In addition, guidance has been developed to support overall management of the funding streams which includes:

- Senior Responsible Owner responsibilities, including the introduction of Lead and Associate SROs for projects where funding spans across numerous partners
- Budget and performance management guidance and the role of the RPB team in supporting these functions
- Reporting timelines
- A 'Who's who' of all SROs and financial support leads across the programmes.

Strict arrangements are in place to ensure that all over commitments are brought back in line with overall allocations by the end of the financial year.

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

Regional Partnership Board Funding Stream Q4 reports 2023-24

The RPB has delegated responsibility for the assurance and performance management of its revenue funding streams to the Strategic Leadership Group (SLG). SLG considered a high-level overview of the emerging financial and performance status provided within the reports for each

funding stream together with an indication of the key leads from across the region who had been asked to verify their content.

Following this review, the SLG approved all reports for submission to Welsh Government on 30th April in line with reporting requirements. These were then ratified by the Regional Partnership Board on 13th May 2024.

Financial Plans for 2024-25

Based upon the recommendations from operational colleagues across the partnership, the Strategic Leadership Group has agreed to accept the recommended over-commitment of RIF and Neurodiversity funding with the expectation that this risk would be managed in year in line with the original Welsh Government allocation.

Recommendation:

The Finance and Performance Committee is requested to note for information:
- the Q4 report for RPB funding in 2023-24
- the agreed RPB budget allocations for 2024-25.

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

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

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

Prevention		Long term		Integration		Collaboration		Involvement	✓

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

Risk: Yes

Risk assessments covering data quality, financial activity and actual performance for each priority continue to be reviewed and updated regularly as part of quarterly performance reporting.

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Safety: Yes

Safety is a consideration at specific project level where appropriate.

Financial: Yes

The match funding requirement contained within the original RIF guidelines has now been cancelled by the Minister. However, the over-commitment referenced within the main report is a risk which will be closely managed throughout the year to ensure a return within allocation by the end of the year.

Workforce: Yes
The capacity and development of our workforce will be fundamental to ensuring delivery of each project within the RIF. Workforce considerations are included within delivery plans for each project.
Legal: Yes
Any legal implications from delivery of specific commitments will be addressed within the delivery plans for each project area.
Reputational: Yes
The RIF contains a series of challenging commitments for focused work over the next 4 years. It will be important for the UHB to be seen to demonstrate ongoing commitment and support to enabling delivery.
Socio Economic: Yes
The RIF has been developed in direct response to WG guidance which outlines the specific needs of key population groups across our region including those with various socio-economic disadvantages e.g. older people, children, people with learning disabilities, etc. The delivery plans for each project include an overview of engagement intentions and the outcomes to be achieved as a result. *Useful Guidance on the application of the Socio-Economic Duty can be found at the following link: The Socio-economic Duty: guidance | GOV.WALES* *(If this has been addressed in the main body of the report, please confirm)*
Equality and Health: No
Given the broad nature of the RIF, Equality Health Impact Assessments (EHIA) will be undertaken for each project where necessary.
Decarbonisation: Yes
Decarbonisation is a shared commitment for all partners within the RPB and project delivery plans will be required to take this into account where appropriate.

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

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Appendix 1: End of Year Overview – Emerging End of Year Position as of 18.04.24

Programme	Amount (£k) 2023-24	Cumulative Q4 Total Spend (£k)	Description	Status @Q3	Status @Q4	Overview of Risk Assessment	Approval process
Regional Integration Fund	*16,714*	*16,747*	Starting Well emPOWER	**Green**	**Green**	Project performance in line with stated objectives.	Becci Ingram, CAV UHB, by email and meeting on 25.4.24.
			Starting Well Complex Health & Learning Disabilities	**Green**	**Green**	Project performance in line with stated objectives.	Becci Ingram, CAV UHB, by email and meeting on 25.4.24.
			Learning Disabilities	**Green**	**Green**	Project performance in line with stated objectives.	Jane Thomas, Cardiff LA 22.4.24.
			Unpaid Carers	**Amber**	**Red**	Issues with delivery due to closure of 3rd sector organisation affected performance and spend. Action plan in place for delivery from April onwards.	Unpaid Carers Board 19.04.24
			@Home	**Green**	**Green**	Project performance in line with stated objectives.	@Home engine room 30.04.24
	397	*397*	Integrated Autism Service	**Green**	**Green**	Project performance in line with stated objectives.	Dan Crossland and Cath Wood, CAV UHB 22.4.24.
	1,500	*1,444*	Dementia	**Green**	**Green**	Project performance in line with stated objectives.	Dementia Delivery Group 14.05.24
	750	773	Infrastructure	**Green**	**Green**	Project performance in line with stated objectives.	Cath Doman
Total	**19,361**	**19,361**					

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Programme	Amount (£k) 2023-24	Cumulative Q4 Total Spend (£k)	Description	Status RAG @Q3	Status RAG @Q4	Overview of Risk Assessment	Approval process
WCCIS	*190*	*190*	Regional data collation for WG. No associated funding.	**Green**	**Green**	Project performance in line with stated objectives.	Cath Doman
Short Breaks	*172*	*172*	*3rd sector grants for unpaid carer short breaks*	**Green**	**Green**	Project performance in line with stated objectives.	Unpaid Carers Board 19.04.24
Neuro-diversity	*501*	*501*	Regional Neurodivergence Improvement Programme	**Green**	**Green**	Project performance in line with stated objectives.	Dan Crossland and Cath Wood, CAV UHB by email w/c 22.4.24.
Regional Innovation Co-ordination Hub	*250*	*250*	Regional Innovation Co-ordination Hub	**Green**	**Green**	Project performance in line with stated objectives.	Cath Doman approved on 19.04.24
Early Years	1,016	1,016	Early Years Integration Transformation Programme	**Green**	**Green**	Project performance in line with stated objectives.	Avril Hooper-Williams, by email w/c 22.4.24 - Q4 and programme closure 31.3.24 - report
IRCF	700	700	Revenue support for capital programmes	**Green**	**Green**	Project performance in line with stated objectives.	Cath Doman

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Report Title:	**2024-25 Month 2 Monthly Financial Monitoring Return**				Agenda Item no.	4.1	
Meeting:	**Finance Committee**		Public	X	Meeting Date:	**19th June 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 May 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:	
Finance Committee	Date: 19th June 2024

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THE WELSH GOVERNMENT FINANCIAL COMMENTARY

FINANCIAL POSITION FOR THE TWO MONTH PERIOD ENDED 31st MAY 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 2 the UHB is reporting an overspend of £8.821m.

This is comprised of £4.614m unidentified savings, £1.557m of operational overspend and the planned deficit of £2.650m (two twelfths of the annual planned deficit of £15.9m set out in 2024-25 draft 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)	(36.9)
Savings Target	(47.2)	
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 31st May 2024.

A full commentary has been provided to cover the tables requested for the month 2 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 2 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 now 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.

At month 2, the risk associated with Industrial Action (IA) by medical staff where IA has been suspended during negotiations has been withdrawn. In addition, the risk associated with the WHSCC ICP has been removed.

The threat that LTAs and SLAs are not agreed, as instructed by Welsh Government, to reflect uplifts in line with the general 3.67% 2024-25 funding uplift provided in the 2024-25 Allocation Letter has been added to the risk schedule at month 2. The risk has been calculated at £5.274m

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 without 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

ACTUAL YEAR TO DATE (TABLE B AND B2)

Table B confirms the year to date deficit of £8.821m which is an in month deterioration of £4.554m. The year to date deficit and the forecast deficit of £15.900m is shown in Table 2.

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

	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**

The month 2 deficit of £8.821m comprised of the following:

- £2.650m planned deficit
- £4.614m unachieved CRP gap
- £1.557m adverse variance against plan.

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It is anticipated that the adverse operational variance of £1.557m and unachieved CRP gap at month 2 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 Performance Reviews with the UHBs Clinical Boards will be on ensuring operational pressures are addressed and managed and 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 and the revised national Optometry Framework in month 2. 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 £0.706m in month primarily due to nursing pressures. £0.490m of the costs recorded in May related to registered nursing and midwifery.

COVID 19 ANALYSIS (TABLE B3)

At month 2, Table B3 reported 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 2 £m	Forecast £m	Funded by WG £m	Variance to Plan/Funding £m
Health Protection/Vaccination & PPE	1.507	9.040	9.040	0.000
Long Covid	0.191	1.144	1.144	0.000
Sub Total WG Funded Covid Expenditure £m	**1.697**	**10.184**	**10.184**	**0.000**

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The Business Plan to the continuing Covid Programmes is currently subject to review and the UHB expects to revise the profile of expenditure included in Table B3 in due course.

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 2, the UHB had identified £20.989m (44%) of green and amber savings to deliver against the £47.2m savings target leaving a further £26.311m schemes unidentified. In addition, there are a further £12.804m of red schemes in the pipeline which will reduce the shortfall to £13.406m 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	33.794	(13.406)

The £4.614m 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 position is expected to be recovered as further schemes develop over the financial year. The reported gap includes red schemes, in accordance with the Welsh Government instruction 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 £6.402m of savings schemes for 2024-25 would be reported as identified at Month 2.

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.

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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 offers, from a number of commissioners, which offer a lower percentage uplift than 3.67%. Commissioners have suggested that Cardiff and Vale UHB should provide additional activity and services if the UHB wishes to increase its overall income by 3.67%.

The current range of offers from commissioners could cause up to a £5.274m shortfall in the income anticipated in the UHB Financial Plan approved by the UHB Board.

The Director of Finance is currently engaged in discussions with commissioner organisation colleagues to resolve this issue. Failure to resolve this disagreement may oblige the UHB to pursue the Welsh Government arbitration process. This places the UHB at risk of a potential adverse judgment that would impact it's Financial Plan by up to £5.274m.

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.

MONTHLY CASFLOW FORECAST (TABLE G)

The closing cash balance at the end of May, was £6.691m.

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

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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 May was 97.8%.

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

Of the UHB's approved Capital Resource Limit, 2% has been expended to date.

All other schemes are currently in line with forecast.

Planned expenditure for the year reflects the CRL received from Welsh Government dated 14th May 2024 - £33.942m.

AGED WELSH NHS DEBTORS (TABLE M)

On the 31st of May 2024 there were invoices raised by the UHB against other Welsh NHS bodies which had been outstanding for more than 17 weeks.

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 two months is a reported overspend of £8.821m which is £6.171m above the £2.650m straight line profile of the planned deficit.

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.....
SUZANNE RANKIN
CHIEF EXECUTIVE

13th June 2024

.....
CATHERINE PHILLIPS
EXECUTIVE DIRECTOR OF FINANCE

13th June 2024

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Cardiff & Vale ULHB **Period : May 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
		£'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
2	Cost Pressures (Non Covid-19) (Negative Value)	-45,400	-45,400		
3	Planned Expenditure For Covid-19 (Negative Value)	-10,184	-10,184		
4	Allocation Letter Revenue Funding Uplift / (Reduction)/ WG RRL / WG Income Uplift / (Reduction/ Non-Covid)	37,300	37,300		
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	10,184	10,184		
6	Other Income Uplift / (Reduction)	5,900	5,900		
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0
8	Planned (Finalised) Green and Amber Savings Plan	20,272	8,928	11,344	13,205
9	Planned (Finalised) Net Income Generation	717	492	226	236
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
12		0	0		
13	Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	26,211	26,211		
14	**Opening IMTP / Annual Operating Plan**	**-15,900**	**33,430**	**-49,330**	**-47,459**
15	Reversal of Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	-26,211	-26,211	0	0
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)	0	0		
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
18	Other Movement in Month 1 Planned & In Year Net Income Generation	-438	-439	1	0
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-6,700	-3,563	-3,136	0
20	Additional In Year Identified Savings - Forecast	0	0	0	0
21	Variance to Planned RRL & Other Income	0	0		
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 plus virements (Positive Value - additional)	0	0		
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0		
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	0	0		
25	In Year Accountancy Gains (Positive Value)	0	0	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	0	0		
27	Savings Gap / Savings Gap Recovery	28,735	0	28,735	31,559
28	Operational Ovespend / Recovery	4,614	4,614		0
29		0	0		
30		0	0		
31		0	0		
32		0	0		
33		0	0		
34		0	0		
35		0	0		
36		0	0		
37		0	0		
38		0	0		
39		0	0		
40	**Forecast Outturn (- Deficit / + Surplus)**	**-15,900**	**7,832**	**-23,732**	**-15,900**
41	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**			
42	**Operational - Forecast Outturn (- Deficit / + Surplus)**	**-15,900**			

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-5,075	-10,150	-60,900
2	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-3,783	-7,567	-45,400
3	-822	-822	-848	-837	-837	-837	-837	-882	-882	-882	-849	-850	-1,645	-10,184
4	3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	3,108	6,217	37,300
5	822	822	848	837	837	837	837	882	882	882	849	850	1,645	10,184
6	492	492	492	492	492	492	492	492	492	492	492	492	983	5,900
7	821	336	-125	194	-398	-126	-185	-49	-51	-50	-75	-291	1,157	0
8	890	1,348	1,804	1,485	2,076	1,805	1,730	1,773	1,775	1,774	1,799	2,014	2,238	20,272
9	38	65	71	71	71	71	204	25	25	25	25	25	103	717
10													0	0
11													0	0
12													0	0
13	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	2,184	4,368	26,211
14	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-1,325**	**-2,650**	**-15,900**
15	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-2,184	-4,368	-26,211
16													0	0
17													0	0
18	0	-57	-47	-47	-47	-47	-181	-2	-2	-2	-2	-2	-57	-438
19	-39	-389	-385	-434	-623	-636	-646	-689	-665	-668	-694	-833	-428	-6,700
20	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21													0	0
22	0	0	0	0	0	0	0	0	0	0	0	0	0	0
23													0	0
24	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26													0	0
27		239	2,616	2,666	2,854	2,867	3,011	2,875	2,851	2,855	2,880	3,020	239	28,735
28	-719	-838	617	617	617	617	617	617	617	617	617	617	-1,557	4,614
29													0	0
30													0	0
31													0	0
32													0	0
33													0	0
34													0	0
35													0	0
36													0	0
37													0	0
38													0	0
39													0	0
40	**-4,267**	**-4,554**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-8,821**	**-15,900**
41	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
42	**-4,267**	**-4,554**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-708**	**-8,821**	**-15,900**

Regan Mills
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Cardiff & Vale ULHB

Period : May 24

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

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Pay	Budget/Plan	466	585	582	652	823	777	773	815	789	788	813	813	1,052	8,678		0	535			
2		Actual/F'cast	497	399	408	470	461	416	404	404	404	399	399	399	896	5,059	17.71%	4,876	183	2,052	3,007	5,602
3		Variance	30	(186)	(174)	(183)	(362)	(362)	(369)	(412)	(386)	(389)	(414)	(414)	(155)	(3,619)	*(14.79%)*	4,876	-352			
4	Non-Pay	Budget/Plan	259	479	810	508	727	594	601	601	629	629	629	845	738	7,311		5,936	1,376			
5		Actual/F'cast	257	259	611	269	478	332	336	336	362	362	362	437	517	4,403	11.74%	3,235	1,167	2,523	1,879	3,193
6		Variance	(2)	(219)	(198)	(239)	(249)	(262)	(265)	(265)	(267)	(267)	(268)	(407)	(221)	(2,909)	*(29.98%)*	-2,700	-208			
7	Primary Care - Drugs & Appliances	Budget/Plan	105	106	106	106	106	106	106	106	106	106	106	106	211	1,268		768	500			
8		Actual/F'cast	41	170	99	99	99	99	99	99	99	99	99	99	211	1,200	17.60%	700	500	0	1,200	1,768
9		Variance	(64)	64	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	(7)	0	(68)	*0.00%*	-68	0			
10	Secondary Care Drugs	Budget/Plan	15	133	259	171	161	238	161	161	161	161	161	161	148	1,940		1,924	16			
11		Actual/F'cast	11	85	253	165	155	232	155	155	155	155	155	155	97	1,836	5.27%	1,820	16	280	1,556	2,078
12		Variance	(3)	(48)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(51)	(104)	*(34.43%)*	-104	0			
13	CHC/FNC	Budget/Plan	45	45	48	48	260	90	90	90	90	90	90	90	90	1,075		225	850			
14		Actual/F'cast	45	45	48	48	260	90	90	90	90	90	90	90	90	1,075	8.37%	225	850	510	565	565
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	*0.00%*	0	0			
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	1,804	1,485	2,076	1,805	1,730	1,773	1,775	1,774	1,799	2,014	2,238	20,272		8,852	0			
35		Actual/F'cast	852	959	1,419	1,051	1,454	1,169	1,084	1,084	1,110	1,105	1,105	1,181	1,811	13,573		10,856	2,716	5,365	8,207	13,205
36		Variance	(39)	(389)	(385)	(434)	(623)	(636)	(646)	(689)	(665)	(668)	(694)	(833)	(428)	(6,700)		2,004	2,716			
37	Variance in month		(4.34%)	(28.85%)	(21.34%)	(29.23%)	(29.98%)	(35.23%)	(37.33%)	(38.85%)	(37.47%)	(37.68%)	(38.56%)	(41.38%)	(19.10%)							
38	In month achievement against FY forecast		6.28%	7.07%	10.45%	7.74%	10.71%	8.61%	7.99%	7.99%	8.18%	8.14%	8.14%	8.70%								

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Table C1- Savings Schemes Pay Analysis

		Month	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD	Full-year forecast	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
1	Pay - General & Substantive	Budget/Plan	167	230	227	233	404	404	399	442	416	415	440	440	397	4,216	0	135			
2		Actual/F'cast	167	211	231	228	220	220	209	209	209	204	204	204	378	2,516	2,381	135	355	2,161	4,321
3		Variance	0	(19)	4	(5)	(183)	(183)	(191)	(233)	(207)	(211)	(236)	(236)	(19)	(1,701)	2380.7261	0			
4	Pay - Variable	Budget/Plan	299	355	355	419	419	373	373	373	373	373	373	373	654	4,462	0	400			
5		Actual/F'cast	330	188	177	241	241	195	195	195	195	195	195	195	518	2,543	2,495	48	1,697	847	1,281
6		Variance	30	(167)	(178)	(178)	(178)	(178)	(178)	(178)	(178)	(178)	(178)	(178)	(136)	(1,919)	2,495	(352)			
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	1,052	8,678	0	535			
11		Actual/F'cast	497	399	408	470	461	416	404	404	404	399	399	399	896	5,059	4,876	183	2,052	3,007	5,602
12		Variance	30	(186)	(174)	(183)	(362)	(362)	(369)	(412)	(386)	(389)	(414)	(414)	(155)	(3,619)	4,876	(352)			

Table C2- V&S Saving Categories

		Month	1 Apr £'000	2 May £'000	3 Jun £'000	4 Jul £'000	5 Aug £'000	6 Sep £'000	7 Oct £'000	8 Nov £'000	9 Dec £'000	10 Jan £'000	11 Feb £'000	12 Mar £'000	Total YTD	Full-year forecast
1	Workforce	Budget/Plan	466	585	582	652	823	777	773	815	789	788	813	813	1,052	8,678
2		Actual/F'cast	497	399	408	470	461	416	404	404	404	399	399	399	896	5,059
3		Variance	30	(186)	(174)	(183)	(362)	(362)	(369)	(412)	(386)	(389)	(414)	(414)	(155)	(3,619)
4	Medicines Management	Budget/Plan	120	239	364	276	266	343	266	266	266	266	266	266	359	3,207
5		Actual/F'cast	53	255	352	264	254	331	254	254	254	254	254	254	308	3,036
6		Variance	(67)	16	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(12)	(51)	(172)
7	Procurement & Non-pay	Budget/Plan	259	479	810	508	727	594	601	601	629	629	629	845	738	7,311
8		Actual/F'cast	257	259	611	269	478	332	336	336	362	362	362	437	517	4,403
9		Variance	(2)	(219)	(198)	(239)	(249)	(262)	(265)	(265)	(267)	(267)	(268)	(407)	(221)	(2,909)
10	CHC	Budget/Plan	45	45	48	48	260	90	90	90	90	90	90	90	90	1,075
11		Actual/F'cast	45	45	48	48	260	90	90	90	90	90	90	90	90	1,075
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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	1,804	1,485	2,076	1,805	1,730	1,773	1,775	1,774	1,799	2,014	2,238	20,272
23		Actual/F'cast	852	959	1,419	1,051	1,454	1,169	1,084	1,084	1,110	1,105	1,105	1,181	1,811	13,573
24		Variance	(39)	(389)	(385)	(434)	(623)	(636)	(646)	(689)	(665)	(668)	(694)	(833)	(428)	(6,700)

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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	850	1,349	1,804	1,485	2,076	1,805	1,730	1,773	1,775	1,774	1,799	2,014	2,239	20,272	8,928	11,344	1,882	13,226
	Month 1 - Actual/Forecast	852	959	1,419	1,051	1,454	1,169	1,084	1,084	1,110	1,105	1,105	1,181	1,811	13,573	5,365	8,207	4,998	13,205
	Variance	(39)	(390)	(385)	(434)	(622)	(636)	(646)	(689)	(665)	(668)	(694)	(833)	(428)	(6,699)	(3,563)	(3,136)	3,116	(21)
	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	850	1,349	1,804	1,485	2,076	1,805	1,730	1,773	1,775	1,774	1,799	2,014	2,239	20,272	8,928	11,344	1,882	13,226
	Total Actual/Forecast	852	959	1,419	1,051	1,454	1,169	1,084	1,084	1,110	1,105	1,105	1,181	1,811	13,573	5,365	8,207	4,998	13,205
	Total Variance	(39)	(390)	(385)	(434)	(622)	(636)	(646)	(689)	(665)	(668)	(694)	(833)	(428)	(6,699)	(3,563)	(3,136)	3,116	(21)
Net Income Generation	Month 1 - Plan	38	85	71	71	71	71	204	25	25	25	25	25	103	717	492	226	10	236
	Month 1 - Actual/Forecast	38	8	23	23	23	23	23	23	23	23	23	23	46	279	53	226	10	236
	Variance	0	(77)	(47)	(47)	(47)	(47)	(181)	(2)	(2)	(2)	(2)	(2)	(57)	(438)	(439)	1	(1)	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	85	71	71	71	71	204	25	25	25	25	25	103	717	492	226	10	236
	Total Actual/Forecast	38	8	23	23	23	23	23	23	23	23	23	23	46	279	53	226	10	236
	Total Variance	0	(77)	(47)	(47)	(47)	(47)	(181)	(2)	(2)	(2)	(2)	(2)	(57)	(438)	(439)	1	(1)	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	1,874	1,555	2,147	1,875	1,934	1,798	1,800	1,799	1,825	2,040	2,341	20,989	9,420	11,570	1,872	13,441
	Month 1 - Actual/Forecast	890	967	1,442	1,074	1,477	1,192	1,107	1,107	1,133	1,128	1,128	1,204	1,857	13,852	5,418	8,434	5,008	13,441
	Variance	(39)	(468)	(432)	(481)	(670)	(683)	(828)	(691)	(667)	(671)	(696)	(836)	(484)	(7,136)	(4,002)	(3,136)	3,136	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	928	1,413	1,874	1,555	2,147	1,875	1,934	1,798	1,800	1,799	1,825	2,040	2,341	20,989	9,420	11,570	1,872	13,441
	Total Actual/Forecast	890	967	1,442	1,074	1,477	1,192	1,107	1,107	1,133	1,128	1,128	1,204	1,857	13,852	5,418	8,434	5,008	13,441
	Total Variance	(39)	(468)	(432)	(481)	(670)	(683)	(828)	(691)	(667)	(671)	(696)	(836)	(484)	(7,136)	(4,002)	(3,136)	3,136	0

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	4,252	4,077	350	**8,680**	279	0
Scheduled Care	0	1,038	0	**1,038**	0	0
Unscheduled Care	0	755	0	**755**	0	0
Mental Health	0	0	0	**0**	0	0
Community Services	0	0	0	**0**	0	0
Primary Care	807	1,218	0	**2,025**	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	**5,059**	**7,088**	**350**	**12,498**	**279**	**0**

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Cardiff & Vale ULHB

Period : May 24

This Table is currently showing 0 errors

This table needs completing monthly from Month: 2

Table G - Monthly Cashflow Forecast

		April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £,000	Total £,000
	RECEIPTS													
1	WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA only	132,945	118,770	92,640	112,105	112,581	99,196	106,386	113,931	99,401	103,746	103,761	75,850	1,271,312
2	WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only	1,180	1,180	420	995	990	990	990	990	990	990	990	990	11,695
3	WG Revenue Funding - Other (e.g. invoices)	3,185	1,319	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	4,490	4,490	23,870
4	WG Capital Funding - Cash Limit - LHB & SHA only	10,000	4,000	2,000	2,000	2,532	2,532	2,532	2,532	2,532	2,532	2,532	2,554	38,274
5	Income from other Welsh NHS Organisations	40,964	47,167	47,396	39,370	41,980	40,423	40,477	43,721	40,573	43,520	42,617	48,869	517,076
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	7,575	15,785	10,827	7,387	15,407	7,387	7,120	15,280	7,120	9,248	119,841
11	TOTAL RECEIPTS	**192,642**	**184,770**	**151,329**	**171,553**	**170,209**	**151,826**	**167,090**	**169,859**	**151,914**	**167,365**	**161,510**	**142,001**	**1,982,069**
	PAYMENTS													
12	Primary Care Services : General Medical Services	6,787	6,329	6,697	6,560	6,560	7,025	6,560	6,560	7,025	6,560	6,560	7,025	80,247
13	Primary Care Services : Pharmacy Services	215	140	125	160	160	160	160	160	320	640	320	320	2,881
14	Primary Care Services : Prescribed Drugs & Appliances	8,718	18,833	0	9,225	18,450	0	9,225	18,450	0	9,225	9,225	9,225	110,576
15	Primary Care Services : General Dental Services	2,354	2,429	2,380	2,390	2,390	2,390	2,390	2,390	2,390	2,390	2,390	2,390	28,674
16	Non Cash Limited Payments	2,112	2,077	2,270	2,185	2,185	2,185	2,185	2,185	2,185	2,185	2,185	2,185	26,124
17	Salaries and Wages	70,344	70,347	70,280	69,900	69,875	69,478	69,933	69,699	69,405	69,726	70,245	70,065	839,298
18	Non Pay Expenditure	80,837	87,303	70,536	79,130	68,057	68,057	74,107	67,881	68,057	74,107	68,057	68,218	874,349
19	Short Term Loan Repayment - Trust only													0
20	PDC Repayment - Trust only													0
21	Capital Payment	12,675	1,730	2,000	2,000	2,532	2,532	2,532	2,532	2,532	2,532	2,532	2,473	38,600
22	Other items (Specify in narrative)													0
23	TOTAL PAYMENTS	**184,043**	**189,188**	**154,289**	**171,550**	**170,208**	**151,827**	**167,092**	**169,856**	**151,914**	**167,365**	**161,514**	**161,901**	**2,000,748**
24	Net cash inflow/outflow	8,599	(4,418)	(2,960)	3	0	(1)	(1)	3	(0)	0	(4)	(19,901)	
25	Balance b/f	2,780	11,379	6,961	4,001	4,004	4,005	4,004	4,002	4,005	4,005	4,005	4,001	
26	Balance c/f	11,379	6,961	4,001	4,004	4,005	4,004	4,002	4,005	4,005	4,005	4,001	(15,900)	

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